South Yorkshire and Bassetlaw Integrated Care System
Mental Health & Learning Disabilities
Crisis Pathway Steering Group

South Yorkshire Section 136 Pathway
&
Standard Operating Procedures for Places of Safety

June 2020, V17

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Foreword

This policy has been developed by the South Yorkshire & Bassetlaw Integrated Care System Mental Health & Learning Disabilities Crisis Pathway Steering Group, which sits under the Mental Health Learning Disability Executive Steering Group. The sub group comprises of representatives from South Yorkshire Police, Yorkshire Ambulance Service, South Yorkshire Mental Health Trusts, South Yorkshire Acute Hospital Trusts, South Yorkshire Local Authorities and South Yorkshire Clinical Commissioning Groups.

The Policy has been developed in line with legislative provision, national guidance and local policy, this includes:

- Mental Health Act 1983 (MHA 2007);
- Mental Health Act 1983 Code of Practice 2015;
- Mental Capacity Act 2005 (MCA);
- Police and Criminal Evidence Act 1984 (PACE);
- Policing and Crime Act (2017)
- College of Policing Authorised Professional Practice for Mental Health and Learning Disabilities (2016)
- National Memorandum of Understanding around Police Use of Restraint in Mental Health settings (2016)
- Guidance for Commissioners Service Provision for s136 of the MHA 1983, Royal College of Psychiatrists (2013)
- Royal College of Emergency Medicine: A brief guide to Section 136 Emergency Departments (2017)
- Royal College of Emergency Medicine: Guidelines for the Management of Excited Delirium / Acute Behavioural Disorder (2016)
- Five Year Forward View for Mental Health (2015)
- Prevention Concordat for better Mental Health (2016)
- South Yorkshire Mental Health Toolkit (2018)
- South Yorkshire SYP/NHS Critical Incident Managers and NHS on-call Managers Escalation Protocol – use of Police cells and Police support at Places of Safety (2017)
- South Yorkshire Process for Escalating 136 Bed Closure (2018)
- South Yorkshire Cross Boundary Mental Health Act s136 Agreement (2019)

Whilst this policy has been developed by the SYB ICS it is recognised that the scope could not practically follow the same footprint as SYB ICS given Police and Ambulance boundaries. For this reason the policy is a South Yorkshire policy.

1. INTRODUCTION

This policy details the section 136 pathway across South Yorkshire from the point of:

i) Where section 136(1) power can be used
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The policy has been prepared to ensure that the use of section 136 is within an accepted framework agreed at a South Yorkshire level, ensuring that agencies are not subject to individual practices, which may be diverse.

Beyond formal section 136 arrangements additional alternative services for crisis support have also been commissioned within each Clinical Commissioning Group (Place) area. These alternatives are identified within Place offers set out within this policy document, with the requirement that these alternatives are considered alongside formal section 136 powers to identify the most appropriate intervention for the assessed situation. Further expansion of the Place offer will be undertaken through 2019/20 in line with requirements set out on commissioners and providers by NHS England within the Five Year Forward View for Mental Health. For the avoidance of doubt, alternative forms of crisis provision would not, and are not intended to, constitute formal definition of Place of Safety.

This document also describes arrangements for cross border working to undertake Mental Health Act (MHA) Assessment and arrangements to escalate / raise awareness of a Place of Safety section 136 closure across South Yorkshire agencies.

2. SCOPE

This policy applies to all statutory agencies who fulfil a role in the undertakings and requirements of section 136 of the MHA 1983 and who operate within the boundaries of South Yorkshire.

In relation to the use of other suitable places commissioners will have in place formal arrangements with third parties to establish bespoke places of safety, alternative forms of crisis support commensurate to need, or by undertaking contingency planning with local partners to identify potential temporary places should all other facilities be unavailable for some reason or both.

The aim of the policy is to ensure that South Yorkshire's most vulnerable individuals are cared for in the most effective and most appropriate way through:

- All agencies who are party to this policy are aware of their roles and responsibilities in line with the criteria set out in this policy which reflects and builds on the content of the South Yorkshire Mental Health Toolkit;
- Persons detained under section 136 MHA 1983 are treated with respect, without discrimination and are assessed as quickly as practicable;
- Persons with mental health issues detained for criminal offences, are processed with due regard to the law (a mental disorder whilst correctly taken into consideration is not an automatic bar to due criminal process); and
- All agencies focus on providing the best possible support for the detained person to enable a quick recovery and return to their place in the community.

Interagency co-operation and communication is vital to the effective implementation of this policy and the rapid access to services most appropriate to the needs of the patient.

3. KEY PRINCIPLES OF THE POLICY

Throughout the consultation process steering group representatives across South Yorkshire identified key principles to ensure the county's most vulnerable individuals are cared for in the most effective and most appropriate way. These principles are embedded within the policy and are outlined below:

- Use of Section 136 powers under the Mental Health Act should be reduced where alternative provision to a place of safety i.e. less restrictive alternative to facilitate crisis de-escalation and stabilisation is available and appropriate to the patient need. Appropriate advice and guidance will be obtained via the local mental health triage pathways, where practicable prior to considering detention. For incidents when the consultation requirement is not undertaken by the police, this must be justified, and the reason recorded as this will be subject to review by the local s136 forums.

- The detention period for a person detained under section 136 begins at the point when the person physically enters a place of safety. Time spent travelling to a place of safety or spent outside awaiting opening of a facility does not count.

- If there is no capacity at the local health based place of safety (dedicated s136 suite) it is the Triage healthcare professionals responsibility to identify and facilitate access to a health based place of safety to ensure that there is capacity to receive the person, through the agreed South Yorkshire Process for Escalating 136 Bed Closure Protocol, whether the person is from that area or not. When the Health Based Place of Safety states that it has capacity, this means it is able to receive the detained person as soon as they arrive on site.

- Under exceptional circumstances, i.e. when a person under s136 presents to an Emergency Department (ED) with no physical health needs (due to limited Health Based Place of Safety capacity), the ED cannot refuse access. Given this, when a person detained under s136 is in the ED the police will provide the necessary support in line with the agreed SYP/NHS Joint Escalation Protocol for Critical Incident Managers and NHS On-Call Managers – Use of Police Cells and Police Support at Places of Safety **(Appendix 9)** unless there is mutual agreement between the Department and the police that they are able to leave.

- An ED can itself be a Place of Safety within the meaning of the Mental Health Act. Therefore, if protracted physical health treatment or care is required, where appropriate, the Acute Trust should accept the s136 detention and take legal responsibility for custody of the person for the purpose of the Mental Health Act assessment being carried out. As detailed above, the SYP/NHS Joint Protocol states that in these circumstances, the Police will **NEVER** leave a s136-detained person in ED unless acceptance of the detention has been agreed and the name of the person taking over the responsibility of the s136 detained person has been obtained. Police must satisfy themselves that there is suitable security for the person and staff prior to leaving the ED. If there are disagreements regarding the joint risk assessment and whether the Police should remain these cases should be referred to the Critical Incident Manager for discussion with a Senior NHS representative or out of hours the On-Call Manager. Following departure of the Police from ED, should the behaviour of the detained person deteriorate Police may be asked to return to assist while additional healthcare resources are sought.

- Intoxication whether through drugs or alcohol should not be used as a basis for exclusion from places of safety, and health based places of safety should not be conducting tests to determine intoxication as a reason for exclusion.

- Police and NHS staff should be aware that **Physical Restraint + Mental Health = Medical Emergency** and they should bear in mind Acute Behavioural Disorder (ABD), the potential for drugs and alcohol to mask problems and that resistant, frightened or aggressive behaviour can indicate underlying medical problems. Restraint only complicates those matters, it never does the opposite. Police / NHS should work closely together to promote ABD awareness, training and management of ABD related incidents. **Remember ABD = ED on every occasion**.

- Health Based Places of Safety and local Emergency Departments should have clear pathways and protocols and the relationships to deliver these for those with physical health problems but for whom urgent transfer to an ED is not the optimum course of action. These should include triage, advice and where possible outreach systems to support appropriate responsive and timely physical health care to those in a Health Based Place of Safety.

- While the police or an AMHP has the legal responsibility for authorising the transfer of the detained person, coordinating the conveyance of people between Health Based Places of Safety and ED's and vice versa should be undertaken by the Mental Health Trusts and Acute Trusts respectively. Coordinating and

arranging transport is not the police's role unless there is mutual agreement between parties that it is in the best interest of the person and there is resource to provide support.

- If the Registered Medical Practitioner (wherever possible approved under s12) sees the person before the AMHP and is satisfied that there is no evidence of underlying mental disorder of any kind, the person can no longer be detained and must be immediately released, even if not seen by an AMHP.

- When a Mental Health Act Assessment is required, the legal duty to assess falls upon the AMHP service for the area where the person is at the point when the assessment is needed, in this case the locality in which they are currently being detained under s136.

- The AMHP and doctor approved under Section 12(2) of the Mental Health Act should attend within 3 hours in all cases where there are not good clinical grounds to delay assessment. Where assessments are not completed within 8 hours, a local review should be undertaken to determine reasons for this.

- Partners should maximise opportunities to work collaboratively in relation to the development and delivery of mental health training across South Yorkshire including s136, place of safety provision and ABD.

4. Detention under Section 136

4.1 Definition of section 136(1)

If a person appears to a constable to be suffering from mental disorder and to be in immediate need of care or control the constable may, if he thinks it necessary to do so, in the interests of that person or for the protection of other persons

a) Remove to a place of safety within the meaning of section 135, or
b) If the person is already at a place of safety within the meaning of that section, keep the person at that place or remove the person to another place of safety.

A person removed to, or kept at a place of safety under this section may be detained there for a period not exceeding the permitted period of detention for the purpose of enabling him to be examined by a registered medical practitioner and to be interviewed by an Approved Mental Health Professional (AMHP) and of making any necessary arrangements for his treatment or care.

"Permitted period of detention" means:

a) the period of 24 hours beginning with:
   i) in a case where the person is removed to a place of safety, the time when the person arrives at that place
   ii) in a case where the person is kept at a place of safety, the time when the constable decides to keep the person at that place

4.2 <u>Where section 136(1) power can be used</u>

The power of a constable under section 136(1) may be exercised where the person is at any place, other than:

a) any house, flat or room where that person, or any other person, is living, or
b) any yard, garden, garage or outhouse that is used in connection with the house, flat or room, other than one that is also used in connection with one or more other houses, flats or rooms.

4.3 <u>Power to Enter and Search Premises under s136</u>

The police have a power to enter and search premises in order to exercise a power under s136.

The police have a power to force entry - "s136 (1B) - for the purpose of exercising the power under subsection (1), a constable may enter any place where the power may be exercised, if need be by force." This provides a power to enter premises where s17 (1)(e) Police and Criminal Evidence Act (PACE) does not always apply.

Section 17 of PACE includes powers to force entry to various premises in a range of different situations, but subsection (1) (e) relates to protecting 'life and limb or preventing serious damage to property' and can be exercised to enter any kind of premises. Where concerns for someone's welfare are not quite that serious, but there is a suggestion that someone is in immediate need of care or control because of a mental disorder, the police can force entry to private premises, other than dwellings, in order to exercise powers under s136.

If the police have entered a dwelling under s17 PACE, they cannot exercise powers under s136 MHA.

4.4 Deciding to use section 136(1) and the consultation requirement

When deciding that detention under section 136 MHA 1983 may be necessary, constables are required, if practicable, to consult with a health care professional which is defined below:

a) a registered medical practitioner
b) a registered nurse
c) an approved mental health professional
d) an occupational therapist
e) a paramedic

The purpose of the consultation is for the constable, who is considering using their powers under Section 136(1), to obtain timely and relevant mental health information and advice. This advice will help the officer to consider alternatives to s136 detention, providing further information on the individual or signposting to alternative services.

This process is facilitated by local triage pathways set up in each of the 4 geographical areas across South Yorkshire. Local arrangements must be in place to ensure that there is always a suitable health professional for the police to consult with prior to detaining the person under s136. In order to support this process a checklist has been developed which will assist constables and health care professionals with regards to what information can be requested/provided as part of the telephone triage process. If the person has a Crisis Care Plan in place, the instructions in the Crisis Care Plan for managing a mental health crisis should be followed wherever possible to avoid detention under s136. The Crisis Care Plan should be accessible via the triage process. However, if the person clearly needs "care or control" (as expressed in the MHA 1983) the s136 pathway should be followed.

4.5 Local Telephone Triage Pathways and Supporting Checklist:

- Doncaster MH Telephone Triage Pathway including alternative provision to places of safety **(Appendix 3)**
- Rotherham MH Telephone Triage Pathway including alternative provision to places of safety **(Appendix 4)**
- Sheffield MH Telephone Triage Pathway including alternative provision to places of safety **(Appendix 5)**
- Barnsley MH Telephone Triage Pathway including alternative provision to places of safety **(Appendix 6)**
- MH Telephone Triage Pathway – Supporting Checklist **(Appendix 7)**

When considering the use of police powers to detain a person under the Act, less restrictive alternatives to detention should be considered. Health and/or social care professionals may be able to identify alternative

options in line with local provision set out within **Appendices 3-6**. Intervention should be commensurate and appropriate to need.

In addition, with the person's consent, the police or any other qualified person may convene a mental health assessment without using Section 135 or Section 136 powers, by requesting that a Section 12 approved doctor attend in order to assess the person and make any arrangements for their on-going care. Where appropriate, and depending on specific circumstances, consultation with carers may help particularly in the case of children and young people.

The police retain ultimate responsibility for the decision to use their Section 136 powers, having considered the advice given to them as part of any consultation. The Police/NHS should ensure that any consultation is recorded, including who was consulted and the advice they gave.

Where it is determined following the consultation process that the use of s136 is appropriate, identification of a suitable Health Based Place of Safety and facilitation of access to it will be actioned by the healthcare professional providing the advice **(Appendix 1).**

For incidents when the consultation requirement is not undertaken by the police officer, the officer must be able to justify why they have not done it and the justification must be documented as this will be subject of review at the local s136 meetings. In these circumstances the police officer involved is expected to phone ahead to the nearest agreed Health Based Place of Safety to inform them of the individual's imminent arrival and to confirm that the site is able to receive them. It is the Trusts responsibility to ensure the numbers are available and communicated to key partners and any changes communicated accordingly **(Appendix 1).** Failure by the police officer to ring ahead may result in the person being unable to be accepted upon arrival, resulting in avoidable delay.

Police and health staff must escalate in line with internal escalation policies any concerns in relation to mental health incidents including access to place of safety provision, access to the local Telephone Triage Pathways and quality of advice given as part of the consultation requirement.

4.6 Children and Young People - Section 136 MHA & Section 46 of the Children Act 1983 (PPO)

When responding to incidents involving children who are experiencing mental health problems or distress, the overriding consideration should always be the welfare of the child, ensuring protection from harm and access to assessment where appropriate.

Children of any age may be detained using section 136 MHA 1983, and any person under 18 years of age may be taken into police protection using section 46 of the Children Act 1989.

Where officers have the option to use both statutes, a police protection order (PPO) under the Children Act 1989 may be used, as this is more likely to ensure that the child is not unnecessarily institutionalised or stigmatised by the process. A PPO provides additional flexibility and does not require a police officer to make judgement as to whether a child is likely to be suffering from a mental disorder and 'in need of immediate care and control'. A PPO may be used if a police officer 'has reasonable cause to believe that a child would otherwise be likely to suffer significant harm'.

There is no restriction on where a PPO can be used so police officers may use a PPO to move a disturbed child who is at home, in the interests of their health and safety. The maximum duration of detention under a PPO is 72 hours as opposed to 24 hours for a detention under s136. During this time, officers are able to request that the child has access to all necessary assessments (including, if required, an assessment for detention under section 2 or section 3 MHA 1983 or an assessment by Children's Services).

4.7 Protective searches under Section 136

For s136 detentions the person is considered to be under arrest and any initial search upon first being detained must be justified under s32 of the Police and Criminal Evidence Act 1984 where constables may search someone if there are reasonable grounds to believe they may present a danger to themselves or others and are in possession of something which may be used to escape from lawful custody.

Once the person has arrived at a place of safety or for the purpose of further searches whilst the person remains detained they can be searched under the Mental Health Act s136C(3)

A constable may search a person:

- Section 136(2) - at any time whilst they are held at a Place of Safety following use of s136 (s136C(3))
- Section 136(4) - at any time after they have been transferred from one Place of Safety to another (s136C(3))

This is not a blanket power of search and the constables must have reasonable grounds to believe the person:

a) may present a danger to himself or herself or to others, and
b) is concealing on his or her person an item that could be used to cause physical injury to himself or herself or to others.

The person detained may only be searched to the extent that is necessary to uncover the item the officer believes the person has, and in any event, this cannot extend to requiring removal of anything other than someone's outer coat, jacket or gloves.

From the time the person is detained, until the time the examination and assessment are complete, the person is deemed to be in lawful custody and where the place of safety is a hospital or other health facility can be detained at the place of safety by police and members of hospital staff, in line with the SYP/NHS Joint Escalation Protocol for Critical Incident Managers and NHS On-Call Managers – Use of Police Cells and Police Support at a Place of Safety **(Appendix 9).**

Whilst Section 136 does not use the term arrest, it is a preserved power of arrest under Section 26 PACE and reasonable force may be used under Section 117 PACE. Section 28 PACE requires an arrested person to be told that they are under arrest and the grounds for the arrest. Whilst a person detained under Section 136 is entitled to know that their liberty is being temporarily restricted, formally telling them that they are 'under arrest' may be counter-productive.

Therefore, the word arrest should be avoided, and instead the police officer should use tact and discretion in communicating to the person that they will have to come with police because of the officer's concern for their well-being, and that they have no choice in the matter. There is no requirement to caution a person detained under S136 and this should not be done.

4.8 Initial action following detention under section 136

Once a person has been detained the Mental Health Act 1983 code of practice requires that the officer detaining is responsible for notifying the place of safety in advance of their arrival and for notifying the local social services authority. However, if the officer has used the local Telephone Triage Pathway the healthcare practitioner will identify a suitable Health Based Place of Safety and facilitate access to it **(Appendix 1)**.

It is the responsibility of the staff at the Health Based Place of Safety (or ED, if the person is being taken to ED) to contact the Approved Mental Health Professional (AMHP) service as soon as practicable of the individual's imminent arrival **(Appendix 1)**.

Information communicated to the Health Based Place of Safety by the police, ambulance service or health care practitioner involved in the consultation process must include:

- The reason for detaining the individual under s136 and events leading up to it
- Detail of behaviours since being detained under s136
- Any suspicion of drugs and alcohol and the degree of intoxication if present
- Any use of weapons or crime
- The involvement of the ambulance service and the medical assessment performed
- Any suspicion of co-morbid physical health condition or concurrent injuries and any other risks to the individual or others

If there is no capacity at the local Health Based Place of Safety when initial contact is made, it is the triage healthcare professionals responsibility to ensure that the person is received into a suitable place of safety, through the agreed South Yorkshire process for escalating 136 bed closure protocol **(Appendix 2)** or making alternative arrangements, whether the person is from that area or not. When the Health Based Place of Safety states it has capacity, this means it is able to receive the detained person as soon as they arrive on site.

5 CONVEYANCE

5.1 Conveyance to a place of safety

Section 136 Mental Health Act is where a person is in immediate need of care or control, therefore, a timely response in relation to getting the person to a place of safety is required. Whenever the Police detain a person under section 136 an ambulance MUST always be requested for the purposes of transporting the detained person.

The MHA 1983 Code of Practice 2015 states that patients should always be conveyed in the manner which is most likely to preserve their dignity and privacy consistent with managing any risk to their health and safety or to other people (MHA 1983 Code of Practice 17.3).

The emphasis is strongly towards the use of ambulance transport arranged by health and social care and the preservation of the patient's dignity and privacy. The key message is that the use of police vehicles to transport patients should only be considered when the patient is violent or dangerous or it is a matter of extreme urgency. Where a police vehicle is used a paramedic should accompany the patient with the ambulance following. Any use of police vehicles must be risk assessed, justified and documented and the authority of a supervisory officer must be secured other than in cases of extreme urgency **(Appendix 19).**

Therefore, the person detained should be taken to the place of safety by ambulance or other health vehicle as outlined in the Yorkshire Ambulance Service Protocol **(Appendix 18).**

Yorkshire Ambulance Service has agreed to arrive at the location in which the police detained the person within 30 minutes of the request, or 18 minutes for physically restrained people where mental health is an impact factor. It may be necessary for Police to travel in the ambulance to assist with the conveyance of an aggressive person or for ambulance staff to travel within the Police vehicle where conveyance by the Police is necessary to safely manage risk of violence or absconsion.

When the police officer makes contact with the Yorkshire Ambulance Service to carry out the conveyance of s136 detainees, officers must be explicit in using the terms "section 136" and "restraint" to help ensure the appropriate triage category is applied and the timeframes above are met.

Before conveyance under s136 of MHA can take place, an assessment will be undertaken by Ambulance and the Police to determine which vehicle is the most appropriate means of conveying the patient to the place of safety. Where an Ambulance is the most appropriate means of conveyance the police are required to follow the Ambulance and / or attend the place of safety to enable a formal handover in line with RAVE risk assessment matrix **(Appendix 8)**.

Where Yorkshire Ambulance Service have identified that there is likely to be a significant delay (60 minutes) this should be communicated to the police. In these circumstances the police may consider transporting the person in a police vehicle. If this is the case, the police should undertake a dynamic risk assessment as to whether or not the person needs to be transported in a police vehicle and, other than in emergencies the authority of their supervisory officer must be secured and the rationale for using the police vehicle should be recorded along with the details of the authorising supervisor.

Whenever police transport is being used, YAS must be updated / informed so they are aware that they no longer have to dispatch an ambulance and the incident log should be updated accordingly.

The Ambulance service or other service transporting the person will go to the Health Based Place of Safety closest to where they were detained. However, Crisis Care Plans may include a preferred place of assessment based on the individuals needs and so should always be taken into account where feasible.

Any operational issues in relation to the transportation of persons detained under the MHA should be reported via internal escalation protocols.

Where the Yorkshire Ambulance Service is being used for conveyance there is no formal handover of responsibility for the detained individual to the Ambulance service. The individual subject to s136 is still in the custody of the police, who must therefore accompany them to the Place of Safety.

While the police still retain overall responsibility for the individual during the initial transfer, clinical judgements during conveyance regarding the detained individual must be made by paramedic staff.

The time of arrival at the Place of Safety must be clearly recorded by the Place of Safety staff and the Police. This information must also be passed on to any further site if the individual is transferred. The detention period for those detained under s136 begins at the point when the person physically enters a place of safety. Time spent travelling to a place of safety or spent outside awaiting opening of a facility does not count.

On arrival at the Place of Safety police must remain with the person until the Place of Safety have accepted responsibility for the person's custody **(Appendix 9).**

5.2 People requiring treatment at ED

Where the person detained is suffering from a physical condition (e.g. injury or apparent illness such as a heart condition) then they should be taken to the Emergency Department for their physical condition to be treated. The YAS crew will make this decision. Upon arrival at the Emergency Department, the police officers involved should make it clear to ED staff that the person is detained under S136. After physical examination, consideration may then be given to transferring them to the local mental health based place of safety.

If the individual is initially taken to ED under s136 the 24-hour detention period commences on arrival at ED, not when they subsequently arrive at the Health Based Place of Safety. When the individual arrives, it is important that it is communicated as a priority to ED staff that the person is detained under s136. The Police will NEVER leave a s136 detained person in ED unless acceptance of the detention has been agreed and the name of the person taking over the responsibility of the s136 detained person has been obtained. Police must satisfy themselves that there is suitable security for the person and staff prior to leaving the ED **(Appendix 9).**

In relation to all s136 detentions regardless of where they are taken for assessment, the electronic South Yorkshire s136 Form must be completed.

5.3 Transfers between Places of Safety

A person detained in a place of safety following the use of Section 136 may be transferred to another place of safety. The following factors need to be considered when transferring someone between places of safety:

- In law a person may be transferred from one place of safety to another by a Police Officer, an Approved Mental Health Professional or a person authorised by either.
- There is no reason why police should be responsible for transferring a person from one place of safety to another in preference to other agencies. The decision about whether police will be involved in such transfers and decisions about using police vehicles will be made by a police supervisor. Clearly, the safety of the detainee and others will be a factor the police supervisor will take into account when risk assessing such decisions.
- Except in an emergency, the agreement of an approved mental health professional, a doctor or another healthcare professional competent to assess whether the transfer would put the person's health or safety (or that of other people) at risk should be obtained before the person is transferred from one place of safety to another.
- In rare cases of emergency where police are involved in the transfer – perhaps urgent first aid or extreme violence - then no such agreements or authorities from either healthcare professionals or police supervisors is required and the person may be taken immediately to the most appropriate place of safety to contain and neutralise the risk to the person and others.
- For reasons of risk to the patient, safety and the avoidance of stigmatisation, transfers should be carried out by ambulance in preference to a Police vehicle. A Police vehicle should only be used where an ambulance has been requested and is unavailable or where the person is too violent to be conveyed by ambulance. In cases where the person is taken by a police vehicle due to the level of violence, then a member of the YAS crew should be asked to travel in the Police vehicle to monitor the detainee and the ambulance should be requested to follow behind to deal with any medical risks or sudden collapse.

All cases where an ambulance has been requested and is unavailable must be reported by accessing the Mental Health Portal and completing the online Mental Health Escalations Form in Mental Health Templates. In addition, the incident log should be updated accordingly.

6 STANDARD OPERATING PROCEDURES FOR PLACES OF SAFETY

The Policing and Crime Act 2017 defines a place of safety as:

A hospital
An independent hospital or care home for mentally disordered persons
A police station (in exceptional circumstances)
Residential accommodation provided by a local social services authority
Any other suitable place (with consent of a person managing or residing at that place)

Within South Yorkshire, it is acknowledged that a person in mental health crisis should be taken to or kept at a place of safety that best meets their needs. The expectation remains that, the persons needs will most appropriately be met by taking them to a health-based place of safety – a dedicated section 136 suite where they can be looked after by properly trained and qualified mental health and other medical professionals.

There are currently four Health Based Places of Safety across South Yorkshire **(Appendix 1)** and each s136 suite has one allocated bed and can therefore only assess one person at a time, with the exception of Sheffield who have two allocated beds.

To ensure people are treated with dignity and respect and are not incurring unnecessary delays in South Yorkshire if the local health based place of safety is not available it is that site's responsibility to ensure that the person is received into a suitable place of safety, through the agreed South Yorkshire process for escalating 136 bed closure Protocol **(Appendix 2).**

6.1 Health Based Places of Safety

A health based place of safety should be a hospital or other health based facility where mental health services are provided (section 136 suites within the mental health trusts). For the avoidance of doubt alternative places for provision of crisis support services do not constitute a formal Place of Safety as defined within the Policing and Crime Act 2017 unless specifically stated within Trust Standard Operating Procedures.

Health Based Places of Safety – Standard Operating Procedures

- **Appendix 10** – Rotherham and Doncaster
- **Appendix 11** – Sheffield
- **Appendix 12** - Barnsley

6.2 Emergency Departments

An ED can itself be a Place of Safety within the meaning of the Mental Health Act in line with **Appendix 13-16** – Standard Operating Procedure for s136 for Emergency Departments.

Therefore, if protracted physical health treatment or care is required, where appropriate, the ED should accept the s136 detention and take legal responsibility for custody of the person for the purpose of the Mental Health Act assessment being carried out. In these circumstances, the person continues to be detained under s136 until formally discharged by a section 12 Doctor and / or AMHP.

Under exceptional circumstances when a person under s136 present to an Emergency Department with no physical health needs due to limited Health Based Place of Safety capacity the ED cannot refuse access.

In these instances, it is vital that information about the person's needs, and any associated risks, are clearly explained to ED staff receiving the person and documented in line with RAVE **(Appendix 8).** Any security staff at the ED must likewise be properly briefed about the person before the ED takes responsibility for them. Due to the nature of ED's, managing people detained under s136 in this environment can be challenging. Given this, when a person detained under s136 is in the ED the police will provide the necessary support in line with the agreed South Yorkshire NHS/SYP Joint Escalation Protocol **(Appendix 9)** unless there is mutual agreement between the Department and the police that they are able to leave.

In these circumstances, the Police will **NEVER** leave an s136 detained person in ED unless acceptance of the detention has been agreed and the name of the person taking over the responsibility of the s136 detained person has been obtained. Police must satisfy themselves that there is suitable security for the person and staff prior to leaving the ED.

If there are disagreements regarding whether the Police should remain at the premises these cases should be referred to the Critical Incident Manager for discussion with a Senior NHS representative in line with the South Yorkshire NHS/SYP Joint Escalation Protocol **(Appendix 9).**

Following departure of police from the place of safety, should the behaviour of the detainee deteriorate police may be asked to return to assist while additional healthcare resources are sought.

6.3 Use of a Police Station

Children - It is unlawful to use a police station as a place of safety for anyone under the age of 18 in

any circumstances. This relates to any part of a police station including police cells. The law states "A child may not, in the exercise of a power to which this section applies, be removed to, kept at or taken to a place of safety that is a police station." There are two points of note:

- A child is anyone under the age of 18yrs - someone who is 17yrs and 364 days old is a child - see section 136A (5)(a) Mental Health Act.
- The size, strength and presentation of the child are completely irrelevant - they must be removed to a non-police station location.

Adults - Police stations can only be used as a place of safety for adults (18 and over) in "exceptional circumstances" as outlined in **Appendix 17**, Use of Police Stations as a Place of Safety.

6.4 Other Suitable Places

In relation to the use of other suitable places commissioners will have in place formal arrangements for the provision of crisis support commensurate to the need and presentation of people exhibiting signs of mental health crisis. Crisis will be defined by the person in crisis and may arise in relation to a long term mental health condition or from severe distress not necessarily related to enduring mental health conditions. This mix of services will operate in addition and alongside formal places of safety, with local operational policy and contingency planning responding to service demand **(Appendices 3-6).**

Any other suitable place will involve the evaluation of a number of factors including, the physical environment, the condition and behaviour of the person, and potentially any relationship between the person and the place. As a minimum a suitable space should be quiet, comfortable and have private space for the person to wait and potential physical risks should be identified and mitigated so far as is possible.

Where consideration is being given to using a private house / flat / room as a place of safety there will need to be authorisation from the occupier or at least one of the occupiers to agree to the place being used as a place of safety.

Where consideration is being given to using other premises other than a private house / flat / room then a person who appears to the Police Officer to be responsible for managing the place must agree to its use as a place of safety.

The request to use these types of premises as places of safety and the agreement should be recorded.

7. EQUALITY AND DIVERSITY

This policy aims to ensure that all people detained under section 136 will be offered services that are safe and effective and led by the needs of the person. The standards within the policy will be applied equally to all persons, including those discharged from services and those who discharge themselves against medical advice.

8. HUMAN RIGHTS ACT

The Human Rights Act 1998 requires public authorities and their employees to respect the Convention rights, to understand those rights and to take them into account when carrying out this policy. Particular reference is made to Article 5:- the right to liberty and security.

9. GOVERNANCE

This policy is owned by the Integrated Care System Mental Health and Learning Disability Workstream Steering Group. It has responsibility for ensuring that the guidelines within this policy are followed, for reviewing emerging 'lessons learnt' and for monitoring performance.

Any changes to this policy may only be ratified by the ICS MH&LDWSG.

10. MONITORING & AUDIT

The ICS Crisis Pathways Steering Group will monitor and audit this policy to identify opportunities for the development of local asset plans for improved care pathways in line with the objectives set out within the national policies; Five Year Forward View for Mental Health and Prevention Concordat for better mental health, and in particular:

- Swift access to holistic integrated and evidenced based care
- By 2020/2021 there will be a comprehensive set of pathways in place….reducing the reliance on acute care trusts
- 7 day NHS providing urgent and emergency mental health crisis care 24 hours a day…delivering 24/7 intensive home treatment services

The group will meet on a monthly basis to progress the three phases of the ICS Crisis Pathways Sub Group work plan:

- Phase One: South Yorkshire Section 136 Pathway and Standard Operating Procedures for Places of Safety
- Phase Two:
    - Local mapping of care pathways across south Yorkshire to include access routes and availability of mental health support in/out of hours.
    - Coordination of local development asset plans for improved care pathways in line with the objectives set out in the national policies
    - Identify opportunities for joint commissioning/provider arrangements
- Phase Three: Identify opportunities through the ICS framework to adopt an all age approach across the South Yorkshire care pathway

South Yorkshire Places of Safety Contact Details

DONCASTER	
Place of safety	Skelbrooke Ward 01302 798174
Doncaster Royal Infirmary Hospital	Switchboard and A&E 01302 366666
Access Team	01302 798400
Force Incident Manager or Duty Inspector	101
Tickhill Road Hospital Switchboard	01302 796000
Emergency Duty Team/ Out of hours AMHP service	Via the Single Point of Access (SPA) 01302 566999
Police Contact Numbers	101

ROTHERHAM	
Place of safety	Kingfisher Ward 01709 447443
Rotherham General Hospital	Switchboard and A&E 01709 820000
Access Team	01709 302670
Force Incident Manager or Duty Inspector	101
Tickhill Road Hospital Switchboard	01302 796000
Emergency Duty Team/ Out of hours AMHP service	Via the Access Team 01709 302670
Police Contact Numbers	101

SHEFFIELD	
Place of safety	Maple Ward 0114 2261607
Northern General Hospital	Switchboard & A&E 0114 2434343
Single Point of Access	0114 2263636
Force Incident Manager or Duty Inspector	101
Sheffield Health & Social Care Switchboard	0114 2716310
AMHP service	0114 2264778
Police Contact Numbers	101

BARNSLEY	
Place of safety	Section 136 Suite contact the Mental Health Senior Nurse Pager on 07623 903243
Barnsley General Hospital	Switchboard and A&E 01226 730000
Force Incident Manager or Duty Inspector	101
Emergency Duty Team/ Out of hours AMHP service	Daytime Mental Health Act Referral line 01226 772448 • Monday-Thursday 08:45-17:00 • Friday 08:45-16:30 Out of Hours EDT 01226 787789
Police Contact Numbers	101

Appendix 2

Process for Escalating 136 Bed Closures within the South Yorkshire Region

Scope:

136 provision by:

- Sheffield (SHSC)
- Barnsley (SWYP)
- Rotherham & Doncaster (RDaSH)
- SYP
- YAS

Purpose:

To have a standardised operational approach for managing and escalating the closure of any 136 suite (to assessment) within the South Yorkshire region. (This does not include 'closure' where a 136 assessment is waiting to take place).

Should the operational need mean that any 136 Suite needs to close:

1. Local procedure to be followed within the organisation for the closure of 136 beds / suite including escalation to Police, YAS, AMHP / Out of Hours Team and Trust Managers both in and out of hours.
2. Once the decision has been approved locally to close the entire 136 Suite on a site it is the responsibility of the local Trust identified lead (as per local policy) to contact and inform the remaining Trusts within the South Yorkshire region (as above).
3. If there is no capacity at the local Health Based Place of Safety it is the Triage Healthcare professional's responsibility to ensure that the person is received into a suitable place of safety, whether the person is from that area or not.
4. The closure of the Suite will remain under regular review (as a minimum shift by shift) until the decision can be made to re-open.
5. When the suite re-opens it is the responsibility of the local Trust identified lead (as per local policy) to contact and inform the remaining Trusts within the South Yorkshire region along with the Police, YAS, AMHP / Out of Hours Team and Trust Managers (in and out of hours).

Contact Details:

Trust / Location	Contact Details In hours	Contact Details Out of Hours
SHSC / Sheffield	Admissions Co-ordinator who will alert the Flow Co-ordinator Tel: **0114 226 4352** Or via switchboard on **0114 271 6310**	Band 7 Co-ordinator via switchboard on: **0114 271 6310**
SWYPT / Barnsley	Senior Nurse pager (please leave call back details with the operator) **07623 903243**	Senior Nurse pager (please leave call back details with the operator) **07623 903243**
RDASH / Rotherham	Nurse in Charge Kingfisher Ward Tel: **01709 447443**	Nurse in Charge Kingfisher Ward Tel: **01709 447443**
RDASH / Doncaster	Nurse in Charge Skelbrooke Ward Tel: **01302 798174**	Nurse in Charge Skelbrooke Ward Tel: **01302 798174**
South Yorkshire Police	101 - switchboard	101 - switchboard
Yorkshire Ambulance Service (YAS)	Regional Operation Centre (ROC) – **0300 3300299**	Regional Operation Centre (ROC) – **0300 3300299**

Appendix 3

Doncaster Crisis HUB
Mental Health Telephone Triage Pathway

Information to South Yorkshire Police on the Use of the New Mental Health Crisis HUB in Doncaster

Background

Like many services across the county RDASH have re-designed their mental health crisis pathway. The new pathway has been designed to offer patients a single point of access to a wide range of services, which meets their needs at a time of crisis.

It also allows other professionals such as those in South Yorkshire Police timely and sound advice in relation to members of the public they are dealing with who are suspected to be experiencing a mental health crisis.

What has changed?

The Doncaster Mental Health Crisis HUB enables Police personnel to be connected quickly to a Single Point of Access to seek advice. All enquiries will be answered by staff that have had specific training in handling physical and mental health related calls, who will direct them to the most appropriate place.

Calls will be assessed and clinically triaged by appropriately trained registered nurses, who will give advice and /or help decide on the most suitable service.

It will provide an all age mental health crisis service including Children and Adolescent Mental Health Services (CAMHS) and Older People Services Mental Health Services.

How do I contact the team?

Due to the sensitive nature of the information discussed with the mental health crisis hub all calls will be monitored. **Any officer wishing to obtain information about an individual will contact the HUB on telephone number 01302 566999.**

The call handler will request **details of the individual concerned** and the **nature of the incident**. The officer will also be required to provide the agreed **password** (**SYP14AX**) along with **their name and contact number**. The mental health triage worker will then call the officer back to provide appropriate advice and or response. (Flowchart below).

Who can be referred?

Any adult where their **mental health has a significant impact on their presentation or who appears to be suffering from an acute mental health crisis** in Doncaster at any time of the day may be referred, and out of hours CAMHS and Older People Mental Health patients.

Between Monday to Friday, during office hours CAMHS and Older People's Mental Health Services can be contacted direct on the following numbers:
CAMHS: 01302 304070
Older people's Mental Health: 01302 796104

It is identified that **either** the **person needs help from a mental health professional** or **police personnel require advice**.
Mental health must be identified as an impact factor and where the officer would benefit from receiving advice or information about the patient. The advice is not to take precedence over any actual or potential investigation, but to add to the information / intelligence which is taken into consideration in the decision-making process.

The officer at the scene will contact the **Crisis HUB** on **01302 566999** provide the **password SYP14AX**, **patients details and incident number/details** before requesting a call back.
Officers can provide the crisis hub with an overview of the nature of the incident and any specific requests they have for advice and guidance. This discussion must be recorded on the incident record. The Crisis Hub may speak to the patient directly if appropriate.

The **officer** at the scene will be **called back by** the **triage worker within 10 minutes**.

The **triage worker will either**:

- **Provide** the officer with **advice**.
- **Provide information** in relation **to patients already in receipt of services.**
- **Speak directly with the person** about whom there are concerns and **undertake a telephone triage**.

The officer will **update Atlas** at the conclusion of the incident **with the advice and outcome**.

Appendix 4

Rotherham
Mental Health Telephone Triage Pathway

It is identified that either the person needs help from a mental health professional, or a police officer requires advice

The officer at the scene will contact the
Single Point of Access Team (SPA Team)
01709 302670

The team work 24/7
But staff may be out of the office conducting assessments

IF A CRISIS MEMBER OF STAFF IS UNAVAILABLE OUT OF HOURS

Please contact **Doncaster Mental Health Hub 01302 566999**

Operated 24/7 with triage practitioners available

The Mental Health Professional will either:

- Provide the officer with direct advice
- Provide information (on a need to know basis) in relation to patients already in receipt of mental health services to assist the officer's action
- Triage the call, (speaking directly with service user if appropriate) to consider further action/follow up needed from Mental Health Services
- Direct to Rotherham A&E for physical health assessment if indicated or mental health assessment if the urgency requires this level of immediacy and intervention

Appendix 5

Sheffield (SHSC)
Mental Health Telephone Triage Pathway

Police Mental Health Consultation Process

Where it is identified that mental health is an impact factor and the Police Officer requires advice/assistance; *particularly if considering the use of S136 MHA*

Police and Crime act amendments to MHA stipulate that (where reasonable) Police officers should consult with a MH professional before s136 detention

08:00 – 16:00
Central AMHP Team
Tel: 0114 2264778

Police Officer to provide basic demographics and current concerns

16:00 – 08:00
Out of Hours Duty Team
Tel: via switchboard –
0114 2716310
(This comprises the SMED/**Street Triage** function between
16:00 – midnight and
16:00 – 02:00 Sat & Sun)
In the event that the duty team is unavailable please ask for the Band 7 Coordinator via Switchboard

Police Officer to provide basic demographics and current concerns

Where available the SMED worker will promptly:

- Review clinical information
- Agree attendance and review if indicated

The Mental Health Professional/Duty AMHP will:

Provide information and advice (on a need to know basis) in relation to patients already in receipt of services to assist the officers' action

Triage the call, (speaking directly with service user if appropriate) to consider further action/follow up needed from Mental Health Services

Advise Police on alternatives to a 136 detention;

- Referral to the Decisions Unit – where suitable the AMHP *or* Out of Hours Team to refer via the Flow Coordinator as per process
- Attendance at ED – to be considered where the primary need is of a physical health nature

Glossary of Terms

SHSC - Sheffield Health and Social Care (Mental Health service providers)
SMED - Street Med Worker (Social worker or Psychiatric Nurse)
MHA - Mental Health Act 1983
FIM - Force Incident Manager (Police)

Appendix 6

Barnsley
Mental Health Telephone Triage Pathway

It is identified that **either** the **person needs help from a mental health professional or police officer requires advice.**

Mental health must be identified as an impact factor and where the officer would benefit from receiving advice or information about the patient. The advice is not to take precedence over any actual or potential investigation, but to add to the information / intelligence which is taken into consideration in the decision-making process.

The officer at the scene will contact the **Mental Health Senior Nurse Pager** on **07623 903243** provide the **password SYP14BX, patients details and incident number/details** before requesting a call back.

The **officer** at the scene will be **called back by** the **Mental Health Senior Nurse** within **5minutes**. *Officers can provide an overview of the nature of the incident and any specific requests they have for advice and guidance. This discussion must be recorded on the incident record. The Mental Health Senior Nurse may speak to the patient directly if appropriate.*

The Mental Health Professional will either:

- **Provide** the officer with **advice.**
- **Provide** information in relation **to patients already in receipt of services** to assist the officers action
- **Triage the call** to consider further action/follow up needed from Mental Health Services
- **Speak directly with the person** about whom there are concerns and **undertake a telephone triage**.

Appendix 7

Mental Health Telephone Triage Check List

The introduction of the Policing and Crime Act (2017) places a requirement on a police officer 'where it is practicable to do so' to consult with a healthcare professional prior to using s136 MHA. The purpose of the consultation is for the police officer – who is considering using their power under Section 136 – to obtain timely and relevant mental health information and advice that will support them to decide a course of action that is in the best interests of the person concerned. The checklist below will assist officers and mental health professionals in relation to what information can be requested/provided as part of the telephone triage process.

History of involvement with mental health services including:

- Details of any current involvement / care team.
- Alcohol misuse / substance misuse issues.
- Regular attendance at S136 suite.

Brief overview of main presenting problems e.g. overdose, self-harm.

Current level of engagement

- when last seen
- next appointment date

Is there a care plan in place to determine medical history and suggestive strategies for appropriately managing a mental health crisis?

- positive behaviour support plan
- crisis care plan
- risk management plan
- relapse plan

Current professional/family/advocate/carer support and contact details

Key risks – including any alerts on the system.

Whether other physical health issues may be of concern or contributing to behaviour (e.g. substance misuse, sign of physical injury or illness).

An opinion on whether this appears to be a mental health issue based on professional observation and, if possible, questioning of the person.

Whether in the circumstances, the proposed use of section 136 powers is appropriate.

Where it is determined that use of Section 136 powers is appropriate – identification of a suitable health based place of safety, and facilitation of access to it.

Where it is determined that use of section 136 is not appropriate – identification and implementation of alternative arrangements.

The police officer retains ultimate responsibility for the decision to use their section 136 powers, having considered the advice given to them as part of any consultation.

Appendix 8

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

Where there is a dispute within this framework, NHS Professionals will have the **right to insist** upon police support where they believe they require it – police supervisors will have the **right to insist** on what that support should be. **Each agency will accommodate the other, through this compromise.**

Where the police feel that the NHS have insisted upon support inappropriately or where the NHS feel the police have provided too much or too little support, this should be referred to the Local S136 Forum for resolution and feedback should be provided by managers to ALL professionals involved.

Appendix 9

SYP/NHS Joint Escalation Protocol for Critical Incident Managers and NHS On-Call Managers – Use of Police Cells and Police Support at Places of Safety

South Yorkshire Police and NHS Escalation Process following Changes to the Police Powers and Places of Safety Provisions in the Mental Health Act 1983

Following a meeting with Strategic Health Partners and South Yorkshire Police on Wednesday 6th December 2017, it was recognised that the regulations, which accompany the legislation change, will significantly reduce the number of circumstances in which a police station may be used as a place of safety throughout the UK.

In summary three criteria must exist in order to allow a police station to be used;

- The detaining officer must reasonably consider that the behaviour of the person poses an imminent risk of serious injury or death, either to themselves or another person; AND
- The officer must believe that no place of safety in the police force area could safely manage that risk; AND
- The decision to rely upon a police station must be authorised by an officer at the rank of Inspector,
- although **in South Yorkshire this decision will be made by the Critical Incident Manager (CIM)**

Once the person arrives in police custody, there are several things to bear in mind:

- Use of Police custody is still subject to the custody officers normal set of considerations in terms of authorising detention;
- It is the custody officer's legal decision to detain further and if the CIM is a Chief Inspector and disagrees with any decision taken by the Sergeant, PACE states this must be referred to a Superintendent (On-Call PACE)
- Once detained the custody officer must ensure several things happen:
- A check by a healthcare professional every thirty minutes;
- Wherever possible, there should be a constant healthcare presence throughout the duration that person is detained;
- If the original grounds for using the police station cease to apply, the person must be transferred elsewhere; unless the S136 assessment is imminent and transferring the person would delay things to their disadvantage;
- If the custody sergeant is not able to ensure the relevant frequency of health checks, the person must be transferred elsewhere; again, this is unless the assessment is imminent, and transfer would delay things to the person's disadvantage.

- **Critical Incident Managers Authority**

Firstly, where the Critical Incident Manager is being asked to authorise use of a police station this should be considered very carefully: by virtue of the two other criteria required (as above) prior to them considering giving their authority, the person concerned may be significantly ill and particular care should be taken to ensure that intoxication by drugs or

alcohol or any resistance, aggression or violence are not symptomatic of something serious that would require medical clearance by a paramedic or an emergency department.

It is advisable that every S136 detention receives some form of medical assessment prior to considering whether custody is appropriate.

A Critical Incident Manager will not be at the scene of an incident where s136 is used – we can imagine this may all be managed by phone or police radio discussion and detaining officers asking whether they could or should remove a detained person to custody?

Factors to consider –

- Firstly – have we called an ambulance? If not, why not? – ensure it is done
- Does the detaining officer have enough support from colleagues to manage that scene and the behaviour of the person? If not, can we get more officers to them?
- Strong oversight consider dispatching a duty sergeant to direct control of events. If there isn't one there already – this incident could develop in a number of ways at this stage, including by ending badly: a first-line supervisor should focus on this and on nothing else, if at all possible
- What is the clinical assessment of RED FLAGS - best done by a paramedic, of course but if they're not yet in attendance or unable to attend at all, it will have to be the officers present to make that call on the basis of their first aid certificate and personal safety training
- Be aware that **Physical Restraint + Mental Health = Medical Emergency** and bear in mind ABD, the potential for drugs and alcohol to mask problems and that resistant frightened or aggressive behaviour can indicate underlying medical problems. Restraint only complicates those matters, it never does the opposite.

A sensible judgement will have to be made about waiting for an ambulance; the greater the concerns about ongoing impact of any restraint, the sooner it may be necessary to move the person; but if arrival of paramedics is imminent, it may be safer to remain there. Paramedics can administer medication in some circumstances (under the Mental Capacity Act) that can assist; equally, they can travel with the person in case of any untoward development en route to the chosen location.

If all of that has happened or been ruled out as being necessary and we still have an 'imminent risk' situation, then and only then should the Critical Incident Manager consider authorising use of a police station, and only where there is that constant healthcare monitoring after arrival.

- **Detention in Custody**

Secondly, the new regulations require health care checks to be carried out every 30 minutes. Remember, without those thirty-minute checks: the custody officer is obliged to transfer the person elsewhere.

The Regulations are focused on police stations, not just on police custody, but they repeatedly refer to the custody officer, which is a position only relevant in police custody. What happens in the rest of the station is a matter for the officer in charge of it. So, the ability to ensure the thirty minute checks will determine whether a particular police station can act as a Place of Safety, and not all (PACE) designated custody areas will be able to do so.

- **Monitoring in Custody**

The healthcare checks that are required, must occur every thirty minutes – the Regulations don't specify who should do this, as long as it is a 'healthcare' professional, as defined by health legislation. For police purposes, this simply means, doctor or nurse. An AMHP would not be able to do this, unless they were also a registered nurse – most AMHPs are mental health social workers, and not healthcare professionals for the purposes of these Regulations. In addition, the custody sergeant must undertake an hourly check of the detainee in the normal way and is at liberty to impose a regime of enhanced observations, as they see necessary and influenced by healthcare advice. This could mean, 1-to-1 obs by a police officer; or even 2-to-1 obs, if necessary – all supplemented by those healthcare checks.

The Regulations do allow for this one-hourly check to be relaxed on healthcare advice, to three hourly checks if the person is sleeping. Whilst this should be based on healthcare advise, it should also be borne in mind that if someone is sleeping, then arguably the criteria for removing them from the police station are met and they should be moved. We should also be wary of someone who may have previously been noisy, frightened and distressed now being silent in a sleeping position: is the person now lying on the floor actually asleep, or are they unconscious or worse?!

Police Officers remaining with the person detained under S136

Police officers will NEVER leave a S136 detained person in the Accident & Emergency Department or any other hospital setting or place of safety unless acceptance of the detention of the person has been agreed and the name of the person taking over the responsibility of the S136 detained person, has been obtained. Police Officers must satisfy themselves that there is suitable security for the person and staff prior to leaving the place of safety.

If there are disagreements regarding the joint risk assessment and whether police officers should remain, these cases should be referred to the Critical Incident Manager for discussion with a senior NHS representative.

Following departure of police from the place of safety, should the behaviour of the detainee deteriorate police may be asked to return to assist while additional healthcare resources are sought.

- **Escalation (Police): Who to speak to?**

If the Critical Incident Manager needs to speak to someone within the Mental Health Trust, helpful contact details are provided below:

Rotherham, Doncaster and South Humber NHS Foundation Trust	
Telephone: 01302 796000	When Switchboard answers ask to speak to the on-call manager. If things cannot be resolved via the on- call manager ask for the issue to be escalated to the on-call Care Group Director and then subsequently to the on-call Director.
Sheffield Health & Social Care NHS	
Telephone: 0114 271 6310	When Switchboard answers, in hours ask for the Service Director or Deputy Service Director, out of hours it will be the on-call manager.

South West Yorkshire Partnership NHS Foundation Trust	
Telephone: 01226 434 000	When Switchboard answers, ask to speak to the On-call manager. If things cannot be resolved via the on- call manager ask to speak to the on-call Director.

- **Escalation (NHS): Who to speak to?**

If a representative/Manager/Director from the NHS needs to contact a senior representative within South Yorkshire Police, they are advised to call 101 and ask to speak to the Critical Incident Manager (CIM) who is available 24/7.

- **Review**

South Yorkshire Police Officers are expected to escalate any issues related to mental health incidents via email: ForceMentalHealth@southyorks.pnn.police.uk.

SOP – RDaSH

Rotherham Doncaster and South Humber NHS Foundation Trust

Section 136

Standard Operating Procedure

DOCUMENT CONTROL:	
Version:	8
Ratified by:	Mental Health Legislation Operational Group
Date approved:	18.04.2019
Name of originator/ Author:	Mental Health Act Manager
Name of responsible individual:	Mental Health Legislation Operational Group
Unique Reference Number:	94
Date issued:	27 November 2019
Review date:	November 2021
Target Audience	Clinical Staff in Mental Health Services in Rotherham and Doncaster
Description of change	No change

1. AIM

The aim of the standard operating procedure is to ensure:

- All agencies that are party to this are aware of their roles and responsibilities;
- Persons detained under section 136 MHA 1983 are treated with respect, without discrimination and are assessed as quickly as practicable;
- All agencies focus on providing the best possible support for the detained person to enable a quick recovery and return to their place in the community.

2. SCOPE

This policy and its procedures apply to all statutory agencies who fulfil a role in the undertakings and requirements of section 136 of the MHA 1983 and who operate within the boundaries of Rotherham and Doncaster.

3. LINK TO OVERARCHING POLICY

Section 136 Policy

4. PROCEDURE

4.1 Arrival at Place of Safety

On arrival at the Health Based Place of Safety, the relevant documentation (**appendix F**) must be completed by the Police Officers accompanying the patient and the patient's rights and information leaflet (**appendix C**) administered by the section 136 coordinator/senior mental health nurse.

The request for the section 136 assessment (see **appendix D** for contact details) will be made at the earliest opportunity and an AMHP and registered medical practitioner informed of the detention so that plans are put in place to enable the assessment to be carried out as soon as practicable.

Any delays will be appropriately logged by the Section 136 Suite staff on the relevant documentation (**appendix F**) and/or systems.

Staff at the Section 136 Suite are empowered by the MHA 1983 to stop and restrain, (using reasonable force) anyone who is attempting to leave if they have been detained under section 136.

4.2 Joint Risk Assessment

A joint risk assessment (**Appendix A**) of the patient **MUST** be undertaken and documented by the Police and Section 136 Suite staff. This is to ensure that all available information held in police, mental health and medical records is considered as part of that risk assessment in order to determine the risk level and what supervision if any is necessary for the detained person.

This risk assessment will be jointly reviewed on a regular basis throughout the detention period and negotiation/agreement between the police officer and nursing staff will determine whether the police officer will be required to remain at the place of safety to provide support. Where police officers are required to stay in attendance the need for them to remain shall continue to be jointly reviewed at regular intervals.

Serious consideration must be given to the releasing of police officers to resume Policing duties as soon as possible. If it is agreed that police officers are not required, there is an expectation that should there be an escalation of risk that police officers will return to the place of safety to provide support.

The risk assessment documentation should accompany the patient in order that periodic informed risk assessments can take place regarding the patient.
This documentation will be monitored on a monthly basis at scheduled Local Section 136 Liaison Meetings against the monthly detentions in order to highlight any operational concerns/difficulties.

4.3 Information and Patient Rights

Patients detained are entitled under Section 132 MHA 1983 to be given information relating to their rights whilst detained under Section 136 (see section 4.12 of the Code of Practice). Leaflets will be available in A&E and at the Section 136 Suites (**appendix C**).

4.4 Assessment

The registered medical practitioner is required to attend the place of safety for the purpose of examining the person and the AMHP must interview the person as soon as is reasonably practicable to do so. However, there may be occasions where the registered medical practitioner is aware that it is necessary or appropriate to delay the assessment process (e.g. Alcohol or Drug intoxication). This assessment should be undertaken as soon as possible from the start time of detention. Good practice recommends that face-to-face contact with the AMHP and the registered medical practitioner should start within 3 hours where clinically appropriate. Where a delay is unavoidable communication should be maintained to advise of the earliest available time for attendance, and the reasons for that delay recorded.

It is preferable for the examination by the registered medical practitioner and the interview by the AMHP to be co-ordinated so that they are performed at the same time. Where this is not possible, the registered medical practitioner may examine and the AMHP may interview the person separately.
If the registered medical practitioner sees the person first and concludes that they have a mental disorder but that admission to hospital is unnecessary, or the person agrees to informal admission, the person must still be interviewed by an AMHP (MHA Code of Practice 2015 16.51).

If the detained person is assessed by the registered medical practitioner as not suffering from a mental disorder as defined by the MHA 1983 then the section 136 power expires and they must be discharged by the registered medical practitioner, even if not seen by an AMHP (MHA Code of Practice 2015 16.50).

Where the outcome of the registered medical practitioner's examination indicates that an assessment under Part II of the MHA 1983 is required, the AMHP will have the responsibility for the co-ordination of such an assessment.

Where the outcome of the registered medical practitioner's examination indicates that an assessment under the MHA 1983 is not required, the person must be interviewed by the AMHP with regard to the making of any necessary arrangements for his treatment or care. Such arrangements need not necessarily be associated with any specific mental health needs, but also include wider community care needs and provision. Where this is the case the AMHP can interview the person over the telephone.

It is desirable for either an AMHP or Consultant Psychiatrist experienced in working with learning disabled people to be available to advise or assess, where it appears that the detained person has a learning disability.

It is also appropriate in the case of a child or young person to consult with a Child Psychiatrist and in the case of an older adult for an Old Age Psychiatrist to be available.

Where language is an issue appropriate translation services should be engaged.

NB: If a person is detained under section 136 and it becomes apparent that they are subject to a Community Treatment Order (CTO) the Registered Medical Practitioner / AMHP should follow the Recall / Revocation procedure within the Trust Community Treatment Order Policy.

4.5 Permitted extension of time limit

The registered medical practitioner may authorise a further period of detention, not exceeding 12 hours. This can be authorized at any time and begins immediately at the end of the period of 24 hours. This can only occur if the registered medical practitioner considers it necessary:

- Because of the condition of the person being detained and it would not be practicable for the assessment to be carried out before the end of the period of 24 hours, or
- If the assessment began within that period, for it to be completed before the end

The registered medical practitioner should record this decision on Form 136B (**appendix I**).

If the person is detained in police custody the further period can only be used if an officer of the rank of Superintendent or above approves it (MHA Section 136B).

4.6 Action Following Assessment

Where admission to hospital is appropriate the person will either consent to admission (informal) or the person will be detained under the formal provisions within the MHA 1983.

If the person is formally detained under the MHA 1983 in any other place than the Section 136 Suite, in the first instance contact should be made with the Ambulance Service to transport the patient to the hospital unit. However, where there is a potential risk to others refer to 8.4 of this policy.

4.7 Discharge from Assessment/Treatment

Where admission to hospital is inappropriate:

- Nursing staff or police officers should assist the person to arrange appropriate transportation to the community, where appropriate, from the place of safety;
- Relevant referrals should be considered / identified, and any issues / concerns highlighted to relevant agencies (including alcohol and drugs referrals);
- A copy of the Outcome Plan should be given to the relevant people (see **appendix E**);
- If the person is known to services, their Care Coordinator should be notified and where appropriate the care plan reviewed;

- Written notification of the detention under section 136 and the outcome will be forwarded to the patient's GP by the local MHA Office.

Brief Section 136 Risk Assessment

Name of individual detained:

Date: **Time:**

Address:

Risk Factor	Yes	No	Not Known	Evidence of Risk
Has there been any recent violence towards others.				
Have there been any recent deliberate self-harm attempts.				
Was the police involvement due to a suicide attempt				
Is there evidence that the person uses illicit substances				
Is there evidence that the person is dependent on alcohol				
Is the person's behaviour out of character				
Is there evidence that this person is at risk of abuse/exploitation from others				
Are there any known issues in respect of safeguarding children				
Are there any identified physical health care risks i.e. head injury, diabetes, epilepsy				

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, ie; personal/physical risk factors and risk of absconding prior to completion of the mental health assessment

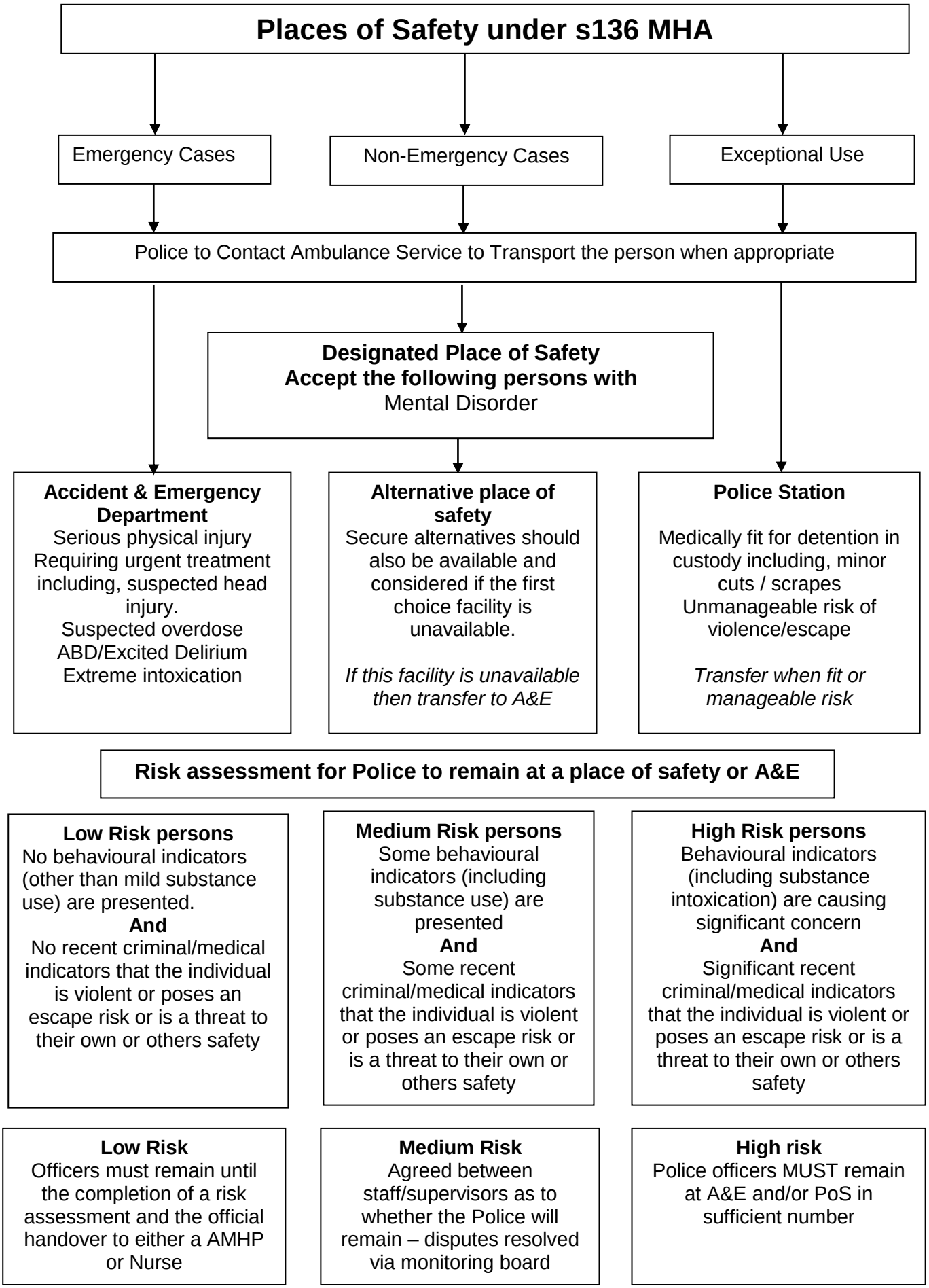
Completed by:

…… **……**

Police Officer **Staff Nurse**

NB: IF THE OUTCOME OF THE SECTION 136 ASSESSMENT IS THAT THE PERSON IS TO REMAIN ON THE WARDS CLINICAL STAFF ARE TO COMPLETE A FULL RISK ASSESSMENT

In cases where the Police Officers have been allowed to leave the person at the Section 136 Suite, if the person's presentation changes the Police can be contacted and they will come back to the Section 136 Suite


Places of Safety under s136 MHA
Emergency Cases
Non-Emergency Cases
Exceptional Use
Police to Contact Ambulance Service to Transport the person when appropriate
Designated Place of Safety
Accept the following persons with
Mental Disorder
Accident & Emergency Department
Serious physical injury
Requiring urgent treatment including, suspected head injury.
Suspected overdose
ABD/Excited Delirium
Extreme intoxication
Alternative place of safety
Secure alternatives should also be available and considered if the first choice facility is unavailable.
If this facility is unavailable then transfer to A&E
Police Station
Medically fit for detention in custody including, minor cuts / scrapes
Unmanageable risk of violence/escape
Transfer when fit or manageable risk
Risk assessment for Police to remain at a place of safety or A&E
Low Risk persons
No behavioural indicators (other than mild substance use) are presented.
And
No recent criminal/medical indicators that the individual is violent or poses an escape risk or is a threat to their own or others safety
Medium Risk persons
Some behavioural indicators (including substance use) are presented
And
Some recent criminal/medical indicators that the individual is violent or poses an escape risk or is a threat to their own or others safety
High Risk persons
Behavioural indicators (including substance intoxication) are causing significant concern
And
Significant recent criminal/medical indicators that the individual is violent or poses an escape risk or is a threat to their own or others safety
Low Risk
Officers must remain until the completion of a risk assessment and the official handover to either a AMHP or Nurse
Medium Risk
Agreed between staff/supervisors as to whether the Police will remain – disputes resolved via monitoring board
High risk
Police officers MUST remain at A&E and/or PoS in sufficient number

PATIENT INFORMATION

S136

POWER TO REMOVE TO, OR KEEP AT, A PLACE OF SAFETY

(Section 136 of the Mental Health Act 1983)

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

Why am I at a place of safety?

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

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

How long will I be here?

Once you have arrived at the place of safety you can be kept here (or in another place where you will be safe) for up to 24 hours so that you can be seen by a doctor and an approved mental health professional.

An approved mental health professional is someone who has been specially trained to help decide whether people need to be kept in hospital.

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

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

If the doctors and the approved mental health professional have not seen you by the end of the 24 hours, the doctor may in limited circumstances extend this timeframe by a further 12 hours. However, this can only be done in circumstances where because of your physical or mental health presentation it is not practicable to complete a mental health act assessment within the 24 hours.

In your case the 24 hours end at:

Date	Time

If the doctor decides to extend this timeframe for a further 12 hours this will end at:

Date	Time

What happens next?

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

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

Can I appeal?

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

Will I be given treatment?

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

Letting your nearest relative know

A copy of this leaflet will be given to the person the Mental Health Act says is your nearest relative.

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

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

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

Changing your nearest relative

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

Your letters

All letters sent to you while you are in hospital will be given to you. You can send letters to anyone except someone who has said they do not want to get letters from you. Letters to these people can be stopped by the hospital staff.

Code of Practice

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

How do I complain?

If you want to complain about anything to do with your care and treatment in hospital, please speak to a member of staff. They may be able to sort the matter out. They can also give you details of the hospital's complaints procedure, which you can use to try to sort out your complaint through what is called local resolution. They can also tell you about any other people who can help you make a complaint.

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

Further help and information

If there is anything you do not understand about your care and treatment, a member of staff will try to help you. Please ask a member of staff to explain if there is anything in this leaflet you do not understand or if you have other questions that this leaflet has not answered.

Please ask if you would like another copy of this leaflet for someone else.

Appendix D – Useful Telephone Numbers

DONCASTER	
Place of safety	Skelbrooke Ward 01302 798174
Doncaster Royal Infirmary Hospital	Switchboard and A&E 01302 366666
Access Team	01302 798400
Force Incident Manager or Duty Inspector	101
Tickhill Road Hospital Switchboard	01302 796000
Emergency Duty Team/ Out of hours AMHP service	Contact Tickhill Road Hospital Switchboard
Police contact Numbers	101

ROTHERHAM	
Place of safety	Kingfisher Ward 01709 447443
Rotherham General Hospital	Switchboard and A&E 01709 820000
Access Team	01709 302670
Force Incident Manager or Duty Inspector	101
Tickhill Road Hospital Switchboard	01302 796000
Emergency Duty Team/ Out of hours AMHP service	Via the Access Team 01709 302670
Police contact Numbers	101

NORTH LINCOLNSHIRE	
Place of safety	Mulberry House, Nursing Office, 01724 382077
Scunthorpe General Hospital	Switchboard and A&E 01724 282282
Crisis Team	01724 382015
Force Incident Manager or Duty Inspector	101
Great Oaks Switchboard	01724 382000
Emergency Duty Team/ Out of hours AMHP service	via Crisis Team 01724 382015
Police contact Numbers	101

S136 Outcome
(To be completed by the AMHP or Mental Health Professional copy handed to the person upon leaving S136 suite and original to be attached to S136 form)

Name:	
Date of Birth:	
Address:	

Outcome of your assessment

Your ongoing support arrangements

Useful contact addresses and telephone numbers:

Consent to inform GP: Y/N

Consent to send copy to home address: Y/N

Name of AMHP or MHP completing this form: …….

Signed: …….

Date: …….

Section 136 Mental Health Act 1983 Communication/Registration Form
(Police to complete pages 1 and 2)
(AMHP/Health Professional to complete page 3)

Custody number (if applicable)		Police Log Number	

Section 136 of the Mental Health Act 1983 empowers a constable to remove to 'a place of safety' any person who is found in a place to which the public have access and appears to be suffering from a mental disorder

AND who is in need of immediate care ☐ or control ☐

AND who needs to be removed in their own interests ☐ or for the protection of others ☐

Date: Time of arrival at PoS:

Place (where person arrested): City or Town:

Person detained – Surname: Forenames:

Address: Postcode:

Place of birth: Date of birth: Age:

Known Disability: Interpreter required? Y/N Language:

Gender: ID code: PNC code: PNC & local check done? Yes ☐ No ☐

Notes of the Incident / arrest:
(describe fully the behaviour and circumstances that resulted in detention)

Telephone triage used Y/N By whom:

Advice/recommendations given:

Since detention, has the person received any medical attention prior to arrival at a place of safety? Yes ☐ No ☐

If 'yes', describe:

Has the person been restrained? Yes ☐ No ☐
If 'yes', how and for how long?

Has the person been searched? Yes ☐ No ☐
If 'yes', has anything been retained?

Is the person on medication? Yes ☐ No ☐ Unknown ☐

Is the person suffering from the effects of drink or drugs? Yes ☐ No ☐ Unknown ☐

Has the person taken an overdose? Yes ☐ No ☐ Unknown ☐

Initial place of safety: HBPoS (S136 Suite) ☐ Police Custody ☐
Private Home ☐ A&E used as place of safety (if not designated HBPoS) ☐ Other ☐
Unknown ☐

If not 136 suite, explain why: Suite full ☐ Intoxicated ☐ Violent ☐ Potentially violent ☐ Other (describe) ☐ Staffing Levels ☐

If police station used explain why: Joint risk assessment ☐ HBPOS no capacity ☐ Arrested substantive Not Known ☐ HBPOS refused admission ☐

offence □ Other □

Page 2

Risk factors that the place of safety or assessment staff should be aware of?
(consider self-harm, suicide, physical aggression, impaired judgement, self-neglect, absconding, etc)

PER form attached: Yes □
No □

Any PNC warning marks? Yes □ No □
Any Local (intelligence systems) checks completed? Yes □ No □

If Yes, details please:

Conveyed to place of safety by: Ambulance □ Police vehicle □ Other (describe) □
Not known □ Health Vehicle □ None (already at PoS) □

Date of arrival: Time of arrival:

Received by:

Reasons why Police vehicle used:

Ambulance/other vehicle not available in 30 mins □ Ambulance not required □

Police/ambulance/other vehicle risk assessment (behaviour) □ Ambulance crew refused to convey □

Ambulance/other vehicle re-tasked to higher priority call □ Not known □

Details of relative or friend

Name:

Address:

Tel no: Informed? Yes □ No □

Examined by FME Yes □ No □

If 'Yes', Name:

Address:

GP (if known)	Name:
	Address:

Date of departure (police) : Time of departure (police):

Officer detaining (signature): Print name:

Rank/Collar no. Station:

Officer completing form: Person receiving form:

Signature: Signature:

Section 136 Mental Health Act 1983-Communication/Registration Form (AMHP/Nurse to complete)Page3

Patient – Surname: Forenames:

1. Place of safety where assessment carried out:

2. AMHP notified (name):
by: Date: Time:

3. Section 12(2) Doctor notified (name):
by: Date: Time:

4. Rights leaflet was given and rights read and explained by (if appropriate):
Signed: (nurse, AMHP or Custody Officer) Date: Time:

5. Background information:

a - currently known to mental health services	Yes	□	No	□	If yes, on CPA	Yes □	No □
b - past history of Section 136 detention	Yes	□	No	□			
c - past history of psychiatric contact	Yes	□	No	□			

6. Patient examined by Section 12(2) Doctor (signature):
Print name: Date: Time:
Section 12 Approved: Yes □ No □ If no, explain why not:

7. Patient interviewed by AMHP (signature):
Print name: Date: Time:

8. Patient examined by 2nd Doctor: Not applicable □ or signature:
Print name: Date: Time:
Section 12 Approved Yes □ No □

9. Has the person required transfer to another place of safety Yes □ No □
Name of unit:
Date of arrival at 2nd place of safety: Time of arrival:
Reason for transfer:
If further transfer Yes □ No □ Record above information on separate form and attach to this

10. Arrangements made after initial assessment

a. Was not suffering from mental disorder and was discharged: □

b. Did not require admission and was discharged: □ Referred to CMHT □ CRHT □ Other □

c. If discharged having seen one doctor were they approved under Section 12 Yes □ No □
Time discharged: Date discharged:

d. Was admitted or transferred on an informal basis □ or under Mental Health Act Section 2 □
or under Mental Health Act Section 3 □ Other □
To (ward): Hospital:
Date arrival on ward: Time of arrival:

Signed (person completing): Date:

11. Time and date when detention under Section 136 ceased: Date: Time:

Any serious untoward incident following detention including in place of safety? Yes □ No □

If yes, Minor self-harm □ Self harm requiring medical attention □ Assault □ Other □

Details of incident (please write on back of sheet if you need to):

Signature: Print name:

Appendix G

Places of Safety – Under 16 years of age

The following have been agreed as the principal places of safety within the NHS Trusts (see **Appendix E** for contact details):

Doncaster

The preferred place of safety **for a person aged 16 and over** is the Section 136 Suite attached to the Psychiatric Intensive Care Unit [Skelbrooke Ward] at St Catherine's Hospital.

The place of assessment for a person under 16 years of age is the A&E Department at Doncaster Royal Infirmary with subsequent referral to Pediatric Services which is the designated place of safety in such circumstances.

Rotherham

The preferred place of safety **for a person aged 16 and over** is the Section 136 Suite attached to the Psychiatric Intensive Care Unit [Kingfisher Ward] at Swallownest Court.

The place of assessment for a person under 16 years of age is the A&E Department at Rotherham General Hospital with subsequent referral to Pediatric Services which is the designated place of safety in such circumstances.

Scunthorpe

The preferred place of safety **for a person aged 16 and over** is the Section 136 Suite attached to Mulberry House at Great Oaks.

The place of assessment for a person under 16 years of age is the A&E Department at Scunthorpe General Hospital with subsequent referral to Pediatric Services which is the designated place of safety in such circumstances.

Appendix H

Out of Hours Contact for initial dispute resolution

RDASH:

- On call Manager (RDASH) via the Tickhill Road Hospital Switchboard (01302) 796000

SYP:

- District Duty Inspector or Force Incident Manager on 101

Appendix I

Mental Health Act, 1983 FORM 136(b)

Record of extension of detention under Section 136

(To be completed by Registered Medical Practitioner)

(PRINT full name of patient)

Was detained under Section 136 of the MHA 1983 on

Date:	Time:

I Dr ……., the Registered Medical Practitioner am authorising an extension of the Section 136 detention for a further period of 12 hours which will end on

Date:	Time:

I consider that the extension is necessary because the condition of the person detained is such that it would not be practicable for the assessment of the person under Section 136 for the following reasons:

Signed:	Print Name:

Designation:

For detentions at a Police Station authorisation must also be given by an officer of the rank of Superintendent or above:

Signed:	Print Name:

Designation:

Date:	Time:

THIS FORM MUST BE SENT TO THE MHA OFFICE

Appendix 11

Crisis and Emergency Care

Standard Operating Procedure

Health Based Place of Safety

CONTENTS

1. AIM

The aim of the standard operating procedure is to ensure:

- All agencies that are party to this are aware of their roles and responsibilities;
- Persons detained under section 136 MHA 1983 are treated with respect, without discrimination and are assessed as quickly as practicable;
- All agencies focus on providing the best possible support for the detained person to enable a quick recovery and return to their place in the community.

2. SCOPE

This policy and its procedures apply to all statutory agencies who fulfill a role in the undertakings and requirements of section 136 of the MHA 1983 and who operate within the city of Sheffield.

3. LINK TO OVERARCHING POLICY

Section 136 Policy

4. INTRODUCTION

The Health Based Place of Safety is a stand-alone unit comprising a nursing reception area, two suites which include a lounge and bedroom with on suite bathroom facilities (Maple Ward is not a HBPOS).

Service users admitted to the HBPOS are to remain within this area until the assessment has been completed by the AMHP and Doctor, with the exception that an emergency intervention or seclusion is required. In circumstances where the criteria for seclusion are indicated access to the seclusion room on Maple Ward is permitted.

A HBPOS nurse will be allocated each shift and will be identified through the health roster system. There will also be an identified support worker to aid the HBPOS nurse with the safe management of the service / 136 assessment process.

5. PROCEDURE

5.1 Access to the Health Based Place of Safety

Once the decision has been made to detain under Section 136 (following the triage pathway/consultation process) and agreement is reached that a HBPOS is required, the Central AMHP/OOH team will contact the Sheffield HBPOS suite located within Maple Ward.

Assessment by the S12 approved doctor and AMHP should begin as soon as possible after the arrival of the individual at the place of safety. In cases where there are no clinical grounds to delay assessment, it is good practice for the doctor and AMHP to attend within three hours; this is in accordance with best practice recommendations made by the Royal College of Psychiatrists. Where possible, the assessment should be undertaken jointly by the doctor and the AMHP.

There may be occasions where the HBPOS nurse or the Police Officer is aware that it is necessary or appropriate to delay the assessment process for reasons such as alcohol or drug intoxication. Where a delay is unavoidable, communication should be maintained with the Central AMHP Team to advise of the earliest available time for attendance. Reasons for delay should be recorded on both the AMHP report and SHSC S136 monitoring form.

To ensure efficient and timely assessment it is agreed that all assessments should be undertaken with one Sec 12 approved doctor (and AMHP) unless the presenting risk, history and information suggests otherwise. Where it is identified that the MHA assessment should take place with 2 x doctors, the AMHP will follow local procedures to identify a second available doctor. Where there is a delay (longer than 3 hours) in obtaining a second doctor then the agreed escalation process must be followed by the AMHP.

5.2 Arrival at the Health Based Place of Safety

On arrival to the HBPOS, the detained person will be received at the Place of Safety Suite by the allocated HBPOS nurse. The time of arrival must be recorded immediately (CoP 16.59) on the SHSC S136 monitoring form. The relevant documentation (Section 136 detention forms) must be completed by the Police Officers accompanying the detained person. This information will include Police Officers Collar number, rank and the required details pertaining to the S136 detention.

The detained persons rights and information leaflet will be given and explained by the HBPOS nurse (Appendix A).

Time Limits
Note that the permitted period of detention is 24 hours, with a possible extension to an absolute maximum of 36 hours. The extension can only occur if the Responsible Medical Practitioner (Duty S12 Doctor) considers it necessary:

- Because of the condition of the person detained and it would not be practicable for the assessment to be carried out before the end of the period of 24 hours, or
- If the assessment began within that period, for it to be completed before the end.

If the person is detained in police custody, the further period can only be used if an officer of the rank of superintendent or above approves this (MHA S136B).

There is no provision to extend the 24-hour period for reasons other than the patient's condition.

Approaching time-limit: If the person has not been assessed by the time 16 hours has elapsed; this should be immediately reported to the Service Director or nominated deputy, or out of hours to the Band 7 coordinator and Senior Manager on call if required.
Exceeding time-limit: An incident form must be completed if time limits (24, or if formally extended, 36 hours) are exceeded, giving details of what action was taken to provide ongoing care and support to the patient.

Risk Assessment & Management
A joint risk assessment (Appendix B) of the patient must be undertaken and documented by the Police and HBPOS nurse. This is to ensure that all available information held in police, mental health and medical records is considered as part of that risk assessment to determine the risk level and what supervision if any is necessary for the detained person.

This risk assessment will be jointly reviewed on a regular basis throughout the detention period and negotiation/agreement between the police officer and HBPOS nurse will determine whether the Police Officer will be required to remain at the place of safety to provide support.
Where the police are required to stay in attendance the need for them to remain shall be jointly reviewed on a regular basis.

Serious consideration must be given to the releasing of police officers to resume Policing duties as soon as possible. If it is agreed that the police officer is not required, there is an

expectation that should there be an escalation of risk that a police officer will return to the place of safety to provide support.

Staff at the HBPOS are empowered by the MHA to stop, and use physical interventions to restrain anyone who is attempting to leave if they have been detained under Section 136. Approved SHSC Respect techniques should be employed.

SHSC incident reporting applies.

Power to return a patient to the HBPOS
Should a person detained under Section 136 leave the HBPOS suite they are only liable to return to the Place of Safety within a 24-hour time period from when the clock started.

Where the level of risk is significantly high that it is deemed to be unmanageable within the HBPOS, the seclusion room on Maple may be utilised if the criteria for seclusion are met and there is no alternative means of maintaining safety of the detained person or staff.

Recording of S136 process
The HBPOS nurse will complete the SHSC 136 monitoring form (Appendix C)

The Police Officer will provide relevant details/information at the time of the assessment or via the agreed nhs.net email address. The Police Officer must not leave the HBPOS suite until the SYP electronic 136 form has been completed and emailed to the nhs.net address. This information can then be accessed directly by the HBPOS nurse who will then input the required data into the SHSC S136 monitoring form. Where the Officer may report that they are unable to complete the SYP form they must ensure they verbally handover all required information to the HBPOS nurse prior to leaving the suite.

The detained person will have their vital signs recorded, monitored and documented on the SHSC S136 monitoring form.

Any detained person who has been restrained (including mechanical restraint) prior to arrival or during their stay or has received rapid tranquilisation/been secluded will have their physical health monitored using the Post Restraint Physical Health Monitoring Form (Appendix D).

Junior medical staff on Maple Ward or the on-call doctor will be responsible for attending to any urgent physical or mental health needs. They will also be expected to prescribe any medication that the person is prescribed by their GP for administration by the nurses (using a paper drug card).

5.3 Assessment & Treatment

Assessment
Assessment by the S12 approved doctor and AMHP should begin as soon as possible after the arrival of the individual at the place of safety. In cases where there are no clinical grounds to delay assessment, it is good practice for the doctor and AMHP to attend within three hours ;(CofP 16.47) this is in accordance with best practice recommendations made by the Royal College of Psychiatrists. Where possible, the assessment should be undertaken jointly by the doctor and the 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. (CofP 16.51)

NB: If a person is detained under section136 and it becomes apparent that they are subject to a Community Treatment Order (CTO) the Registered Medical Practitioner / AMHP should follow the Recall / Revocation procedure as per policy.

The authority to detain a person under section 135(1) or 136 ends as soon as the assessment has been completed and suitable arrangements have been made. This may include detention under part 2 of the Act, informal admission, an offer of community treatment or other arrangements necessary for a safe discharge, Police powers and places of safety including necessary social arrangements. 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.

Treatment
The Mental Health Act Code of Practice covers consent to treatment and states "Detaining a patient in a place of safety under sections 135 or 136 does not confer any power under the Act to treat them without their consent. In other words, they are in exactly the same position in respect of consent to treatment as patients who are not detained under the Act." If a patient has capacity to consent and is accepting medication then this should be clearly documented in their records.

Persons with a Learning Disability
If possible, either a consultant psychiatrist in learning disabilities or an AMHP with knowledge and experience of working with people with learning disabilities should be available to make the assessment where it appears that the detained person has a learning disability.

Where spoken language is an issue the appropriate interpreting services should be engaged at the earliest opportunity and will be organised by the Central AMHP team.

Support will be provided for any detained person where communication difficulties have been identified, to enable an appropriate assessment to take place.

Young People (16-17-year olds) detained under Section 136
The Sheffield Children's Hospital Child and Adolescent Mental Health Service provide a HBPOS provision for Young People at the Becton Centre.
All referrals for 16 and 17-year olds requiring a detention under S136 will be directed to HBPOS suite at Becton. Should this HBPOS be in use, it is the CAMHS service that has responsibility for locating an alternative HBPOS, the nearest being Leeds. Young People under 16 who are detained under Section 136 and who require a HBPOS should be directed to Sheffield Children's Hospital.

Violence, Aggression, Drink or Drugs
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.

In such cases intoxication may necessitate the retention of escorting officers to assist with the care and supervision of the person following a joint risk assessment (Appendix B). Delays in the assessment process may occur because of intoxication.

Where the individual is so intoxicated by alcohol or drugs that they present a health risk to themselves, the police should follow the normal 'drunk and incapable' procedures and ensure they are taken to the local Accident and Emergency Department for medical assessment.

The Police will not be required to remain at the place of safety unless to provide support where increased risk has been identified. Where an individual poses an unmanageable high risk to others they should be transferred to Police Custody to enable safe management. In the event that Police Officers remain at the place of safety to provide support the need for them to remain

shall be jointly reviewed on a regular basis. If however, intoxicated individuals present such a risk of harm to themselves or others that they cannot be safely managed at the HBPOS, they should be taken to a police station.

There may be some circumstances in which violent behaviour is connected to conditions for which appropriate medical assessment and treatment is required. Where necessary, police should work with staff from the ward or A&E to explore other options such as the assistance of appropriately trained staff to maintain a safe environment for both detained person and staff.

There are times when people display aggressive behaviour that is not influenced by drugs and alcohol and this should be managed accordingly (SHSC Aggression and Violence: Respectful Response and Reduction policy 2016).

An incident report should be made if a person is excluded from a health based place of safety and taken into a police station as a place of safety, this should include a record of the decision, of who made the decision, and it was made (CoP 16.62).

5.4 Outcome on Completion of Assessment

If admission is required:

Formal Admission
When an application for admission is to be made by an AMHP, they have a responsibility to ensure that all necessary arrangements are made for the person to be conveyed to hospital, which may be on a different in-patient site in Sheffield or Out of City. The person responsible for arranging a bed on behalf of the Doctor is the Band 7 Flow coordinator contactable on SHSC 24-hour Switchboard 0114 271 6310
.
Where difficulty is experienced in locating and securing an in-patient bed, communication will be maintained with the police to advise of the on-going situation. There is a Senior Manager available 24/7 to support (where required) in exceptional circumstances.

Informal Admission
Following assessment and discussion with the Band 7 Flow coordinator
the Decisions Unit or the Crisis House may be considered a suitable alternative for people who do not require in-patient care but their presentation requires a level of support immediately following assessment

Where an informal admission is required the Flow coordinator will facilitate the admission process and identify an available bed.

Insight Form CAT1 must be completed to record informed consent to informal admission

Out of Area Detentions
If a person is detained to a Sheffield HBPOS but lives out of area, the AMHP should, if possible, have a telephone conversation with the AMHP from the local area as soon as possible. This is to inform the local team that the person has been detained and to gather any known information about the detained person. The assessment process will continue with Sheffield teams unless agreed otherwise following discussion (ref Cross Border Memorandum of Understanding - Appendix E)

5.5 Discharge

Once the assessment has been concluded, it is the responsibility of the doctors and AMHPs involved to make any necessary further arrangements for the person's treatment or care. (CoP 16.73).

On the conclusion of a Section 136 the AMHP will complete the outcome plan as part of the SHSC S136 monitoring form and offer a copy to the individual.

6) INFORMATION SHARING

Information sharing for the protection of life and prevention of crime (assault) is described in the 'South Yorkshire Multi-Agency Information Sharing Protocol (Mental Health Issues) 2005'.

Where a detained person is transferred between the Police Station and the hospital, written information will accompany them. It will include sufficient detail to identify any risk to themselves or other individuals, details of medication and medical condition. This is to enable the receiving agency to assess risk and the further care needs of the individual – and to ensure staff safety. The police will include the above details on form BQ009 PER (Person Escort Record) and any accompanying Police Custody Healthcare provider medical notes.

7) DATA COLLECTION

An appropriate IT system has been developed to enable comprehensive and relevant data collection.

Monitoring forms should be completed at the start of detention and sent to or retained on Maple Ward by the AMPH or Custody Officer. A copy will be retained on the ward and the original sent to the Mental Health Act office. Performance information in relation to Section 136 detentions and incidents at the HBPOS should be made available to the Liaison Group/136 and the Mental Health Act Committee to enable monitoring of this policy and to enable any lessons learnt to be reviewed and improvements made.

Data to be collected includes:

- Use of Section 136 MHA in Health and Police Custody
- Age Gender and Ethnicity of the detained person/patient
- People who are repeatedly detained under Section 136 (CoP16.32)
- Triage / consultation process
- Methods of conveyance
- Time of arrival at Place of safety
- Length of time awaiting assessment
- Disputes
- Lawful extensions
- Outcomes of detention and assessment
- Occasions when the Place of Safety is not available and why
- Feedback from People who used the Place of Safety

Data will be collated by the Ward Manager and Governance Officer and provided to the Mental Health Act Office on a monthly basis. This is also fed into the monthly South Yorkshire Crisis pathways subgroup.

8) CONTINGENCIES (refer to escalation process)

Approved Mental Health Professional (AMHP)
If there is a delay in contacting the Central AMHP team to coordinate an assessment under the Act, the AMHP Manager or Senior Practitioner should be contacted/ notified during core hours and the Band 7 Flow coordinator out of hours

Registered Medical Practitioner
If a Consultant Psychiatrist/Section 12 approved Doctor is not available:

In hours – contact the Medical director (Peter Bowie, Helen Crimlisk or Jonathan Mitchell)
Out of hours - contact the on-call consultant via switchboard

An incident form should be completed if a Consultant Psychiatrist/Section 12 approved doctor is not contactable within one hour.

9) DISPUTES

Where there is a dispute regarding the suitability as to the HBPOS or any other issues arising this should be referred to the designated individuals from each organisation as highlighted below.

South Yorkshire Police	Duty Inspector	0114 2964104
Sheffield Health and Social Care	Band 7 Flow coordinator or Senior Operational Manager (in hours)	0114 2716310 0114 2718046
Sheffield Teaching Hospitals	Duty Matron at NGH	0114 2434343

This should be followed up with a post discussion between the agencies involved within 7 days of the incident and reviewed at the Section 136 Group.
Any unresolved issues should then be escalated to the Joint Liaison Group.

10) DISSEMINATION, STORAGE AND ARCHIVING (control)

A copy of the policy will be placed on the SHSC intranet within seven days of ratification and the previous version removed by the Quality Improvement team.
An email will be sent to all SHSC employees informing them of the revised policy.

Managers are responsible for ensuring the hard copies of the previous versions are removed from any policy/procedure manually or files stored locally.

APENDICIES

Appendix A – Information Leaflet and Patient Rights

BEING BROUGHT TO A PLACE OF SAFETY FROM A PUBLIC PLACE

(Section 136 of the Mental Health Act 1983)

Your Name	
Name of Place of Safety	

Why am I in a place of safety?

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

You are being kept here under S136 of the Mental Health Act 1983 so that you can be assessed to see if you need support/help/treatment.

How long will I be kept here?

You can be kept here (or in another place where you will be safe) for up to 24 hours so that you can be seen by a doctor and an approved mental health professional (AMHP). A further period of up to 12 hours may be authorised in specific circumstance. The maximum period you can be kept under these arrangements is 36 hours.

An approved mental health professional is someone who has been specially trained to help decide whether people need to be kept in hospital.

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

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

If the doctors and the approved mental health professional have not seen you by the end of the 24 hours (or within 36 hours) you will be free to leave. You may decide to stay on as a voluntary patient. But if you do want to leave, please talk to a member of staff first.

In your case the 24/36 hours end at:

24 Hours Date	Time
36 Hours Date	Time

What happens next?

When the doctors and an AMHP have seen you, they may say that you need to be in hospital.

Appendix B – Joint Risk Assessment

Brief Section 136 Risk Assessment

Name of individual detained:

Date: **Time:**

Address:

Risk Factor	Yes	No	Not Known	Evidence of Risk
Has there been any recent violence towards others				
Have there been any recent deliberate self harm attempts.				
Was the police involvement due to a suicide attempt				
Is there evidence that the person uses illicit substances				
Is there evidence that the person is dependent on alcohol				
Is the person's behaviour out of character				
Is there evidence that this person is at risk of abuse/exploitation from others				
Are there any known issues in respect of safeguarding children				
Is this person felt to be at risk of absconding				
Are there any identified physical health care risks i.e. head injury, diabetes, epilepsy				

Risk Assessment and Immediate Risk Management Plan

Please use this space to document risk assessment and risks identified and immediate plan for managing these risks. This should include personal/physical risk factors and risk of absconding prior to completion of the mental health assessment

Completed by:

....

Police Officer **Staff Nurse**

In cases where the Police Officers have been allowed to leave the person at the Section 136 Suite, if the person's presentation changes the Police can be contacted and they will come back to the Section 136 Suite

Appendix C – SHSC Monitoring Form

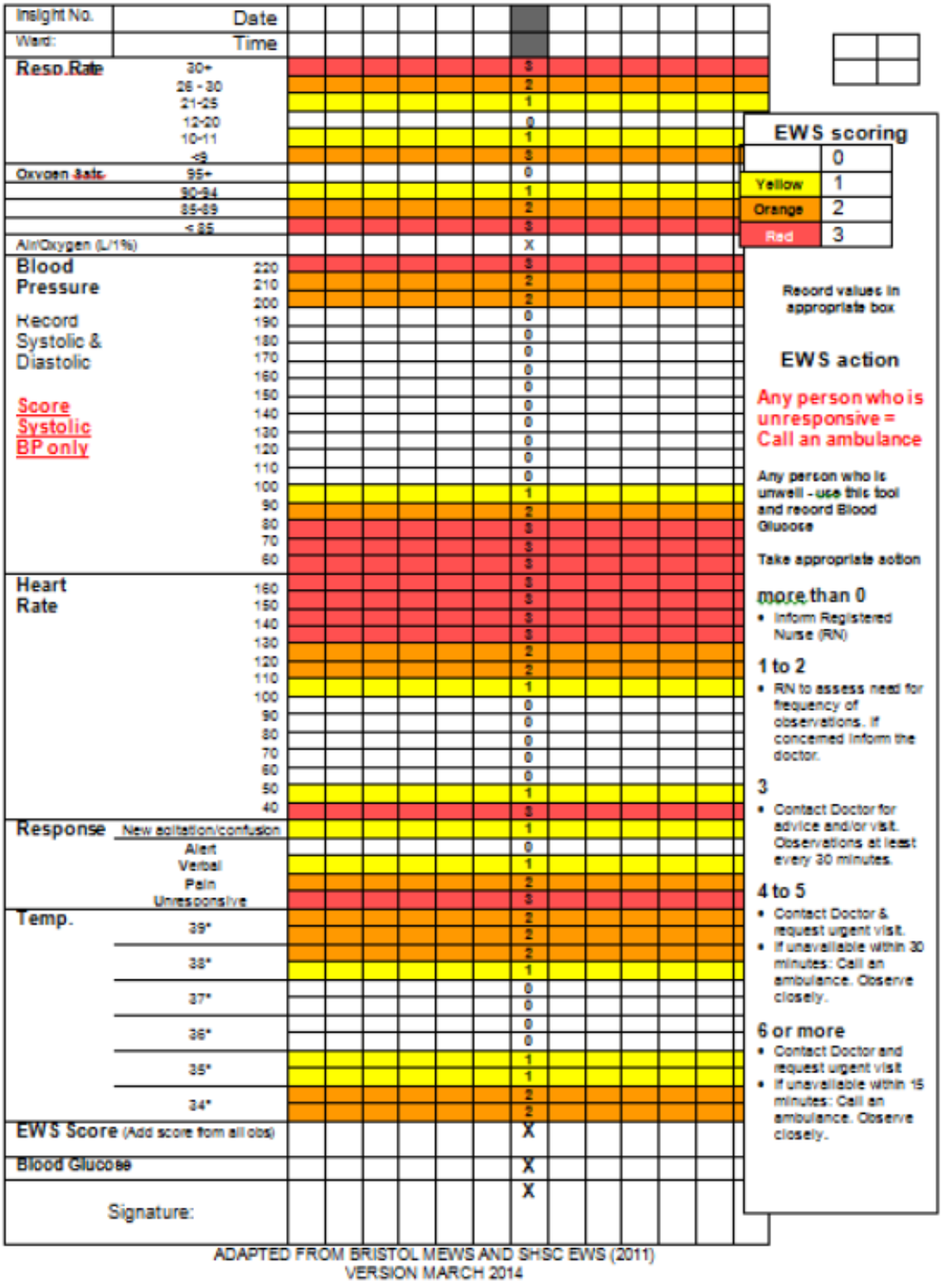
Appendix G – Section 136 Monitoring Form
Section 136 Mental Health Act 1983 Communication/Registration Form (Police to complete pages 1 and 2, AMHP and/or Health Professional to complete page 3)

Custody number (if applicable)		Police Log Number		Insight No	

Section 136 of the Mental Health Act 1983 empowers a constable to remove to 'a place of safety' any person who is found in a place to which the public have access and appears to be suffering from a mental disorder					
AND who is in need of immediate care ☐	or control ☐				
AND who needs to be removed in their own interests ☐	or for the protection of others ☐				
Date: (enter year in full)	Time of Arrival at Place of Safety.:				
Place (where person arrested):	City or Town:				
Person detained – Surname:	Forenames:				
Address:	Postcode:				
Place of birth:	Date of birth:	Age:			
Known Disability	Interpreter Required	Language			
Gender: ID code:	Self-defined ethnicity code:	PNC & local check done?	Yes ☐	No ☐	
For the information of the place of safety and assessment team describe fully the behaviour and circumstances that resulted in detention overleaf. If any of the following apply give details.					
Since detention, has the person received any medical attention prior to arrival at a place of safety?	Yes ☐	No ☐			
If 'yes', describe:					
Has the person been restrained ?	Yes ☐	No ☐	If 'yes', how and for how long?		
Has the person been searched?	Yes ☐	No ☐	If 'yes', has anything been retained?		
Is the person on medication	Yes ☐	No ☐	Unknown ☐		
Is the person suffering from the effects of drink or drugs?	Yes ☐	No ☐	Unknown ☐		
Has the person taken an overdose?	Yes ☐	No ☐	Unknown ☐		
Initial place of safety:	136 Suite: ☐		Police Station ☐		
	A&E ☐	Other ☐			
If not 136 suite, explain why:	Suite full ☐	Too Intoxicated ☐	Too Violent ☐	Potentially too violent ☐	Other (describe) ☐
	Staffing Levels ☐				
Conveyance to place of safety:	Ambulance ☐	Police vehicle ☐	Other (describe) ☐		
Date of arrival: (enter year in full)	Time of arrival:				
Received by:					
Date of departure (police): (enter year in full)	Time of departure (police):				
Officer detaining (signature):					
Print name:	Rank/Collar no.:	Station:			
Officer completing form:	Person receiving form (AMHP/Nurse):				
Signature:	Signature:				

Appendix D – Post Restraint Physical Health Monitoring Forms

Name: Month/Year: Frequency:



ADAPTED FROM BRISTOL MEWS AND SHSC EWS (2011)
VERSION MARCH 2014

Sheffield Health and Social Care
NHS Foundation Trust

RAPID TRANQUILISATION/ /SECLUSION/ POST RESTRAINT PHYSICAL HEALTH MONITORING FORM

Service user's details

Forename:	
Surname:	
NHS no.:	Date of birth:
Gender:	Ethnicity:
Insight number:	Date of form:

Following administration of **Rapid Tranquilisation** medication
(IM Lorazepam, IM Haloperidol, IM Aripiprazole, IM Promethazine)

YOU MUST MONITOR AND RECORD

• Pulse • BP • Respiratory rate	• Temperature • Level of consciousness • Hydration

Either

- Every hour until no concern and at least twice.
- Every 15 minutes if above BNF limits.
- Every 15 minutes if used alcohol/substances, is asleep or sedated, has physical health concerns or experienced harm during physical intervention.
- Following **Restraint for service users with a physical health** condition observations should be recorded as above initially until no concerns and continue 4-6 hourly for 24 hours.
- **DISCUSS ANY CONCERNS WITH MEDICAL STAFF.**

Medicines administered and date and time of administration.

X all that apply

Rapid Tranquilisation		Seclusion		Restraint	

Time								
Pulse (bpm)								
BP (mmHg)								
Respiration (RPM)								
Oxygen sats (% indicate air or O^2)								
Temp (°C)								
Level of consciousness (AVPU)								
Staff initials								
Hydration: When did the service user last have a drink. Record of fluids offered post Rapid Tranquilisation.								

IF UNABLE TO TAKE / SERVICE USER REFUSING PHYSICAL OBSERVATIONS PLEASE COMPLETE THE FOLLOWING AT THE SAME FREQUENCY AS IDENITIFED ABOVE.
USE AN ADDITTIONAL FORM IF REQUIRED

WHERE YOU ARE UNABLE TO TAKE PHYSICAL OBSERVATIONS
you must use the AVPU and continue to attempt to
take observations at the earliest opportunity .

Reason why:

Time				
(A) Airway. Is the airway clear? Is the service user able to speak – if so their airway is clear? Is their breathing noisy – coming from the throat?				
(B) Breathing. Can you see the chest rising? Can you see if rising equally? Is breathing noisy – coming from the chest?				
(C) Circulation. Has the service user's colour changed – blue lips or finger tips?				
(D) Disability – level of consciousness. Use AVPU (**A**lert, responds to **V**oice, responds to **P**ain, **U**nresponsive)				

Hydration: When did the service user last have a drink. Record of fluids offered post Rapid Tranquillisation.	

DISCUSS ANY CONCERNS WITH MEDICAL STAFF

Appendix 12

South West Yorkshire Partnership NHS Foundation Trust

PLACE OF SAFETY

MENTAL HEALTH ACT (1983)

Standard Operating Procedure

Updated December 2017

December 2017 V3

With all of us in mind.

Standard Operating Procedure

1.0 Introduction

The Trust currently borders with 2 police forces and 4 local authorities. There are two multi agency place of safety policies one covering South Yorkshire Police and one covering West Yorkshire Police.

The aim of this procedure is to describe the process for the assessment of patients whilst in the place of Safety suite in South West Yorkshire Partnership NHS Foundation Trust.

The suites operate 24 hours, 365 day per year. The suites can only accommodate one person at a time. The management of the individual suites are under the Business Delivery Unit (BDU) which they are located in.

Each place of Safety has a place of safety coordinator allocated from the nursing team.

Unavailability of the Place of Safety suite

The Senior Manager / On-Call Manager will decide the suite is unavailable. If the suite becomes unavailable partner suites across the Trust must be informed. The place of safety Co-coordinator in the suite is responsible for completing the DATIX report for the unavailability of the suite.

Allocation of Place of Safety Coordinator

Allocated through the off duty rota system.

2.0 Background

The provisions of the MHA under Section 135 & Section 136 are that those persons subject to these sections and certain conditions may be taken and removed to a place of safety for a period of up to 24 hours (unless a doctor certifies that an extension of up to 12 hours is necessary) to a maximum of 36 hours – but only in very limited circumstances. These are that, because of the persons condition (physical or mental), it is not practicable to complete a mental Health Act assessment within the 24hour period. This might arise, for example, if the person is too mentally distressed, or is particularly intoxicated with alcohol or drugs and cannot cooperate with the assessment process.

A decision to extend the detention period can only be taken by the responsible medical practitioner. (The doctor responsible for the medical assessment of the person whilst detained to the suite). The police ultimately have the power under Section 136 to remove a person to a place of safety.

The Trust operates within the boundaries of more than 1 police force and therefore staff across the Trust is working to more than one multi agency policy relating to the use of Section 136 MHA 1983. All staff involved in assessing a patient under Section 136 must have regard for the multi-agency policy.

This SOP has been developed to provide consistent practice within the Trust for our medical and nursing staff. This SOP must be read along with the multi-agency policy for the area that the Trust Place of Safety suite is located.

The definition of a Place of Safety is referenced under Section 135 (6) MHA 1983 with the definition of residential accommodation provided by a local services authority being found under part iii of the National Assistance Act 1948.

A Place of Safety is now defined in the Act as:

- A hospital;
- An independent hospital or care home for mentally disordered persons;
- A police station;
- Residential accommodation provided by a local social services authority
- Any other suitable place (with the consent of a person managing or residing at that place).
- By virtue of the new Section 136A(1) a police station may NOT be used as a place of safety for a person under the age of 18 years under any circumstances

A police station may now only be used as a place of safety for a person aged 18 and over in the specific circumstances set out in The Mental Health Act 1983 (Places of Safety) Regulations 2017, namely, where:

(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.

This SOP is only applicable to SWYPT places of Safety

3.0 Scope

When a person is accepted by the trust into the trust Place of Safety, the trust becomes responsible for the person until such time as the powers are concluded.

REFERRAL TO PLACE OF SAFETY

Please note: Prior to use of 136, the Police Officer with the detainee should, wherever possible consult with a Mental Health Professional as per local agreements **(see Figure 1 below).** If section 136 staff unavailable then mental health advice call can be made to the Police Liaison staff if available or IHBT staff. As per good practice service users should be seen within 3 hours but there needs to have been a clinical triage within 4 hours for under-18s and six hours for adults. In addition,

- For service users under 18, any bed management issues need to escalated at 4 hours
- All clinical reviews need to be documented in clinical notes
- Bed management discussions need to be documented
- The decision to extend the detention for a further 12 hours must be clearly documented and cannot be applied for in respect of bed management difficulties
- Out of hours, the manager on call to liaise with section 136 staff regarding options available for bed management once this has been escalated to them. Decisions will be made in accordance with bed management protocol
- On-call manager will escalate to Director on call if any potential breaches to the legislation.
- All breaches will require a DATIX report and initial fact find completing.

Police officer with the detainee – contact the suite prior to attending to ensure that the suite is available and to discuss the initial referral

If the suite is in use or unavailable, the POS suite coordinator will advise the police of alternative places of safety within the Trust and nearby.

Police and place of Safety Coordinator – complete and record the Risk Assessment to determine the need for continued police presence (*Appendix 1)*

Place of Safety Coordinator and Police – assess the level of staffing required to maintain the safety of both patient and staff. If required to request police assistance to maintain safety of all.

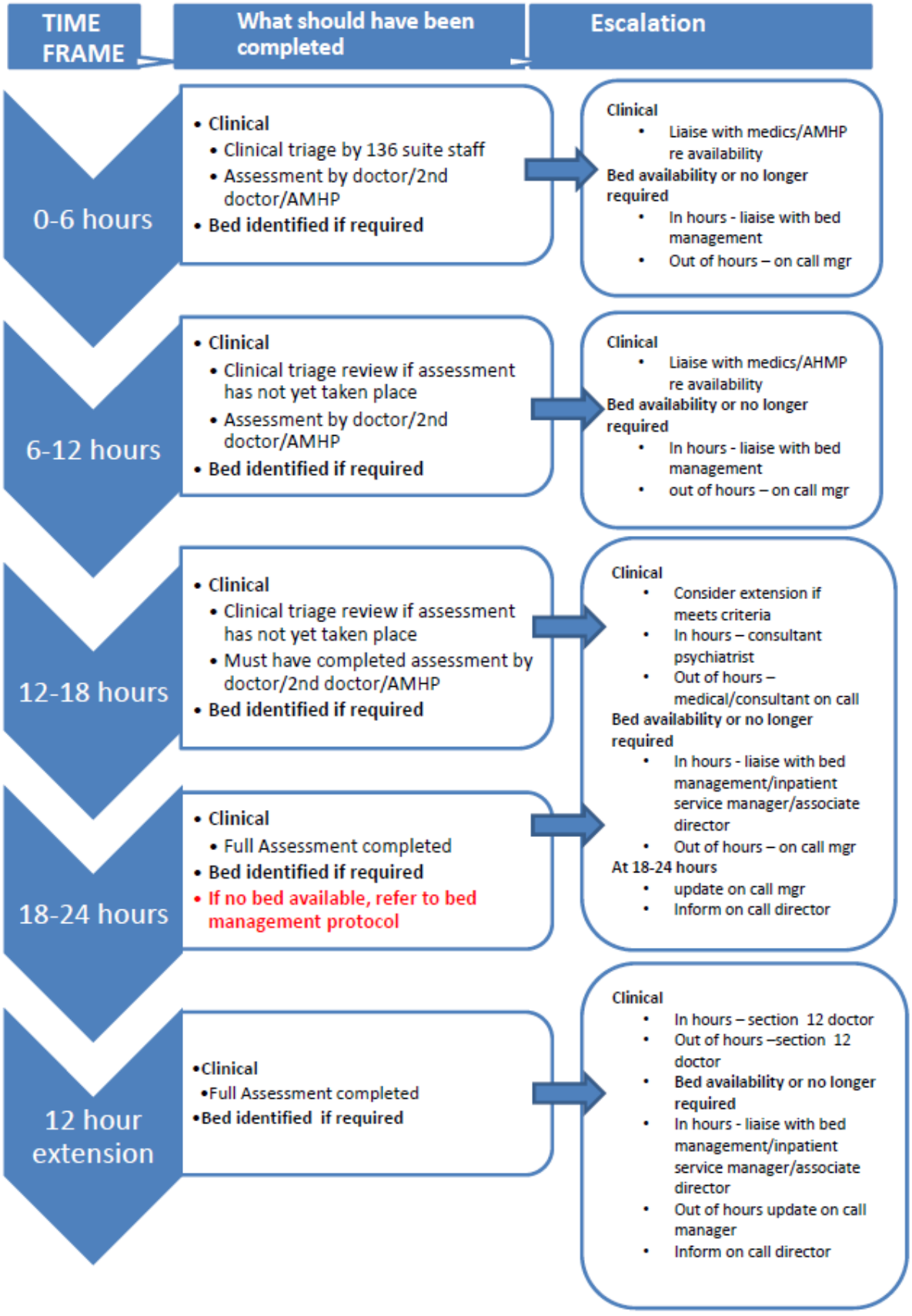
On acceptance to the **Place of Safety the Coordinator** will ensure the following occurs:

ACCEPTANCE TO PLACE OF SAFETY

Police Officer – complete page 1&2 of the Detention Form *(Appendix 2)* Signed copy to be returned to the Place of Safety Coordinator with the admission suite

Place of Safety Coordinator – explains rights under section 132 and provide statutory Department of Health leaflet to patient. Completes section 132 relevant recording form (*Appendix 3, 8 9*)

Figure 1 ADULT SECTION 136 ESCALATION PLAN



Place of Safety Coordinator – assess if patient is capable of understanding reason for being in the Place of Safety and if they understand their rights. Record same into RIO progress notes. If patient is unable to understand then a record of the capacity assessment should be made in the RIO progress notes and should be supported by a consent care plan.

Place of Safety Coordinator – complete initial health screening and record on RIO

Place of Safety Coordinator – identify any medication requirements for physical and mental health

Place of Safety Coordinator – complete body mapping if clinically necessary, observe for any injuries and record. Action any injuries found

Place of Safety Coordinator – start any recording forms such as BP monitoring, fluid balance charts if clinically necessary

Place of Safety Coordinator – assess if person is in the correct place of safety
If no – arrange for transfer under Section 136 to appropriate place of safety – see below (transfer from one place of safety to another)
If yes – continue

Place of Safety Coordinator – contact Approved Mental Health Professional to discuss presentation *(Appendix 4)*

AMHP – contact medical staff required to carry out assessment *(Appendix 4)*
Place of Safety Coordinator – inform medical staff of any concerns and any medication requirements

Place of Safety Coordinator – invite IHBT for relevant area to MHA assessment, and inform bed manager

Place of Safety Coordinator – open up referral on RIO

Place of Safety Coordinator – commence RIO template *(Appendix 5)* and upload to progress notes on RIO

Place of Safety Coordinator – complete Sainsbury risk assessment Level 1 and comprehensive assessment on RIO

Place of Safety Coordinator – record interactions and outcome on RIO progress notes using the template

Place of Safety Coordinator – if admitted and not previously known to services MHCT to be completed

MHA ASSESSMENT

Registered Medical Practitioner – review patients mental state, record in RIO progress notes at time of assessment. NB – time frame now up to 24 hours, do you need to extend this up to 36 hours – need to keep this under review during the 24 hour period if not an issue at the time of assessment

Registered Medical Practitioner – undertake physical health assessment if clinically indicated, record in RIO progress notes

Registered Medical Practitioner – if formal admission to hospital required complete relevant MHA document (if section 3 – bed needs be identified before completion of recommendation)

Registered Medical Professional – if voluntary admission required proceed with arranging admission

Registered Medical Practitioner - complete RIO Template *(Appendix 5)*

Approved Mental Health Professional – assess if admission is required or care can be provided in the community

Approved Mental Health Professional – if admission required, determine formal or voluntary

Intensive Home Based Treatment and Bed Manager – source bed availability. If difficulties identifying a bed refer to bed management protocol

Approved Mental Health Professional – if no admission required assess and arrange for community support. Record outcome on detention form *(Appendix 2)*

Approved Mental Health Professional – on receipt of second medical recommendation and completion of AMHP application AMHP is to arrange conveyance to hospital. AMHP to ensure MHA paperwork is given to authorised transport provider

Approved Mental Health Professional – to discuss with Place of Safety Coordinator appropriate transport for informal patients

DISCHARGE FROM PLACE OF SAFETY SUITE

AMHP or Assessing Team – inform patient that they are no longer subject to MHA

Place of Safety Coordinator and Doctor – complete Section 136 outcome plan on RIO template

Place of Safety Coordinator – inform patients GP assessment and outcome in writing, record in RIO and save letter to RIO *(Appendix 6)*

Place of Safety Coordinator – inform other involved services of assessment and outcome ensuring care coordinator is emailed, record on RIO template

AMHP / Doctor – complete and send all referrals to services as required

Place of Safety Coordinator – give patient copy of friends and family test *(Appendix 10)*

Place of Safety Coordinator – discuss required transport with patient and assist with obtaining same

TRANSFER FROM ONE PLACE OF SAFETY TO ANOTHER

Place of Safety Coordinator/AMHP/Registered Medical Practitioner – discuss reasons and need for transfer with receiving Place of Safety

Place of Safety Coordinator – transfer within trust, detention pack with authority to detain to be sent at the time of transfer, referral to be transferred on RIO to relevant suite

Police/AMHP – arrange transport and appropriate level of escort to Place of Safety (Police and AMHP can authorise a person to organise on their behalf)

4. REPORTING AND MONITORING

Place of Safety Coordinator – fax completed detention form to AMHP lead and Local MHA office *(Appendix 2)*

Place of Safety Coordinator – fax completed monitoring form to MHA office *(Appendix 4)*

MHA admin – enter 136 data into MHA module on RIO

MHA admin – scan detention form and upload into MHA document store *(Appendix 2)*

MHA admin – follow up admission to hospital with admitting ward (if within the Trust)

REPORTING AND MONITORING FORUMS – NEED TERMS OF REFRENCE FOR THESE GROUPS

South West Yorkshire Partnership NHS Trust – MHA committee – Chris Jones (chair) Dr Adrian Berry (lead Director) – quarterly

South West Yorkshire Partnership NHS Trust – Place of Safety working group – Mike Doyle (chair) – quarterly

West Yorkshire multi agency police liaison meeting – Calderdale, Kirklees – Gary Auckland

South Yorkshire multi agency police liaison meeting – Barnsley – Mick Oldham

DISAGREEMENTS BETWEEN PROFESSIONALS ESCALATION PROCESS

Disagreements between any agencies whilst a patient is in the place of Safety suite should be escalated to the General Manager in hours for the suite or the on call Manager out of hours.
The General Manager should escalate to their equivalent within the agencies involved. If required escalate to Director on call

CONTACT DETAILS FOR AGENCIES INVOLVED IN ASSESSMENT

AMHP contact details

Barnsley – 01226 775188 / 07792306309

Wakefield – 01977 465708/465716

Calderdale – 07702656892

Kirklees – 01924 316842

POLICE CONTACT DETAILS

Barnsley – Control Room 01142 202020

Wakefield – Custody Suite 01924 878568 / Duty Inspector 01924 878196

Calderdale – Halifax Patrol Sergeant 01422 337056 / 01422 337059
Huddersfield Patrol Sergeant 01484 436656 / 01484 436659

Kirklees – N/A

APPLICABLE POLICY

- MULTI AGENCY SOUTH YORKSHIRE 136 PROTOCOL
- MULTI AGENCY WEST YORKSHIRE 136 POLICY
- 7 DAY FOLLOW UP
- CPA
- BED MANAGEMENT
- MEDICATION
- MANAGEMENT OF VIOLENCE AND AGRESSION
- DATA PROTECTION ACT
- CONVEYANCING & HOSPITAL TRANSPORT

LEGISLATION

- MHA 1983 AS AMENDED 2007
- MCA 2005

- MHA CODE OF PRACTICE 2015
- MCA CODE OF PRACTICE 2006
- CARE ACT
- HUMAN RIGHTS ACT
- NATIONAL ASSISTANCE ACT 1948
- EQUALITY ACT 2010

DEFINITIONS

Place of Safety Coordinator – registered nurse

AMHP –Approved Mental Health Professional

RMP – Registered Medical Practitioner

APPENDICES

No:	Name
1	**Risk Assessment Form** 1. s.136 Risk Assessment Form.doc
2	**s.136 MHA Detention Form** 2. s.136 MHA Detention Form.doc
3	**s.132 Patient Rights Recording Form** 3. s.132 Patient Rights Recording Forı
4	**s.136 Place of Safety Recording Form** 4. s.136 MHA Monitoring Form.doc
5	**s.136 RIO Template** 5. s.136 RIO template.docx
6	**s.136 GP Letter Template** 6. s.136 GP Letter.doc
7	**s.136 Suite Checklist** 7. s.136 Suite Checklist September 2
8	**s.136 Patient Rights' Guidance** 8. 136 Patient Rights Guidance.docx
9	**s.136 Patient Information Leaflet** 9. s.136 Patient Information Leaflet.rt
10	**s.135 Patient Information Leaflet**

	10. s.135 Patient Information Leaflet.rt
11	**Friends & Family Test** 11. Friends and Family Test.pdf

South West Yorkshire Partnership NHS Foundation Trust

Appendix 13

Guide to Section 136 for DBHT Emergency Department (DRI)

Scope

This guide outlines the process to be followed when police bring a person to the DBHT Emergency Department (DRI) under a section 136 of the Mental Health Act and highlights the responsibilities of the different agencies caring for the person.

Reason for Development

This guide has been produced using the Royal College of Emergency Medicine's A Brief Guide to Section 136 for Emergency Departments and in consultation with DBHT.

General Principles

Those attending ED on s136 should be treated with respect and kindness as for any other patient. They should not be made to feel unwelcome and any discussion of the appropriateness of their attendance should occur between professionals in an appropriate manner. They must be kept up to date with progress and be provided with information, verbally and in written form, about the s136 (see Appendix 3 for example leaflet for patients).

Transfers should take place only when it is in the person's best interests. This may be the case when a section 136 suite would provide a calmer environment than the Emergency Department. However if this will delay assessment it may not be appropriate.

Whenever possible a parallel assessment of physical and mental health needs should be considered, to reduce time spent under section 136 and to speed up definitive care for the person concerned. Ongoing discussion with those responsible for arranging assessment is needed.

There will always be a group of people detained on section 136 who need to attend ED for physical health needs therefore thought must be given to providing appropriate staff training (including security) and assessment areas.

The Role of an Emergency Department (ED) in the Section 136 Pathway

An Emergency Department can itself be a Place of Safety within the meaning of the Mental Health Act. Therefore, if protracted physical health treatment or care is required, where appropriate, the ED should accept the s136 detention and take legal responsibility for custody of the person for the purpose of the Mental Health Act assessment being carried out. In these circumstances, the person continues to be detained under s136 until formally discharged by a section 12 Doctor and / or AMHP.

In exceptional circumstances when a person under s136 presents to an Emergency Department with no physical health needs due to limited Health Based Place of Safety capacity the ED cannot refuse access.

In these instances, it is vital that information about the person's needs, and any associated risks, are clearly explained to ED staff receiving the person and documented on the Joint Risk Assessment **(Appendix 6).** Any security staff at the ED must likewise be properly briefed about the person before the ED takes responsibility for them. Due to the nature of ED's, managing people detained under s136 in this environment can be challenging. Given this, when a person detained under s136 is in the ED the police will provide the necessary support in line with the agreed South Yorkshire NHS/SYP Joint Escalation Protocol **(Appendix 7)** unless there is mutual agreement between the Department and the police that they are able to leave.

South Yorkshire Police will **NEVER** leave a s136 detained person in ED unless acceptance of the detention has been agreed and the name of the person taking over the responsibility of the s136 detained person has been obtained. Police must satisfy themselves that there is suitable security for the person and staff prior to leaving the ED.

If there are disagreements regarding the joint risk assessment **(Appendix 6)** and whether the Police should remain, these cases should be referred to the Critical Incident Manager for discussion with a

Senior NHS representative in line with the South Yorkshire SYP/NHS Joint Escalation Protocol **(Appendix 7).**

Following departure of police from the place of safety, should the behaviour of the detainee deteriorate police may be asked to return to assist while additional healthcare resources are sought.

If the decision is taken that it is in the individual's best interest to transfer them from the ED to a mental health based place of safety for the purpose of the Mental Health Act Assessment, it must first be confirmed that the place of safety has capacity and is willing to receive the individual before the transfer takes place. It is the police's responsibility with the support of ED staff to secure this confirmation.

Parallel Assessments in the Emergency Department

A Mental Health Act assessment should not be delayed for delivery of physical health treatment that has no predictable significant impact upon mental state. A MHA assessment should not however take place if there is suspicion that a physical condition is leading to or significantly worsening a disturbance of mind. On initial presentation in ED consideration should be given immediately to the appropriate assessment of both physical and mental health needs.

If an individual has been assessed in an ED and requires admission as an inpatient for further physical health care treatment at the Acute Trust, the patient will continue to be detained under Section 136 unless one of the following take place:

- The s12 doctor (or other doctor with mental health training and expertise) finds the person to have no underlying mental disorder, in which case they can discharge the individual from the s136 without input from the AMHP;
- A Mental Health Act assessment has been undertaken by a s12 doctor and AMHP and any necessary arrangements for the person's mental health care have been made, at which point the AMHP should formally discharge the S136;
- The detention period under S136 has elapsed, however it is not good practice to let this happen.

In these circumstances the DBHT ED should take responsibility for the person's custody; there should be a mutual agreement between ED and the police officers about when the officers are able to leave, taking into consideration the risk presented by that individual and police capacity to provide support.

While the detained individual is in the ED and is being treated for their physical health, the ED staff have a clinical duty of care to that individual with support from medical and psychiatry specialities. This duty of care continues until the individual leaves the ED.

The clinical duty of care for the individual outlined above should not be confused with overall legal responsibility. During the time in ED, the overall legal responsibility for the individual remains with the police, unless ED staff formally accept responsibility for the person's custody, and only an AMHP and s12 doctor can discharge the S136 once they are satisfied that the necessary care arrangements have been made.
(**Appendix 2** – flowchart at the ED)

The Joint SYP/NHS Escalation Protocol for Use of Police Cells as a Place of Safety and Police Support at Health Based Places of Safety **(Appendix 7)** outlines arrangements for police officers to remain in attendance when a person arrives at DBHT ED or a mental health-based place of safety.

The protocol states that Police Officers will **NEVER** leave a S136 detained person in the Emergency Department or any other hospital setting or place of safety unless acceptance of the detention of the person has been agreed and the name of the person taking over the responsibility

of the s136 detained person, has been obtained. The length of time that officers remain with the detainee will depend on the circumstances and risks associated with the individual and officers should be able to leave when the situation is agreed to be safe for the detained person and healthcare staff. Other than in an Emergency Department, the Police Officer should not normally be expected to stay for longer than one hour (Royal College of Psychiatrists Guidance). This handover period should enable the health-based place of safety to become appropriately staffed.

If there are disagreements regarding the joint risk assessment and whether police officer should remain, these cases should be referred to the Critical Incident Manager for discussion with a senior NHS representative.

Following departure of police from the place of safety, should the behavior of the detainee deteriorate police may be asked to return to assist while additional healthcare resources are sought.

Escalation (Police): Who to speak to?

If the Critical Incident Manager needs to speak to someone within the Mental Health Trust, helpful contact details are provided below:

Rotherham Doncaster and South Humber NHS Foundation Trust

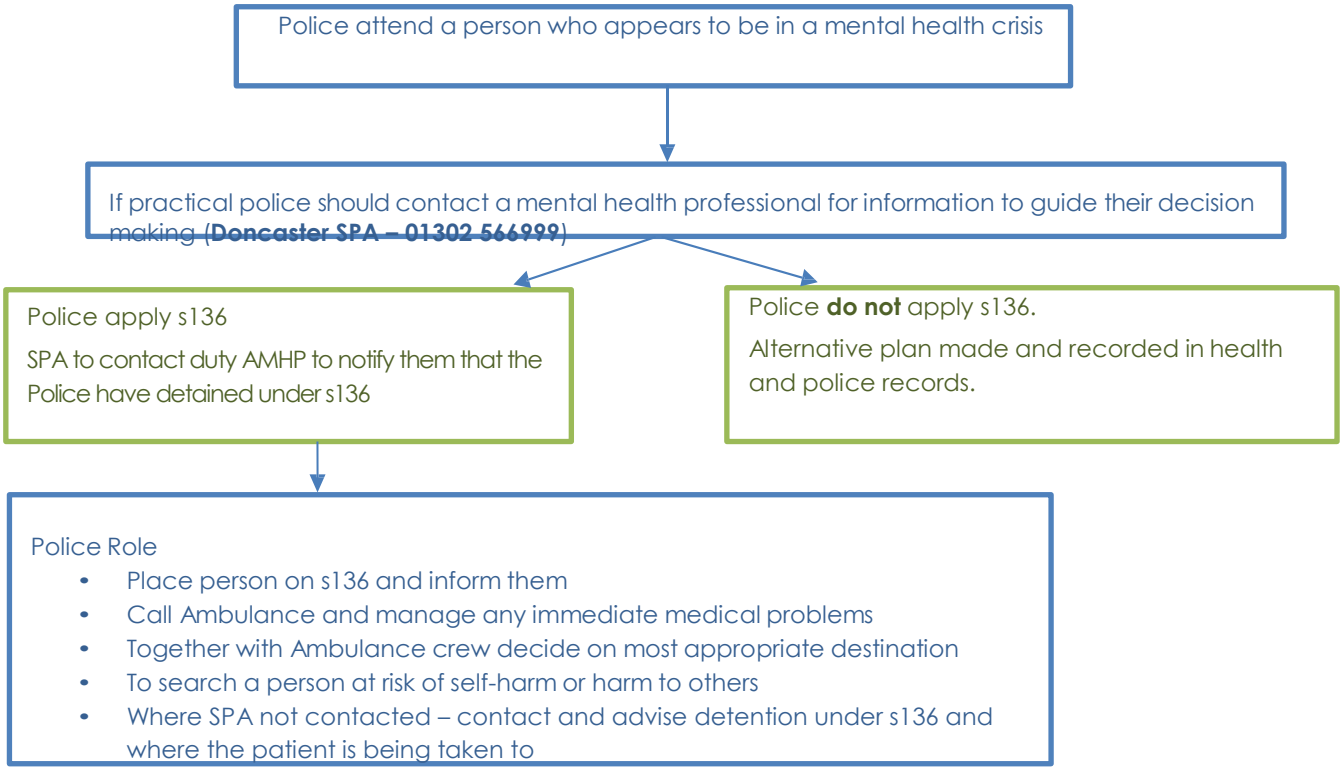
Telephone: 01302 796000
When Switchboard answers ask to speak to the on-call manager. If things cannot be resolved via the on-call manager, ask for the issue to be escalated to the on-call Care Group Director and then subsequently to the on-call Director.

Escalation (NHS): Who to speak to?

If a representative/Manager/Director from the NHS needs to contact a senior representative within South Yorkshire Police, they are advised to call 101 and ask to speak to the Critical Incident Manager (CIM) who is available 24/7.

Appendix 1

Section 136 Flowchart – Pre Hospital



NB on arrival at ED, Police should notify staff that the patient is detained under s136 MHA. The clock starts at this point and the MHA assessment must be completed within **24 hours**

Emergency Department

s136 requiring urgent medical treatment with red flag features.

(See Appendix 2 for red flags.)

Appendix 2

Section 136 Flowchart – At the Emergency Department

Nurse in charge and senior medic to review patient on arrival with police and ambulance crew and assess medical needs and RAVE risks of Resistance, Aggression, Violence and Escape (see Appendix 3)

Inform Psychiatric Liaison that there is a patient on a s136 in ED

Clock starts with **24** hours available for the MHA assessment. Please note the time of arrival.

Police to share Information and complete appropriate electronic s136 paperwork onto Police Portal and email to rdash.doncaster-s136@nhs.net

Requires medical care in hospital

Person placed in appropriate area and treatment commenced

Psychiatric Liaison Team to advise patient of their rights; leaflet given to patient

Contact SPA (01302 566999) and inform them of patient and likely time the patient will be fit for assessment. Ongoing discussion as treatment continues

No medical needs

s136 suite available

Person transferred by police and Ambulance service

If no s136 suite available ED **may** be the most appropriate place for assessment

Police will remain at the hospital with the patient until the patient is medically fit and transferred to the s136 suite or the s136 assessment is completed in ED

Medical care completed quickly.

If local s136 suite available and appropriate; transfer for assessment with police and ambulance.

If no local s136 suite available, consider assessment in s136 suite across South Yorkshire or ED **may** be the most appropriate place for assessment

Medical care likely to be prolonged

If patient is fit for assessment; conduct s136 assessment in parallel with medical treatment in ED

If patient's fitness for assessment is likely to be delayed, contact MHA organiser to arrange s12 approved clinician to consider extension to time.

Consider assessment in ED as per local arrangement when no alternative PoS.

Liaise with MHA organiser to facilitate assessment.

Appendix 3

ADMISSION OF MENTALLY DISORDERED PERSONS FOUND IN A PUBLIC PLACE (Section 136 of the Mental Health Act 1983)

1. Patient's name	
2. Name of hospital and ward	

Why am I in hospital?

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

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

How long will I be here?

You can be kept here (or in another place where you will be safe) for up to 24 hours so that you can be seen by a doctor and an approved mental health professional. This can be extended to 36 hours if it is felt that it is not possible to assess you properly because of physical health concerns.

An approved mental health professional is someone who has been specially trained to help decide whether people need to be kept in hospital.

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

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

If the doctors and the approved mental health professional have not seen you by the end of the 24 hours, you will be free to leave. You may decide to stay on as a voluntary patient. But if you do want to leave, please talk to a member of staff first.

In your case the 24 hours end at:

Date	***Time***

What happens next?

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

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

Can I appeal?

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

Will I be given treatment?

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

Letting your nearest relative know

A copy of this leaflet will be given to the person the Mental Health Act says is your nearest relative.

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

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

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

Changing your nearest relative

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

Code of Practice

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

How do I complain?

If you want to complain about anything to do with your care and treatment in hospital, please speak to a member of staff. They may be able to sort the matter out. They can also give you information about the hospital's complaints procedure, which you can use to try to

sort out your complaint locally. They can also tell you about any other people who can help you make a complaint, for example an independent mental health advocate (see above).

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

Further help and information

If there is anything you do not understand about your care and treatment, a member of staff will try to help you. Please ask a member of staff to explain if there is anything in this leaflet you do not understand or if you have other questions that this leaflet has not answered.

Please ask if you would like another copy of this leaflet for someone else.

Appendix 4

Red Flag criteria used by Police and Ambulance Services

<table>
<tr><th colspan="2">S136 RED FLAG CRITERIA (this is not an exhaustive list) Police Officer / Paramedic triggers for conditioquiring Treatment or Assessment in an Emergency Department</th></tr>
<tr><td>Dangerous Mechanisms:

Patient has been hit by Taser
Blows to the body (significant potential)
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</td><td>Serious Physical Injuries:

Noisy Breathing
Not rousable to verbal command
Head Injuries:
• Loss of consciousness at any time
• Facial swelling
• Bleeding from nose or ears
• Deep cuts
• Suspected broken bones</td></tr>
<tr><td>Actual (current) Attempt of self-harm:

Actively head banging
Actual use of edged weapon (to self-harm)
Ligature use Evidence of overdose or poisoning Psychiatric Crisis (with self-harm)
Delusions / Hallucinations / Mania</td><td>Possible Excited Delirium (agitated patient):

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</td></tr>
<tr><td>Senior Clinical Staff where available.
ONLY AT THE REQUEST OF PARAMEDICS / TECHNICIANS – ACCESSED VIA EOC

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

This should include situations where rapid tranquilisation is considered necessary, in accordance with NICE GUIDELINES 2005.</td><td>Conveyance to the nearest ED:

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

This includes remaining in ED until the person is medically fit for discharge to PoS, to Police Station or from s136 detention. It is the responsibility of the Police to outline to ED the LEGAL ASPECTS of detention; it is the responsibility of the Ambulance Service to outline the MEDICAL ASPECTS.</td></tr>
</table>

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

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

Appendix 6

Brief Section 136 Risk Assessment

Name of individual detained:

Date: **Time:**

Address:

Risk Factor	Yes	No	Not Known	Evidence of Risk
Has there been any recent violence towards others.				
Have there been any recent deliberate self-harm attempts.				
Was the police involvement due to a suicide attempt				
Is there evidence that the person uses illicit substances				
Is there evidence that the person is dependent on alcohol				
Is the person's behaviour out of character				
Is there evidence that this person is at risk of abuse/exploitation from others				
Are there any known issues in respect of safeguarding children				
Are there any identified physical health care risks i.e. head injury, diabetes, epilepsy				

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, ie; personal/physical risk factors and risk of absconding prior to completion of the mental health assessment

Completed by:

…… **……**

Police Officer **Staff Nurse**

NB: IF THE OUTCOME OF THE SECTION 136 ASSESSMENT IS THAT THE PERSON IS TO REMAIN ON THE WARDS CLINICAL STAFF ARE TO COMPLETE A FULL RISK ASSESSMENT

In cases where the Police Officers have been allowed to leave the person at the Section 136 Suite, if the person's presentation changes the Police can be contacted and they will come back to the Section 136 Suite

Appendix 7

SYP/NHS Joint Escalation Protocol for Critical Incident Managers and NHS On-Call Managers – Use of Police Cells and Police Support at Places of Safety

South Yorkshire Police and NHS Escalation Process following Changes to the Police Powers and Places of Safety Provisions in the Mental Health Act 1983

Following a meeting with Strategic Health Partners and South Yorkshire Police on Wednesday 6th December 2017, it was recognized that the regulations, which accompany the legislation change, will significantly reduce the number of circumstances in which a police station may be used as a place of safety throughout the UK.

In summary three criteria must exist in order to allow a police station to be used;

- The detaining officer must reasonably consider that the behavior of the person poses an imminent risk of serious injury or death, either to themselves or another person; AND
- The officer must believe that no place of safety in the police force area could safely manage that risk; AND
- The decision to rely upon a police station must be authorised by an officer at the rank of Inspector,

• although in South Yorkshire this decision will be made by the Critical Incident Manager (CIM)

Once the person arrives in police custody, there are several things to bear in mind:

- Use of Police custody is still subject to the custody officers normal set of considerations in terms of authorising detention;
- It is the custody officer's legal decision to detain further and if the CIM is a Chief Inspector and disagrees with any decision taken by the Sergeant, PACE states this must be referred to a Superintendent (On-Call PACE)
- Once detained the custody officer must ensure several things happen:
- A check by a healthcare professional every thirty minutes;
- Wherever possible, there should be a constant healthcare presence throughout the duration that person is detained;
- If the original grounds for using the police station cease to apply, the person must be transferred elsewhere; unless the S136 assessment is imminent and transferring the person would delay things to their disadvantage;
- If the custody sergeant is not able to ensure the relevant frequency of health checks, the person must be transferred elsewhere; again, this is unless the assessment is imminent and transfer would delay things to the person's disadvantage.

• Critical Incident Managers Authority

Firstly, where the Critical Incident Manager is being asked to authorise use of a police station this should be considered very carefully: by virtue of the two other criteria required (as above) prior to them considering giving their authority, the person concerned may be significantly ill and particular care should be taken to ensure that intoxication by drugs or alcohol or any resistance, aggression or violence are not symptomatic of something serious that would require medical clearance by a paramedic or an emergency department.

- **It is advisable that every S136 detention receives some form of medical assessment prior to considering whether custody is appropriate.**

A Critical Incident Manager will not be at the scene of an incident where s136 is used – we can imagine this may all be managed by phone or police radio discussion and detaining officers asking whether they could or should remove a detained person to custody?

Factors to consider –

- Firstly – have we called an ambulance? … if not, why not? – ensure it is done.
- Does the detaining officer have enough support from colleagues to manage that scene and the behaviour of the person? … if not, can we get more officers to them?
- Strong oversight: consider dispatching a duty sergeant to direct control of events, if there isn't one there already – this incident could develop in a number of ways at this stage, including by ending badly: a first-line supervisor should focus on this and on nothing else, if at all possible.
- What is the 'clinical assessment' of RED FLAGS – best done by a paramedic, of course; but if they're not yet in attendance or unable to attend at all, it will have to be the officers present to make that call on the basis of their first-aid certificate and personal safety training.
- Be aware that **Physical Restraint + Mental Health = Medical Emergency** and bear in mind ABD, the potential for drugs and alcohol to mask problems and that resistant, frightened or aggressive behaviour can indicate underlying medical problems. Restraint only complicates those matters, it never does the opposite.

A sensible judgement will have to be made about waiting for an ambulance; the greater the concerns about ongoing impact of any restraint, the sooner it may be necessary to move the person; but if arrival of paramedics is imminent, it may be safer to remain there. Paramedics can administer medication in some circumstances (under the Mental Capacity Act) that can assist; equally, they can travel with the person in case of any untoward development en route to the chosen location.

If all of that has happened or been ruled out as being necessary and we still have an 'imminent risk' situation, then and only then should the Critical Incident Manager consider authorising use of a police station, and only where there is that constant healthcare monitoring after arrival.

- **Detention in Custody**

Secondly, the new regulations require health care checks to be carried out every 30 minutes. Remember, without those thirty-minute checks: the custody officer is obliged to transfer the person elsewhere.

The Regulations are focused on police stations, not just on police custody, but they repeatedly refer to the custody officer, which is a position only relevant in police custody. What happens in the rest of the station is a matter for the officer in charge of it. So the ability to ensure the thirty minute checks will determine whether a particular police station can act as a Place of Safety, and not all (PACE) designated custody areas will be able to do so.

- **Monitoring in Custody**

The healthcare checks that are required, must occur every thirty minutes – the Regulations don't specify who should do this, as long as it is a 'healthcare' professional, as defined by health legislation. For police purposes, this simply means, doctor or nurse. An AMHP would not be able to do this, unless they were also a registered nurse – most AMHPs are mental health social workers, and not healthcare professionals for the purposes of these Regulations. In addition, the custody sergeant must undertake an hourly check of the detainee in the normal way and is at liberty to impose a regime of enhanced observations, as they see necessary and influenced by healthcare advice. This could mean, 1-to-1 obs by a police officer; or even 2-to-1 obs, if necessary – all supplemented by those healthcare checks.

The Regulations do allow for this one-hourly check to be relaxed on healthcare advice, to three hourly checks if the person is sleeping. Whilst this should be based on healthcare advise, it should also be borne in mind that if someone is sleeping, then arguably the criteria for removing them from the police station are met and they should be moved. We should also be wary of someone who may have previously been noisy, frightened and distressed now being silent in a sleeping position: is the person now lying on the floor actually asleep, or are they unconscious or worse?!

- **Police Officers remaining with the person detained under S136**

Police officers will NEVER leave a S136 detained person in the Accident & Emergency Department or any other hospital setting or place of safety unless acceptance of the detention of the person has been agreed and the name of the person taking over the responsibility of the S136 detained person, has been obtained. Police Officers must satisfy themselves that there is suitable security for the person and staff prior to leaving the place of safety.

If there are disagreements regarding the joint risk assessment and whether police officers should remain, these cases should be referred to the Critical Incident Manager for discussion with a senior NHS representative.

Following departure of police from the place of safety, should the behaviour of the detainee deteriorate police may be asked to return to assist while additional healthcare resources are sought.

- **Escalation (Police): Who to speak to?**

If the Critical Incident Manager needs to speak to someone within the Mental Health Trust, helpful contact details are provided below:

Rotherham, Doncaster and South Humber NHS Foundation Trust	
Telephone: 01302 796000	When Switchboard answers ask to speak to the on-call manager. If things cannot be resolved via the on-call manager ask for the issue to be escalated to the on-call Care Group Director and then subsequently to the on-call Director.
Sheffield Health & Social Care NHS Foundation Trust	
Telephone: 0114 271 6310	When Switchboard answers, in hours ask for the Service Director or Deputy Service Director, out of hours it will be the on-call manager.
South West Yorkshire Partnership NHS Foundation Trust	
Telephone: 01226 434 000	When Switchboard answers, ask to speak to the On-call manager. If things cannot be resolved via the on-call manager ask to speak to the on-call Director.

- **Escalation (NHS): Who to speak to?**

If a representative/Manager/Director from the NHS needs to contact a senior representative within South Yorkshire Police, they are advised to call 101 and ask to speak to the Critical Incident Manager (CIM) who is available 24/7.

- **Review**

South Yorkshire Police Officers are expected to escalate any issues related to mental health incidents via email: ForceMentalHealth@southyorks.pnn.police.uk.

Guide to S136
TRFT Emergency Department
Rotherham (RGH)

Scope

This guide outlines the process to be followed when police bring a person to the TRFT Emergency Department (RGH) under a section 136 of the Mental Health Act and highlights the responsibilities of the different agencies caring for the person.

Reason for development

This guide has been produced using the Royal College of Emergency Medicine's A Brief Guide to Section 136 for Emergency Departments and in consultation with TRFT, Rotherham Doncaster and South Humber NHS FT, Rotherham Metropolitan Borough Council and South Yorkshire Police.

General Principles

Those attending ED on s136 should be treated with respect and kindness as for any other patient. They should not be made to feel unwelcome and any discussion of the appropriateness of their attendance should occur between professionals in an appropriate manner. They must be kept up to date with progress and be provided with information, verbally and in written form, about the s136 (see Appendix 3 for example leaflet for patients).

Transfers should take place only when it is in the person's best interests. This may be the case when a section 136 suite would provide a calmer environment than the Emergency Department. However if this will delay assessment it may not be appropriate.

Whenever possible a parallel assessment of physical and mental health needs should be considered, to reduce time spent under section 136 and to speed up definitive care for the person concerned. Ongoing discussion with those responsible for arranging assessment is needed.

There will always be a group of people detained on section 136 who need to attend ED for physical health needs therefore thought must be given to providing appropriate staff training (including security) and assessment areas.

The role of an Emergency Department (ED) in the Section 136 Pathway

An Emergency Department can itself be a Place of Safety within the meaning of the Mental Health Act. Therefore, if protracted physical health treatment or care is required, where appropriate, the ED should accept the s136 detention and take legal responsibility for custody of the person for the purpose of the Mental Health Act assessment being carried out. In these circumstances, the person continues to be detained under s136 until formally discharged by a section 12 Doctor and / or AMHP.

In exceptional circumstances when a person under s136 presents to an Emergency Department with no physical health needs due to limited Health Based Place of Safety capacity the ED cannot refuse access.

In these instances, it is vital that information about the person's needs, and any associated risks, are clearly explained to ED staff receiving the person and documented on the Joint Risk Assessment **(Appendix 6).** Any security staff at the ED must likewise be properly briefed about the person before the ED takes responsibility for them. Due to the nature of ED's, managing people detained under s136 in this environment can be challenging. Given this, when a person detained under s136 is in the ED the police will provide the necessary support in line with the agreed South Yorkshire NHS/SYP Joint Escalation Protocol **(Appendix 7)** unless there is mutual agreement between the Department and the police that they are able to leave.

South Yorkshire Police will **NEVER** leave a s136 detained person in ED unless acceptance of the detention has been agreed and the name of the person taking over the responsibility of the s136 detained person has been obtained. Police must satisfy themselves that there is suitable security for the person and staff prior to leaving the ED.

If there are disagreements regarding the joint risk assessment **(Appendix 6)** and whether the Police should remain, these cases should be referred to the Critical Incident Manager for discussion with a Senior NHS representative in line with the South Yorkshire SYP/NHS Joint Escalation Protocol **(Appendix 7).**

Following departure of police from the place of safety, should the behaviour of the detainee deteriorate police may be asked to return to assist while additional healthcare resources are sought.

If the decision is taken that it is in the individual's best interest to transfer them from the ED to a mental health based place of safety for the purpose of the Mental Health Act Assessment, it must first be confirmed that the place of safety has capacity and is willing to receive the individual before the transfer takes place. It is the police's responsibility with the support of ED staff to secure this confirmation.

Parallel Assessments in the Emergency Department

A Mental Health Act assessment should not be delayed for delivery of physical health treatment that has no predictable significant impact upon mental state. A Mental Health Act assessment should not however take place if there is suspicion that a physical condition is leading to or significantly worsening a disturbance of mind. On initial presentation in ED consideration should be given immediately to the appropriate assessment of both physical and mental health needs.

If an individual has been assessed in an ED and requires admission as an inpatient for further physical health care treatment at the Acute Trust, the patient will continue to be detained under Section 136 unless one of the following take place:

- The s12 doctor (or other doctor with mental health training and expertise) finds the person to have no underlying mental disorder, in which case they can discharge the individual from the s136 without input from the AMHP;
- A Mental Health Act assessment has been undertaken by a s12 doctor and AMHP and any necessary arrangements for the person's mental health care have been made, at which point the AMHP should formally discharge the s136;
- The detention period under s136 has elapsed, however it is not good practice to let this happen.

In these circumstances the TRFT ED should take responsibility for the person's custody; there should be a mutual agreement between ED and the police officers about when the officers are able to leave, taking into consideration the risk presented by that individual and police capacity to provide support.

While the detained individual is in the ED and is being treated for their physical health, the ED staff have a clinical duty of care to that individual with support from medical and psychiatry specialities. This duty of care continues until the individual leaves the ED.

The clinical duty of care for the individual outlined above should not be confused with overall legal responsibility. During the time in ED, the overall legal responsibility for the individual remains with the police, unless ED staff formally accept responsibility for the person's custody, and only an AMHP and s12 doctor can discharge the s136 once they are satisfied that the necessary care arrangements have been made.
(**Appendix 2** – flowchart at the ED)

The Joint SYP/NHS Escalation Protocol for Use of Police Cells as a Place of Safety and Police Support at Health Based Places of Safety **(Appendix 7)** outlines arrangements for police officers to remain in attendance when a person arrives at TRFT ED or a mental health-based place of safety.

The protocol states that Police Officers will **NEVER** leave a S136 detained person in the Emergency Department or any other hospital setting or place of safety unless acceptance of the detention of the person has been agreed and the name of the person taking over the responsibility of the s136 detained person, has been obtained. The length of time that officers remain with the detainee will depend on the circumstances and risks associated with the individual and officers should be able to leave when the situation is agreed to be safe for the detained person and healthcare staff. Other than in an Emergency Department, the Police Officer should not normally be expected to stay for longer than one hour (Royal College of Psychiatrists Guidance). This handover period should enable the health-based place of safety to become appropriately staffed.

If there are disagreements regarding the joint risk assessment and whether police officer should remain, these cases should be referred to the Critical Incident Manager for discussion with a senior NHS representative.

Following departure of police from the place of safety, should the behavior of the detainee deteriorate police may be asked to return to assist while additional healthcare resources are sought.

Escalation (Police): Who to speak to?

If the Critical Incident Manager needs to speak to someone within the Mental Health Trust, helpful contact details are provided below:

Rotherham Doncaster and South Humber NHS Foundation Trust

In hours: Crisis Team Service Manager – 01709 302670

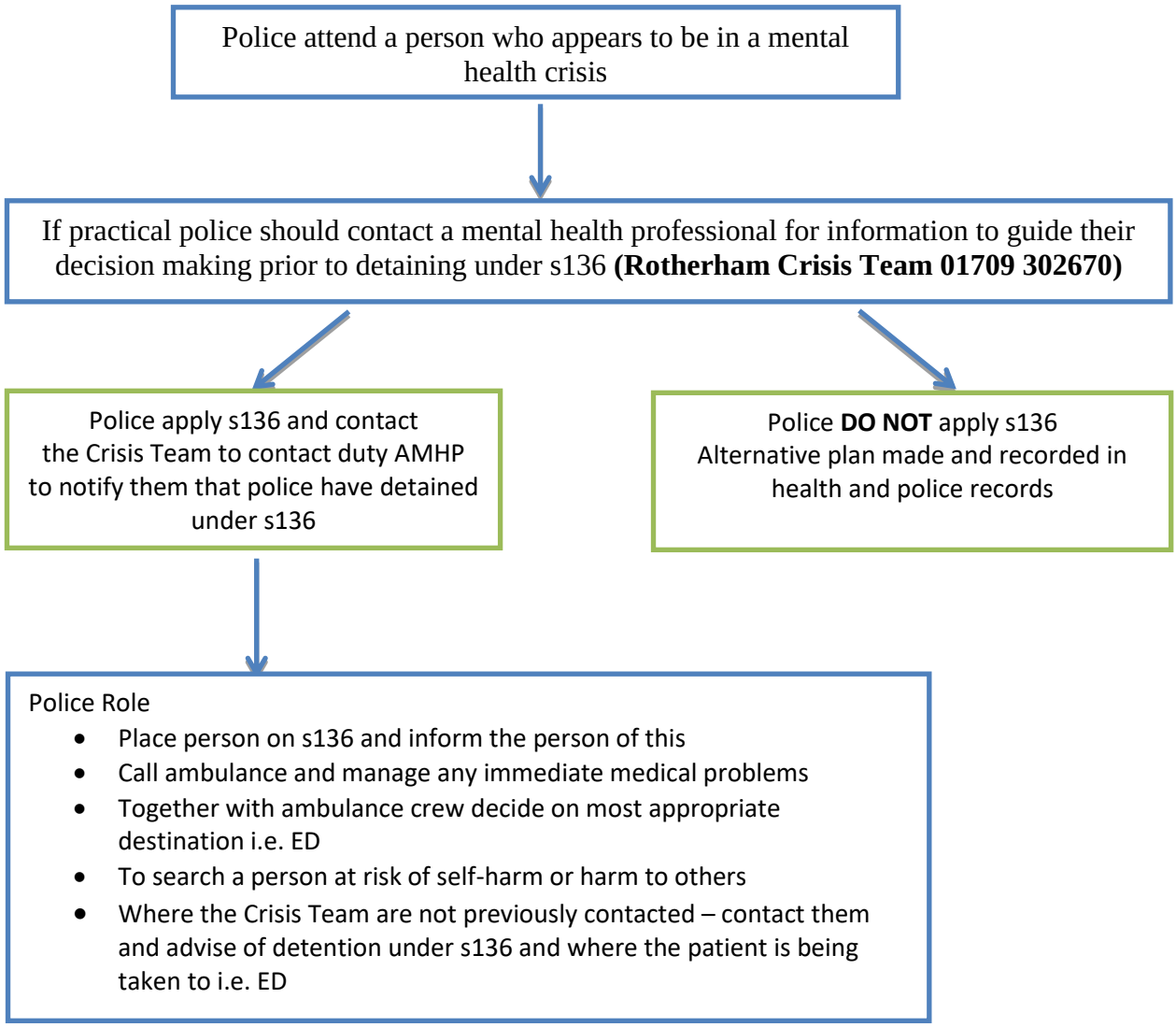
Out of hours: Telephone: 01302 796000
When Switchboard answers ask to speak to the on-call manager (bronze). If things cannot be resolved via the on-call manager, ask for the issue to be escalated to the on-call Care Group Director (silver) and then subsequently to the on-call Director (gold).

Escalation (NHS): Who to speak to?

If a representative/Manager/Director from the NHS needs to contact a senior representative within South Yorkshire Police, they are advised to call 101 and ask to speak to the Critical Incident Manager (CIM) who is available 24/7.

Appendix 1

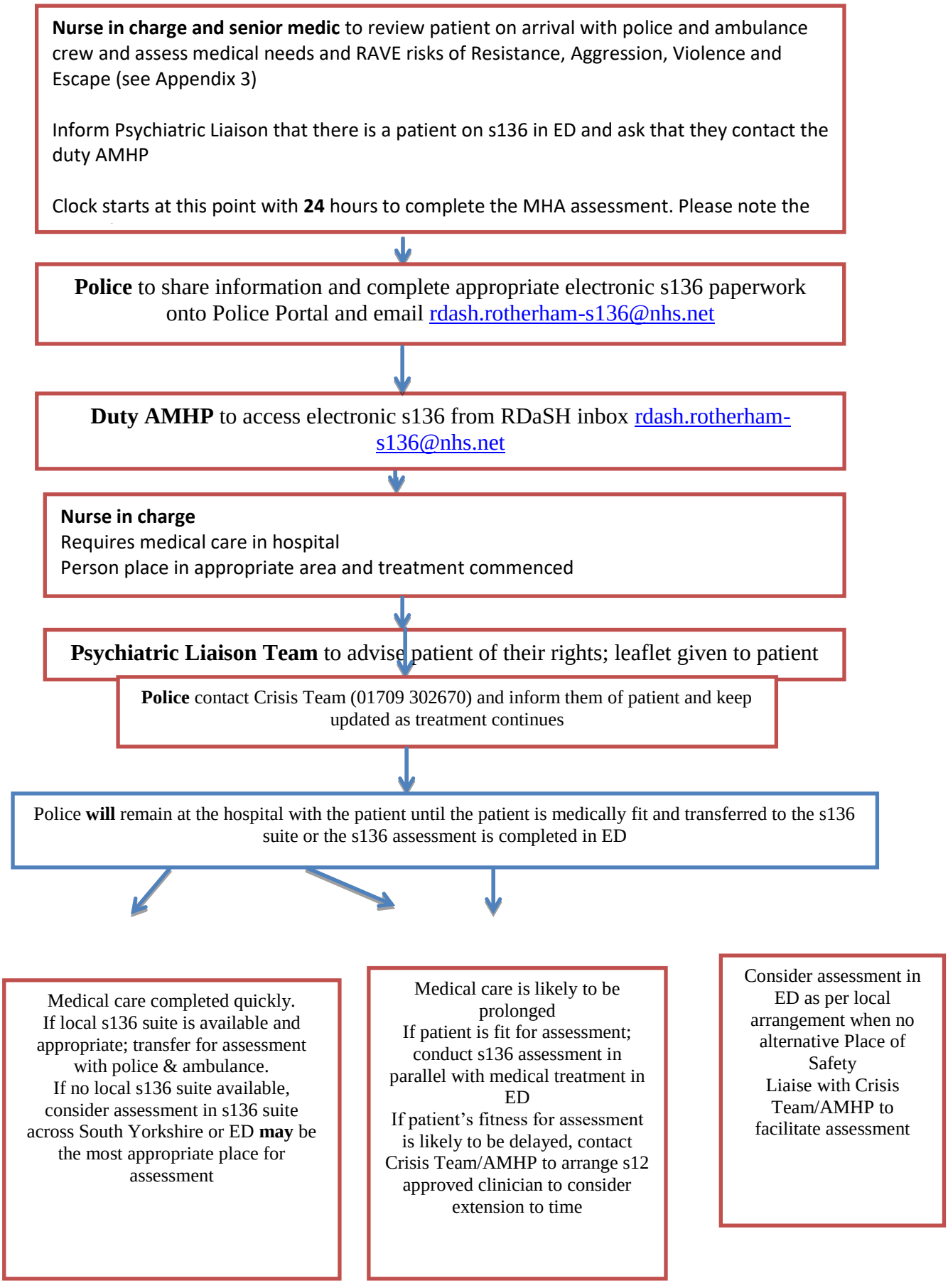
Section 136 Flowchart – Pre Hospital



NB on arrival, police should notify staff that the patient is detained under s136 MHA. The clock starts at this point and the MHA assessment must be completed within **24 hours**.

Emergency Department
s136 requiring urgent medical treatment with red flag features
(See Appendix 2 for red flags)

S136 Flowchart – At ED **Appendix 2**



Appendix 3

ADMISSION OF MENTALLY DISORDERED PERSONS FOUND IN A PUBLIC PLACE (Section 136 of the Mental Health Act 1983)

1. Patient's name	
2. Name of hospital and ward	

Why am I in hospital?

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

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

How long will I be here?

You can be kept here (or in another place where you will be safe) for up to 24 hours so that you can be seen by a doctor and an approved mental health professional. This can be extended to 36 hours if it is felt that it is not possible to assess you properly because of physical health concerns.

An approved mental health professional is someone who has been specially trained to help decide whether people need to be kept in hospital.

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

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

If the doctors and the approved mental health professional have not seen you by the end of the 24 hours, you will be free to leave. You may decide to stay on as a voluntary patient. But if you do want to leave, please talk to a member of staff first.

In your case the 24 hours end at:

Date	***Time***

What Happens Next?

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

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

Can I appeal?

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

Will I be given treatment?

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

Letting your nearest relative know

A copy of this leaflet will be given to the person the Mental Health Act says is your nearest relative.

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

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

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

Changing your nearest relative

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

Code of Practice

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

How do I complain?

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

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

Further help and information

If there is anything you do not understand about your care and treatment, a member of staff will try to help you. Please ask a member of staff to explain if there is anything in this leaflet you do not understand or if you have other questions that this leaflet has not answered.

Please ask if you would like another copy of this leaflet for someone else.

Appendix 4

Red Flag criteria used by Police and Ambulance Services

<table>
<tr><th colspan="2">S136 RED FLAG CRITERIA (this is not an exhaustive list) Police Officer / Paramedic triggers for conditioquiring Treatment or Assessment in an Emergency Department</th></tr>
<tr><td>Dangerous Mechanisms:

Patient has been hit by Taser
Blows to the body (significant potential)
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</td><td>Serious Physical Injuries:

Noisy Breathing
Not rousable to verbal command
Head Injuries:
• Loss of consciousness at any time
• Facial swelling
• Bleeding from nose or ears
• Deep cuts
• Suspected broken bones</td></tr>
<tr><td>Actual (current) Attempt of self-harm:

Actively head banging
Actual use of edged weapon (to self-harm)
Ligature use Evidence of overdose or poisoning Psychiatric Crisis (with self-harm)
Delusions / Hallucinations / Mania</td><td>Possible Excited Delirium (agitated patient):

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</td></tr>
<tr><td>Senior Clinical Staff where available.
ONLY AT THE REQUEST OF PARAMEDICS / TECHNICIANS – ACCESSED VIA EOC

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

This should include situations where rapid tranquilisation is considered necessary, in accordance with NICE GUIDELINES 2005.</td><td>Conveyance to the nearest ED:

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

This includes remaining in ED until the person is medically fit for discharge to PoS, to Police Station or from s136 detention. It is the responsibility of the Police to outline to ED the LEGAL ASPECTS of detention; it is the responsibility of the Ambulance Service to outline the MEDICAL ASPECTS.</td></tr>
</table>

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

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

Appendix 6

Brief Section 136 Risk Assessment

Name of individual detained:

Date: **Time:**

Address:

Risk Factor	Yes	No	Not Known	Evidence of Risk
Has there been any recent violence towards others.				
Have there been any recent deliberate self-harm attempts.				
Was the police involvement due to a suicide attempt				
Is there evidence that the person uses illicit substances				
Is there evidence that the person is dependent on alcohol				
Is the person's behaviour out of character				
Is there evidence that this person is at risk of abuse/exploitation from others				
Are there any known issues in respect of safeguarding children				
Are there any identified physical health care risks i.e. head injury, diabetes, epilepsy				

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, ie; personal/physical risk factors and risk of absconding prior to completion of the mental health assessment

Completed by:

…… **……**

Police Officer **Staff Nurse**

NB: IF THE OUTCOME OF THE SECTION 136 ASSESSMENT IS THAT THE PERSON IS TO REMAIN ON THE WARDS CLINICAL STAFF ARE TO COMPLETE A FULL RISK ASSESSMENT

In cases where the Police Officers have been allowed to leave the person at the Section 136 Suite, if the person's presentation changes the Police can be contacted and they will come back to the Section 136 Suite

Appendix 7

SYP/NHS Joint Escalation Protocol for Critical Incident Managers and NHS On-Call Managers – Use of Police Cells and Police Support at Places of Safety

South Yorkshire Police and NHS Escalation Process following Changes to the Police Powers and Places of Safety Provisions in the Mental Health Act 1983

Following a meeting with Strategic Health Partners and South Yorkshire Police on Wednesday 6th December 2017, it was recognized that the regulations, which accompany the legislation change, will significantly reduce the number of circumstances in which a police station may be used as a place of safety throughout the UK.

In summary three criteria must exist in order to allow a police station to be used;

- The detaining officer must reasonably consider that the behavior of the person poses an imminent risk of serious injury or death, either to themselves or another person; AND
- The officer must believe that no place of safety in the police force area could safely manage that risk; AND
- The decision to rely upon a police station must be authorised by an officer at the rank of Inspector,
  - **although in South Yorkshire this decision will be made by the Critical Incident Manager (CIM)**

Once the person arrives in police custody, there are several things to bear in mind:

- Use of Police custody is still subject to the custody officers normal set of considerations in terms of authorising detention;
- It is the custody officer's legal decision to detain further and if the CIM is a Chief Inspector and disagrees with any decision taken by the Sergeant, PACE states this must be referred to a Superintendent (On-Call PACE)
- Once detained the custody officer must ensure several things happen:
- A check by a healthcare professional every thirty minutes;
- Wherever possible, there should be a constant healthcare presence throughout the duration that person is detained;
- If the original grounds for using the police station cease to apply, the person must be transferred elsewhere; unless the S136 assessment is imminent and transferring the person would delay things to their disadvantage;
- If the custody sergeant is not able to ensure the relevant frequency of health checks, the person must be transferred elsewhere; again, this is unless the assessment is imminent and transfer would delay things to the person's disadvantage.

- **Critical Incident Managers Authority**

Firstly, where the Critical Incident Manager is being asked to authorise use of a police station this should be considered very carefully: by virtue of the two other criteria required (as above) prior to them considering giving their authority, the person concerned may be significantly ill and particular care should be taken to ensure that intoxication by drugs or alcohol or any resistance, aggression or violence are not symptomatic of something serious that would require medical clearance by a paramedic or an emergency department.

- **It is advisable that every S136 detention receives some form of medical assessment prior to considering whether custody is appropriate.**

A Critical Incident Manager will not be at the scene of an incident where s136 is used – we can imagine this may all be managed by phone or police radio discussion and detaining officers asking whether they could or should remove a detained person to custody?

Factors to consider –

- Firstly – have we called an ambulance? … if not, why not? – ensure it is done.
- Does the detaining officer have enough support from colleagues to manage that scene and the behaviour of the person? … if not, can we get more officers to them?
- Strong oversight: consider dispatching a duty sergeant to direct control of events, if there isn't one there already – this incident could develop in a number of ways at this stage, including by ending badly: a first-line supervisor should focus on this and on nothing else, if at all possible.
- What is the 'clinical assessment' of RED FLAGS – best done by a paramedic, of course; but if they're not yet in attendance or unable to attend at all, it will have to be the officers present to make that call on the basis of their first-aid certificate and personal safety training.
- Be aware that **Physical Restraint + Mental Health = Medical Emergency** and bear in mind ABD, the potential for drugs and alcohol to mask problems and that resistant, frightened or aggressive behaviour can indicate underlying medical problems. Restraint only complicates those matters, it never does the opposite.

A sensible judgement will have to be made about waiting for an ambulance; the greater the concerns about ongoing impact of any restraint, the sooner it may be necessary to move the person; but if arrival of paramedics is imminent, it may be safer to remain there. Paramedics can administer medication in some circumstances (under the Mental Capacity Act) that can assist; equally, they can travel with the person in case of any untoward development en route to the chosen location.

If all of that has happened or been ruled out as being necessary and we still have an 'imminent risk' situation, then and only then should the Critical Incident Manager consider authorising use of a police station, and only where there is that constant healthcare monitoring after arrival.

- **Detention in Custody**

Secondly, the new regulations require health care checks to be carried out every 30 minutes. Remember, without those thirty-minute checks: the custody officer is obliged to transfer the person elsewhere.

The Regulations are focused on police stations, not just on police custody, but they repeatedly refer to the custody officer, which is a position only relevant in police custody. What happens in the rest of the station is a matter for the officer in charge of it. So the ability to ensure the thirty minute checks will determine whether a particular police station can act as a Place of Safety, and not all (PACE) designated custody areas will be able to do so.

- **Monitoring in Custody**

The healthcare checks that are required, must occur every thirty minutes – the Regulations don't specify who should do this, as long as it is a 'healthcare' professional, as defined by health legislation. For police purposes, this simply means, doctor or nurse. An AMHP would not be able to do this, unless they were also a registered nurse – most AMHPs are mental health social workers, and not healthcare professionals for the purposes of these Regulations. In addition, the custody sergeant must undertake an hourly check of the detainee in the normal way and is at liberty to impose a regime of enhanced observations, as they see necessary and influenced by healthcare advice. This could mean, 1-to-1 obs by a police officer; or even 2-to-1 obs, if necessary – all supplemented by those healthcare checks.

The Regulations do allow for this one-hourly check to be relaxed on healthcare advice, to three hourly checks if the person is sleeping. Whilst this should be based on healthcare advise, it should also be borne in mind that if someone is sleeping, then arguably the criteria for removing them from the police station are met and they should be moved. We should also be wary of someone who may have previously been noisy, frightened and distressed now being silent in a sleeping position: is the person now lying on the floor actually asleep, or are they unconscious or worse?!

- **Police Officers remaining with the person detained under S136**

Police officers will NEVER leave a S136 detained person in the Accident & Emergency Department or any other hospital setting or place of safety unless acceptance of the detention of the person has been agreed and the name of the person taking over the responsibility of the S136 detained person, has been obtained. Police Officers must satisfy themselves that there is suitable security for the person and staff prior to leaving the place of safety.

If there are disagreements regarding the joint risk assessment and whether police officers should remain, these cases should be referred to the Critical Incident Manager for discussion with a senior NHS representative.

Following departure of police from the place of safety, should the behaviour of the detainee deteriorate police may be asked to return to assist while additional healthcare resources are sought.

- **Escalation (Police): Who to speak to?**

If the Critical Incident Manager needs to speak to someone within the Mental Health Trust, helpful contact details are provided below:

Rotherham, Doncaster and South Humber NHS Foundation Trust	
Telephone: 01302 796000	When Switchboard answers ask to speak to the on-call manager. If things cannot be resolved via the on-call manager ask for the issue to be escalated to the on-call Care Group Director and then subsequently to the on-call Director.
Sheffield Health & Social Care NHS Foundation Trust	
Telephone: 0114 271 6310	When Switchboard answers, in hours ask for the Service Director or Deputy Service Director, out of hours it will be the on-call manager.
South West Yorkshire Partnership NHS Foundation Trust	
Telephone: 01226 434 000	When Switchboard answers, ask to speak to the On-call manager. If things cannot be resolved via the on-call manager ask to speak to the on-call Director.

- **Escalation (NHS): Who to speak to?**

If a representative/Manager/Director from the NHS needs to contact a senior representative within South Yorkshire Police, they are advised to call 101 and ask to speak to the Critical Incident Manager (CIM) who is available 24/7.

- **Review**

South Yorkshire Police Officers are expected to escalate any issues related to mental health incidents via email: ForceMentalHealth@southyorks.pnn.police.uk

Sheffield Teaching Hospitals NHS
NHS Foundation Trust

Guide to Section 136 for Sheffield Teaching Hospitals: Emergency Department

Scope

This guide outlines the process to be followed when police bring a person to Sheffield Teaching Hospitals (STH) Emergency Department (ED) under a section 136 of the Mental Health Act and highlights the responsibilities of the different agencies caring for the person.

Reason for development

This guide has been produced using the Royal College of Emergency Medicine's A Brief Guide to Section 136 for Emergency Departments (Dec 2017) and in consultation with STH ED.

General Principles

Those attending ED on s136 should be treated with respect and kindness as for any other patient. They should not be made to feel unwelcome and any discussion of the appropriateness of their attendance should occur between professionals in an appropriate manner. They must be kept up to date with progress and be provided with information, verbally and in written form, about the s136 (see Appendix 3 for example leaflet for patients).

Transfers should take place only when it is in the person's best interests. This may be the case when a section 136 suite would provide a calmer environment than the Emergency Department. However, if this will delay assessment it may not be appropriate.

Whenever possible a parallel assessment of physical and mental health needs should be considered, to reduce time spent under section 136 and to speed up definitive care for the person concerned. Ongoing discussion with those responsible for arranging assessment is needed.

There will always be a group of people detained on section 136 who need to attend ED for physical health needs therefore thought must be given to providing appropriate staff training (including security) and assessment areas.

The role of an Emergency Department (ED) in the Section 136 Pathway

An Emergency Department can itself be a place of safety within the meaning of the Mental Health Act. Therefore, if protracted physical health treatment or care is required, where appropriate, the ED should accept the s136 detention and clinical duty of care for the individual outlined this should not be confused with overall legal responsibility. During the time in ED, the overall legal responsibility for the individual remains with the police, unless ED staff formally accept responsibility for the person's custody, and only an AMHP and s12 doctor can discharge the S136 once they are satisfied that the necessary care arrangements have been made.

In exceptional circumstances when a person under s136 presents to an Emergency Department with no physical health needs due to limited health based place of safety capacity the ED cannot refuse access.

In these instances, it is vital that information about the person's needs, and any associated risks, are clearly explained to ED staff receiving the person and documented on the Joint Risk Assessment**.** Any security staff at the ED must likewise be properly briefed about the person before the ED takes responsibility for them. Due to the nature of ED's, managing people detained under s136 in this environment can be challenging. Given this, when a person detained under s136 is in the ED the police will provide the necessary support in line with the agreed South Yorkshire NHS/SYP Joint Escalation Protocol unless there is mutual agreement between the ED and the police that they are able to leave.

South Yorkshire Police will **NEVER** leave a s136 detained person in ED unless acceptance of the detention has been agreed and the name of the person taking over the responsibility of the s136

detained person has been obtained. Police must satisfy themselves that there is suitable security for the person and staff prior to leaving the ED.

If there are disagreements regarding the joint risk assessment and whether the Police should remain, these cases should be referred to the Critical Incident Manager for discussion with a Senior NHS representative in line with the South Yorkshire SYP/NHS Joint Escalation Protocol**.**

Following departure of police from the place of safety, should the behaviour of the detainee deteriorate police may be asked to return to assist while additional healthcare resources are sought.

If the decision is taken that it is in the individual's best interest to transfer them from the ED to a mental health based place of safety for the purpose of the Mental Health Act Assessment, it must first be confirmed that the place of safety has capacity and is willing to receive the individual before the transfer takes place. It is the police's responsibility with the support of ED staff to secure this confirmation.

Parallel Assessments in the Emergency Department

A Mental Health Act assessment should not be delayed for delivery of physical health treatment that has no predictable significant impact upon mental state. A MHA assessment should not however take place if there is suspicion that a physical condition is leading to or significantly worsening a disturbance of mind. On initial presentation in ED consideration should be given immediately to the appropriate assessment of both physical and mental health needs.

If an individual has been assessed in an ED and requires admission as an inpatient for further physical health care treatment at the Acute Trust, the patient will continue to be detained under Section 136 unless one of the following take place:

- The s12 doctor (or other doctor with mental health training and expertise) finds the person to have no underlying mental disorder, in which case they can discharge the individual from the s136 without input from the AMHP;
- A Mental Health Act assessment has been undertaken by a s12 doctor and AMHP and any necessary arrangements for the person's mental health care have been made, at which point the AMHP should formally discharge the S136;
- The detention period under S136 has elapsed, however it is not good practice to let this happen.

In these circumstances the STH ED should take responsibility for the person's custody; there should be a mutual agreement between ED and the police officers about when the officers are able to leave, taking into consideration the risk presented by that individual and police capacity to provide support.

While the detained individual is in the ED and is being treated for their physical health, the ED staff h a s a clinical duty of care to that individual with support from medical and psychiatry specialties. This duty of care continues until the individual leaves the ED.

The clinical duty of care for the individual outlined above should not be confused with overall legal responsibility. During the time in ED, the overall legal responsibility for the individual remains with the police, unless ED staff formally accept responsibility for the person's custody, and only an AMHP and s12 doctor can discharge the S136 once they are satisfied that the necessary care arrangements have been made.

The Joint SYP/NHS Escalation Protocol for Use of Police Cells as a place of safety and Police support at health based places of safety outlines arrangements for police officers to remain in attendance when a person arrives at STH ED or a mental health-based place of safety.

The protocol states that Police Officers will **NEVER** leave a S136 detained person in the Emergency Department or any other hospital setting or place of safety unless acceptance of the detention of the person has been agreed and the name of the person taking over the responsibility of the s136 detained person, has been obtained. The length of time that officers remain with the detainee will depend on the circumstances and risks associated with the individual and officers should be able to leave when the situation is agreed to be safe for the detained person and healthcare staff. **Other than in an Emergency Department,** the Police Officer should not normally be expected to stay for longer than one hour (Royal College of Psychiatrists Guidance). This handover period should enable the health-based place of safety to become appropriately staffed.

If there are disagreements regarding the joint risk assessment and whether police officer should remain, these cases should be referred to the Critical Incident Manager for discussion with a senior NHS representative.

Following departure of police from the place of safety, should the behavior of the detainee deteriorate police may be asked to return to assist while additional healthcare resources are sought.

Escalation (Police): Who to speak to?

If the Critical Incident Manager needs to speak to someone within Sheffield Health and Social Care (SHSC), helpful contact details are provided below:

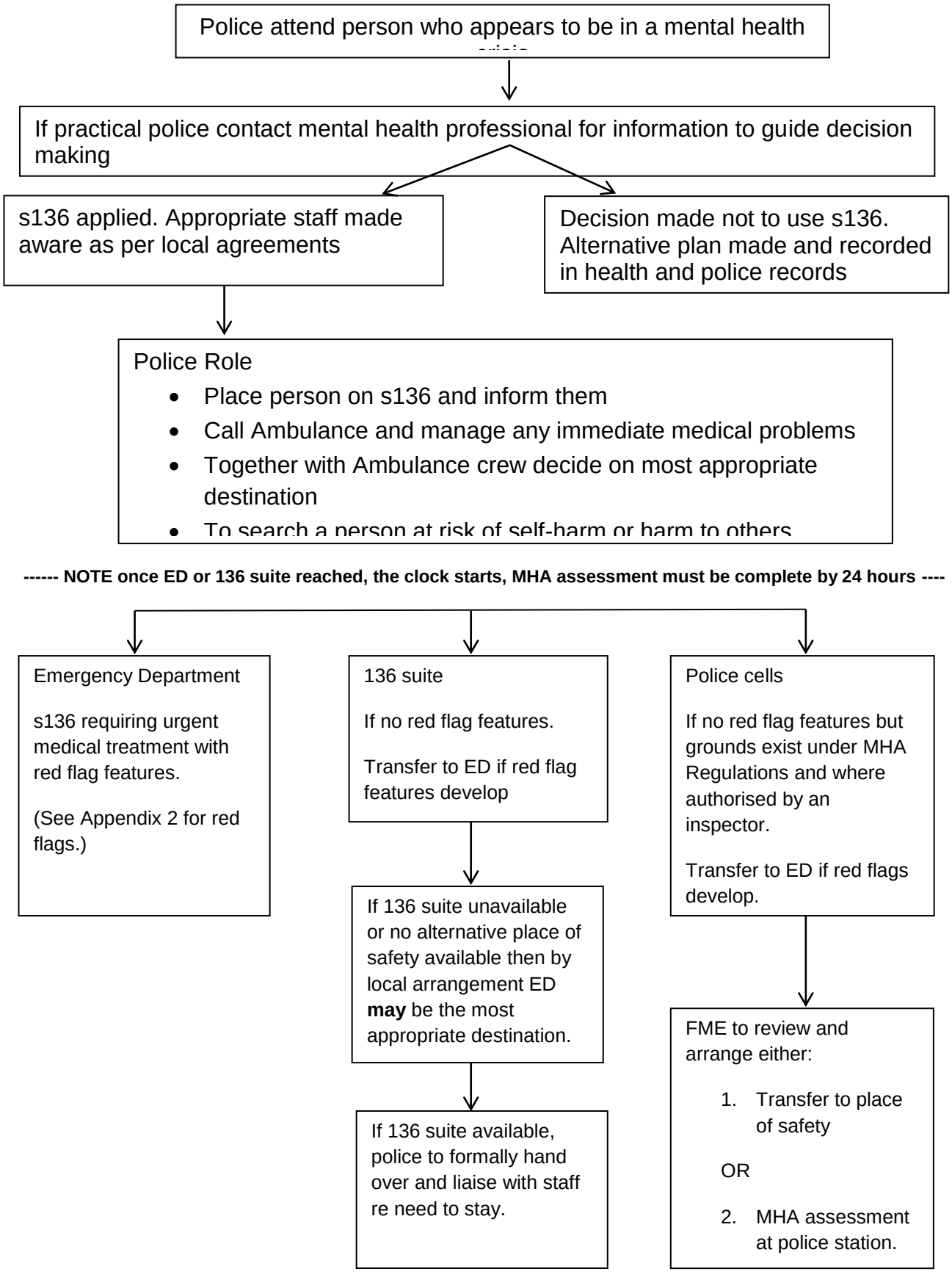
Telephone: 01142716310 and ask for the flow coordinator. This is a 24 /7 service. Alternatively ask for Central AMHP Team if no answer from flow coordinator line.

When Switchboard answers ask to speak to the on-call manager. If things cannot be resolved via the on-call manager, ask for the issue to be escalated to the on-call Care Group Director and then subsequently to the on-call Director.

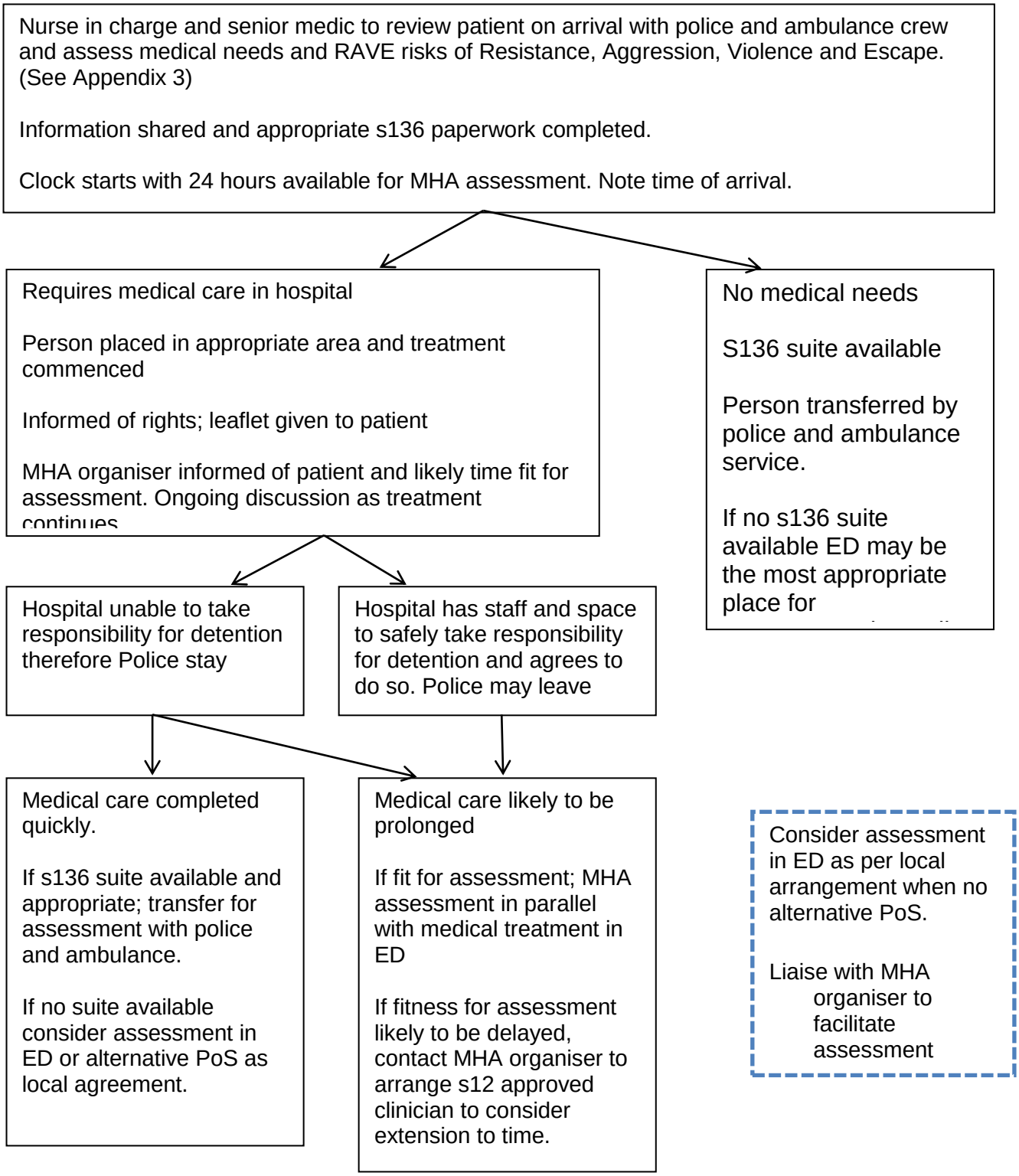
Escalation STH ED:

If there are disagreements regarding the joint risk assessment and whether police officer should remain, these cases should be referred to the Critical Incident Manager for discussion. IF the ED Consultant in Charge (CIC) or STH First on Call (FoC) needs to contact a senior representative within South Yorkshire Police, they are advised to call 101 and ask to speak to the Critical Incident Manager (CIM) who is available 24/7.

Section 136 flowchart - pre-hospital



Section 136 flowchart- At the Emergency Department



ADMISSION OF MENTALLY DISORDERED PERSONS FOUND IN A PUBLIC PLACE (Section 136 of the Mental Health Act 1983)

1. Patient's name	
2. Name of hospital and ward	

Why am I in hospital?

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

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

How long will I be here?

You can be kept here (or in another place where you will be safe) for up to 24 hours so that you can be seen by a doctor and an approved mental health professional. This can be extended to 36 hours if it is felt that it is not possible to assess you properly because of physical health concerns.

An approved mental health professional is someone who has been specially trained to help decide whether people need to be kept in hospital.

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

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

If the doctors and the approved mental health professional have not seen you by the end of the 24 hours, you will be free to leave. You may decide to stay on as a voluntary patient. But if you do want to leave, please talk to a member of staff first.

In your case the 24 hours end at:

Date	***Time***

What happens next?

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

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

Can I appeal?

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

Will I be given treatment?

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

Letting your nearest relative know

A copy of this leaflet will be given to the person the Mental Health Act says is your nearest relative.

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

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

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

Changing your nearest relative

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

Code of Practice

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

How do I complain?

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

If you do not feel that the hospital complaints procedure can help you, you can complain to an independent Commission. This is called the Care Quality Commission and it monitors how the Mental Health Act is used, to make sure it is used correctly and that patients are

cared for properly while they are in hospital. The hospital staff can give you a leaflet explaining how to contact the Commission.

Further help and information

If there is anything you do not understand about your care and treatment, a member of staff will try to help you. Please ask a member of staff to explain if there is anything in this leaflet you do not understand or if you have other questions that this leaflet has not answered.

Please ask if you would like another copy of this leaflet for someone else.

Red Flag criteria used by Police and Ambulance Services

<table>
<tr><th colspan="2">S136 RED FLAG CRITERIA (this is not an exhaustive list) Police Officer / Paramedic triggers for conditioquiring Treatment or Assessment in an Emergency Department</th></tr>
<tr><td>Dangerous Mechanisms:

Patient has been hit by Taser
Blows to the body (significant potential) 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</td><td>Serious Physical Injuries:

Noisy Breathing
Not rousable to verbal command Head Injuries:
• Loss of consciousness at any time
• Facial swelling
• Bleeding from nose or ears
• Deep cuts
• Suspected broken bones</td></tr>
<tr><td>Actual (current) Attempt of self-harm:

Actively head banging
Actual use of edged weapon (to self-harm)
Ligature use Evidence of overdose or poisoning
Psychiatric Crisis (with self-harm) Delusions / Hallucinations / Mania</td><td>Possible Excited Delirium (agitated patient):

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</td></tr>
<tr><td>Senior Clinical Staff where available. ONLY AT THE REQUEST OF PARAMEDICS / TECHNICIANS – ACCESSED VIA EOC

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

This should include situations where rapid tranquilisation is considered necessary, in accordance with NICE GUIDELINES 2005.</td><td>Conveyance to the nearest ED:

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

This includes remaining in ED until the person is medically fit for discharge to PoS, to Police Station or from s136 detention. It is the responsibility of the Police to outline to ED the LEGAL ASPECTS of detention; it is the responsibility of the Ambulance Service to outline the MEDICAL ASPECTS.</td></tr>
</table>

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

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

Brief Section 136 Risk Assessment

Name of individual detained:

Date: **Time:**

Address:

Risk Factor	Yes	No	Not Known	Evidence of Risk
Has there been any recent violence towards others.				
Have there been any recent deliberate self-harm attempts.				
Was the police involvement due to a suicide attempt				
Is there evidence that the person uses illicit substances				
Is there evidence that the person is dependent on alcohol				
Is the person's behaviour out of character				
Is there evidence that this person is at risk of abuse/exploitation from others				
Are there any known issues in respect of safeguarding children				
Are there any identified physical health care risks i.e. head injury, diabetes, epilepsy				

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, ie; personal/physical risk factors and risk of absconding prior to completion of the mental health assessment

Completed by:

…… **……**

Police Officer **Staff Nurse**

NB: IF THE OUTCOME OF THE SECTION 136 ASSESSMENT IS THAT THE PERSON IS TO REMAIN ON THE WARDS CLINICAL STAFF ARE TO COMPLETE A FULL RISK ASSESSMENT

In cases where the Police Officers have been allowed to leave the person at the Section 136 Suite, if the person's presentation changes the Police can be contacted and they will come back to the Section 136 Suite

SYP/NHS Joint Escalation Protocol for Critical Incident Managers and NHS On-Call Managers – Use of Police Cells and Police Support at Places of Safety

South Yorkshire Police and NHS Escalation Process following Changes to the Police Powers and Places of Safety Provisions in the Mental Health Act 1983

Following a meeting with Strategic Health Partners and South Yorkshire Police on Wednesday 6th December 2017, it was recognized that the regulations, which accompany the legislation change, will significantly reduce the number of circumstances in which a police station may be used as a place of safety throughout the UK.

In summary three criteria must exist in order to allow a police station to be used;

- The detaining officer must reasonably consider that the behavior of the person poses an imminent risk of serious injury or death, either to themselves or another person; AND
- The officer must believe that no place of safety in the police force area could safely manage that risk; AND
- The decision to rely upon a police station must be authorised by an officer at the rank of Inspector,

• although in South Yorkshire this decision will be made by the Critical Incident Manager (CIM)

Once the person arrives in police custody, there are several things to bear in mind:

- Use of Police custody is still subject to the custody officers normal set of considerations in terms of authorising detention;
- It is the custody officer's legal decision to detain further and if the CIM is a Chief Inspector and disagrees with any decision taken by the Sergeant, PACE states this must be referred to a Superintendent (On-Call PACE)
- Once detained the custody officer must ensure several things happen:
- A check by a healthcare professional every thirty minutes;
- Wherever possible, there should be a constant healthcare presence throughout the duration that person is detained;
- If the original grounds for using the police station cease to apply, the person must be transferred elsewhere; unless the S136 assessment is imminent and transferring the person would delay things to their disadvantage;
- If the custody sergeant is not able to ensure the relevant frequency of health checks, the person must be transferred elsewhere; again, this is unless the assessment is imminent and transfer would delay things to the person's disadvantage.

• Critical Incident Managers Authority

Firstly, where the Critical Incident Manager is being asked to authorise use of a police station this should be considered very carefully: by virtue of the two other criteria required (as above) prior to them considering giving their authority, the person concerned may be significantly ill and particular care should be taken to ensure that intoxication by drugs or alcohol or any resistance, aggression or

violence are not symptomatic of something serious that would require medical clearance by a paramedic or an emergency department.

- **It is advisable that every S136 detention receives some form of medical assessment prior to considering whether custody is appropriate.**

A Critical Incident Manager will not be at the scene of an incident where s136 is used – we can imagine this may all be managed by phone or police radio discussion and detaining officers asking whether they could or should remove a detained person to custody?

Factors to consider –

- Firstly – have we called an ambulance? … if not, why not? – ensure it is done.
- Does the detaining officer have enough support from colleagues to manage that scene and the behaviour of the person? … if not, can we get more officers to them?
- Strong oversight: consider dispatching a duty sergeant to direct control of events, if there isn't one there already – this incident could develop in a number of ways at this stage, including by ending badly: a first-line supervisor should focus on this and on nothing else, if at all possible.
- What is the 'clinical assessment' of RED FLAGS – best done by a paramedic, of course; but if they're not yet in attendance or unable to attend at all, it will have to be the officers present to make that call on the basis of their first-aid certificate and personal safety training.
- Be aware that **Physical Restraint + Mental Health = Medical Emergency** and bear in mind ABD, the potential for drugs and alcohol to mask problems and that resistant, frightened or aggressive behaviour can indicate underlying medical problems. Restraint only complicates those matters, it never does the opposite.

A sensible judgement will have to be made about waiting for an ambulance; the greater the concerns about ongoing impact of any restraint, the sooner it may be necessary to move the person; but if arrival of paramedics is imminent, it may be safer to remain there. Paramedics can administer medication in some circumstances (under the Mental Capacity Act) that can assist; equally, they can travel with the person in case of any untoward development en route to the chosen location.

If all of that has happened or been ruled out as being necessary and we still have an 'imminent risk' situation, then and only then should the Critical Incident Manager consider authorising use of a police station, and only where there is that constant healthcare monitoring after arrival.

- **Detention in Custody**

Secondly, the new regulations require health care checks to be carried out every 30 minutes. Remember, without those thirty-minute checks: the custody officer is obliged to transfer the person elsewhere.

The Regulations are focused on police stations, not just on police custody, but they repeatedly refer to the custody officer, which is a position only relevant in police custody. What happens in the rest of the station is a matter for the officer in charge of it. So the ability to ensure the thirty minute checks will determine whether a particular police station can act as a Place of Safety, and not all (PACE) designated custody areas will be able to do so.

- **Monitoring in Custody**

The healthcare checks that are required, must occur every thirty minutes – the Regulations don't specify who should do this, as long as it is a 'healthcare' professional, as defined by health legislation. For police purposes, this simply means, doctor or nurse. An AMHP would not be able to do this, unless they were also a registered nurse – most AMHPs are mental health social workers, and not healthcare professionals for the purposes of these Regulations. In addition, the custody sergeant must undertake an hourly check of the detainee in the normal way and is at liberty to impose a regime of enhanced observations, as they see necessary and influenced by healthcare advice. This could mean, 1-to-1 obs by a police officer; or even 2-to-1 obs, if necessary – all supplemented by those healthcare checks.

The Regulations do allow for this one-hourly check to be relaxed on healthcare advice, to three hourly checks if the person is sleeping. Whilst this should be based on healthcare advise, it should also be borne in mind that if someone is sleeping, then arguably the criteria for removing them from the police station are met and they should be moved. We should also be wary of someone who may have previously been noisy, frightened and distressed now being silent in a sleeping position: is the person now lying on the floor actually asleep, or are they unconscious or worse?!

- **Police Officers remaining with the person detained under S136**

Police officers will NEVER leave a S136 detained person in the Accident & Emergency Department or any other hospital setting or place of safety unless acceptance of the detention of the person has been agreed and the name of the person taking over the responsibility of the S136 detained person, has been obtained. Police Officers must satisfy themselves that there is suitable security for the person and staff prior to leaving the place of safety.

If there are disagreements regarding the joint risk assessment and whether police officers should remain, these cases should be referred to the Critical Incident Manager for discussion with a senior NHS representative.

Following departure of police from the place of safety, should the behaviour of the detainee deteriorate police may be asked to return to assist while additional healthcare resources are sought.

- **Escalation (Police): Who to speak to?**

If the Critical Incident Manager needs to speak to someone within the Mental Health Trust, helpful contact details are provided below:

Rotherham, Doncaster and South Humber NHS Foundation Trust	
Telephone: 01302 796000	When Switchboard answers ask to speak to the on-call manager. If things cannot be resolved via the on- call manager ask for the issue to be escalated to the on-call Care Group Director and then subsequently to the on-call Director.
Sheffield Health & Social Care NHS	
Telephone: 0114 271 6310	When Switchboard answers, in hours ask for the Service Director or Deputy Service Director, out of hours it will be the on-call manager.
South West Yorkshire Partnership NHS Foundation Trust	

Telephone: 01226 434 000	When Switchboard answers, ask to speak to the On- call manager. If things cannot be resolved via the on- call manager ask to speak to the on-call

- **Escalation (NHS): Who to speak to?**

If a representative/Manager/Director from the NHS needs to contact a senior representative within South Yorkshire Police, they are advised to call 101 and ask to speak to the Critical Incident Manager (CIM) who is available 24/7.

- **Review**

South Yorkshire Police Officers are expected to escalate any issues related to mental health incidents via email: ForceMentalHealth@southyorks.pnn.police.uk.

Appendix 16

Appendix 17 – Standard Operating Procedures - Police Stations

Children - It is unlawful to use a police station as a place of safety for anyone under the age of 18 in any circumstances. This relates to any part of a police station including police cells. The law states "A child may not, in the exercise of a power to which this section applies, be kept at or removed to, a place of safety that is a police station." There are two points of note:

- A child is anyone under the age of 18yrs - someone who is 17yrs and 364 days old is a child - see section 136A(5)(a) Mental Health Act.
- The size, strength and presentation of the child are completely irrelevant - they must be removed to a non-police station location.

Adults - Police stations can only be used as a place of safety for adults (18 and over) in "exceptional circumstances" - when someone poses an imminent risk of serious injury or death, to themselves or another and where it is authorised by the Force Critical Incident Manager.

Three criteria must exist in order to allow a police station to be used;

- The detaining officer must reasonably consider that the behaviour of the person poses an imminent risk of serious injury or death, either to themselves or another person; AND
- The officer must believe that no place of safety in the police force area could safely manage that risk; AND
- The decision to rely upon a police station must be authorised by the Force Critical Incident Manager (CIM). Whilst the regulations state this decision can be made by an officer at the rank of Inspector, our position in South Yorkshire Police is that police stations are not a suitable environment as a place of safety for ANY person detained under s136 and that it is always better to take someone to a health-based place of safety for assessment where they can receive the appropriate care and treatment required. Therefore, in these circumstances, CIM authority is required without exception. The CIM will factor into their decision making whether there is adequate health care provision within the police station/custody area to carry out the mandatory health checks to ensure that the detention is lawful.

Once the person arrives in police custody, there are several things to bear in mind:

- Use of police custody is still subject to the custody officer's normal set of considerations in terms of authorising detention.
- It is the custody officer's legal decision to detain further and if the Force Critical Incident Manager who authorised use of the police station disagrees with any decision by the sergeant, PACE states this must be referred to an officer at the rank of superintendent (On- Call PACE).
- Once detained, the custody officer must ensure several things happen:
- A check by a healthcare professional every thirty minutes.
- Wherever possible, there should be a constant healthcare presence throughout the duration that person is detained.
- If the original grounds for using the police station cease to apply, the person must be transferred elsewhere; unless the s136 assessment is imminent and transferring the person would delay things to their disadvantage.
- If the custody sergeant is not able to ensure the relevant frequency of health checks, the person must be transferred elsewhere; again, this is unless the assessment is imminent and transfer would delay things to the person's disadvantage.

The Force Critical Incident Managers Authority

The force CIM is being asked to authorise use of a police station as a place of safety and this should be considered very carefully: by virtue of the two other criteria (as above) prior to them considering giving their authority, the person concerned may be significantly ill and particular care should be taken to ensure that intoxication by drugs or alcohol or any resistance, aggression or violence are not symptomatic of something serious that would require medical clearance by a paramedic or an emergency department.

It is advisable that every s136 detention receives some form of medical assessment prior to considering whether custody is appropriate.

There are medical guidelines from the Royal College of Emergency Medicine, the Faculty of Forensic and Legal Medicine on Acute Behavioural Disturbance as well as a Patient Safety Alert from NHS England that have bearing on the medical needs which may be overlooked if the CIM authorises things too quickly.
CIMs are advised to take time to understand this provision because it is a crucial decision which will be scrutinised closely in the event of a serious untoward incident.
A CIM will not be at the scene of an incident where s136 is used - this will be managed by phone or police radio discussion with detaining officers asking whether they could or should remove a detained person to custody?
Factors to consider:

- Have we called an ambulance? If not, why not? Ensure it is actioned/recorded on incident.
- Does the detaining officers have enough support from colleagues to manage that scene and the behaviour of the person? … if not, can we get more officers to them?
- Strong oversight: consider dispatching a duty sergeant to direct control of events, if there isn't one there already – this incident could develop in a number of ways at this stage, including by ending badly: a first-line supervisor should focus on this and on nothing else, if at all possible.
- What is the 'clinical assessment' of RED FLAGS - best done by a paramedic, but if they're not yet in attendance or unable to attend at all, it will have to be the officers present to make that call on the basis of their first-aid certificate and personal safety training.
- Be aware that **Physical Restraint + Mental Health = Medical Emergency** and bear in mind ABD, the potential for drugs and alcohol to mask problems and that resistant, frightened or aggressive behaviour can indicate underlying medical problems. Restraint only complicates those matters, it never does the opposite.

A sensible judgement will have to be made about waiting for an ambulance; the greater the concerns about ongoing impact of any restraint, the sooner it may be necessary to move the person; but if arrival of paramedics is imminent, it may be safer to remain there. Paramedics can administer medication in some circumstances (under the Mental Capacity Act) that can assist; equally, they can travel with the person in case of any untoward development en route to the chosen location.
If all of that has happened or been ruled out as being necessary and we still have an 'imminent risk' situation, then and only then should the CIM consider authorising use of a police station, and only where there is provision for constant healthcare monitoring after arrival.

Detention in Custody

Regulations require mandatory health care checks to be carried out every 30 minutes and without those thirty-minute checks the custody officer is obliged to transfer the person elsewhere.

The Regulations are focused on police stations, not just on police custody, but they repeatedly refer to the custody officer which is a position only relevant in police custody. What happens in the rest of the station is a matter for the officer in charge of it. The ability to ensure the thirty minute checks will determine whether a particular police station can act as a place of safety, and not all (PACE) designated custody areas in SYP will be able to do so.

Monitoring in Custody

The healthcare checks that are required, must occur every thirty minutes - the Regulations don't specify who should do this, as long as it is a 'healthcare' professional. For police purposes, this simply means a doctor or nurse. An Approved Mental Health Practitioner (AMHP) would not be able to do this, unless they were also a registered nurse – most AMHPs are mental health social workers, and not healthcare professionals for the purposes of these Regulations. In addition, the custody sergeant must undertake an hourly check of the detainee in the normal way and is at liberty to impose a regime of enhanced observation, as they see necessary and influenced by healthcare advice. This could mean, 1-to-1 observations by a police officer; or even 2-to-1 observation, if necessary - all supplemented by the mandatory healthcare checks.

The Regulations do allow for this one-hourly check to be relaxed on healthcare advice, to three hourly checks if the person is sleeping. Whilst this should be based on healthcare advise, it should also be borne in mind that if someone is sleeping, then arguably the criteria for removing them from the police station are met and they should be moved. We should also be wary of someone who may have previously been noisy, frightened and distressed now being silent in a sleeping position: is the person now lying on the floor actually asleep or are they unconscious or worse?

Legal Time Limits & Extension of Detention

A person can be held in a place of safety for up to 24 hours (see s136(2A) Mental Health Act).
The 24hrs time limit can be extended to a maximum of 36hrs however, this may only occur where the condition of the person prevents an earlier assessment:

"S136B(2) - an authorisation may be given only if the registered medical practitioner considers that the extension is necessary because the condition of the person detained is such that it would not be practicable for the assessment of the person for the purpose of section 135 or 136 to be carried out before the end of the period of 24 hours."

Four points to emphasise:

- The DR who is conducting the s136 assessment must authorise the extension before the 24hrs is complete.
- The DR can only extend detention where there is difficulty in arranging the assessment 'because of the condition of the person' – they CANNOT extend detention because there is difficulty, for example, in finding a bed or finding professionals.
- If the person is detained in a police station as a place of safety, the DR may give this authorisation only if a police officer at the rank of superintendent approves it – there is no contingency for an inspector to authorise this where no superintendent is available, although nothing prevents the superintendent authorising this verbally by telephone. It is not in any way related to superintendents' extensions under s41 PACE.
- Where an extension is authorised, the DR (and superintendent) must specify how long they are authorising beyond 24hrs. It's not an automatic entitlement to a further twelve hours every time - see s136(2A)(b).

Where someone is intoxicated and assessment is delayed; OR where it is necessary to take someone to an Emergency Department for urgent medical treatment before assessment: these situations would allow the DR to extend detention.

Escalation

Any issues identified should be dealt with at the time in line with the below SYP/NHS joint escalation protocol:

Escalation (Police): Who to speak to?

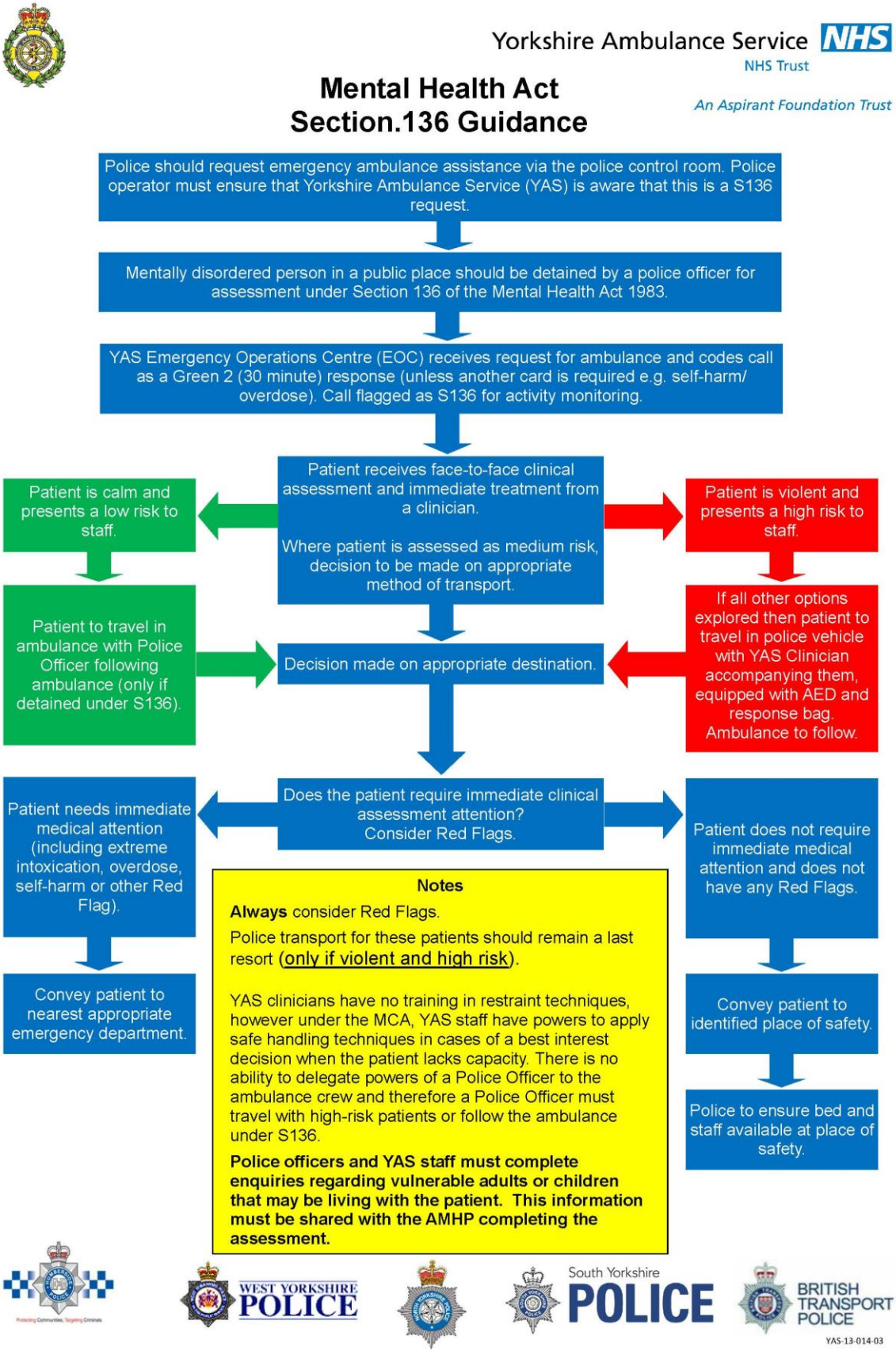
If the Critical Incident Manager needs to speak to someone within the Mental Health Trust, helpful contact details are provided below:

Rotherham, Doncaster and South Humber NHS Foundation Trust	
Telephone: 01302 796000	When Switchboard answers ask to speak to the on-call manager. If things cannot be resolved via the on- call manager ask for the issue to be escalated to the on-call Care Group Director and then subsequently to the on-call Director.
Sheffield Health & Social Care NHS	
Telephone: 0114 271 6310	When Switchboard answers, in hours ask for the Service Director or Deputy Service Director, out of hours it will be the on-call manager.
South West Yorkshire Partnership NHS Foundation Trust	
Telephone: 01226 434 000	When Switchboard answers, ask to speak to the On-call manager. If things cannot be resolved via the on- call manager ask to speak to the on-call Director.

Escalation (NHS): Who to speak to?

If a representative/Manager/Director from the NHS needs to contact a senior representative within South Yorkshire Police, they are advised to call 101 and ask to speak to the Critical Incident Manager (CIM) who is available 24/7.

YAS s136 Protocol - conveyance



Police Role and Use of Police Vehicles

The emphasis within the Mental Health Act 1983 codes of practice is strongly towards the use of ambulance transport arranged by health and social care and the preservation of the patient's dignity and privacy. The key message is that the use of police vehicles to transport patients should only be considered when the patient is violent or dangerous or it is a matter of extreme urgency.

Of the 8 types of situation described in the table, the code of practice only recognises 4 scenarios where police vehicles may be used to transport patients. Very exceptionally police may be directed by the court to convey a patient to hospital. This reinforces previous instructions prohibiting the use of police transport to move detained patients between hospitals or from hospital to court.

Scenario	Police Role	Supporting notes	Code Ref
S136 patient to a place of safety	Detaining police officer to ride in ambulance with detainee	Patient may be transported in a police vehicle in cases of extreme urgency, risk of violence etc. On these occasions the highest qualified member of YAS crew should ride in police vehicle and ambulance follow directly behind	16.41 17.15 17.16
Transfers of S136 detainees between places of safety	No defined role within legislation or code. Police may assist by riding in ambulance with detainee	As above	17.29
Transfer of patient who has been "Sectioned" under S2 or S3 following an assessment or removed under a S135(1) warrant for assessment elsewhere	Police may escort the patient by riding in the ambulance and/or following in a police vehicle if the patient is likely to be violent or dangerous	Where the AMHP is the applicant, they have a professional responsibility to ensure that all the necessary arrangements are made for the patient to be transported to hospital.	17.8 17.9 17.13 17.14 17.15
Returning patients who are AWOL or who are recalled to hospital	Police only assist if necessary and may escort the patient by riding in the ambulance and/or following in a police vehicle if the patient is likely to be violent or dangerous	Where a patient who is absent without leave from a hospital is taken into custody by someone working for another agency, the managers of the hospital from which the patient is absent are responsible for making sure that any necessary transport arrangements are put in place for the patient's return.	17.14 17.15 17.16 17.30

Transfer of a detained "in-patient" from one hospital to another	Police should only be used in exceptional circumstances. Police may escort the patient by riding in the ambulance and/or following in a police vehicle if the patient is likely to be violent or dangerous	Police transport should never be used to carry the patient. Where a patient requires transport between hospitals, it is for the managers of the hospitals concerned to make sure that appropriate arrangements are put in place.	17.29
Transfer of a detained "in-patient" from hospital to court	As above	Police transport should never be used to carry the patient	22.36

Cross Boundary s.136 Memorandum of Understanding between Barnsley, Doncaster and Sheffield Local Authorities

May 2020

s.136 MENTAL HEALTH ACT ASSESSMENTS ON INDIVIDUALS FROM OTHER AREAS

Context

A Memorandum of Understanding has been agreed between Barnsley, Doncaster and Sheffield Local Authorities on the pathway to be taken relating to s136 Mental Health Act (MHA) assessments on service users aged 18 plus regarding conveyance to a place of safety within another Local authority (LA) area due to a lack of s.136 capacity in their home area. It should be noted that at the time of publication Rotherham Local Authority are not a signatory to the cross-boundary agreement and RMBC local policy should be referred to for assessments in this area.

This pathway follows discussions between AMHP Leads in South Yorkshire. A Memorandum of Understanding is a non-binding agreement between 2 or more parties, expressing an intended common line of action. It is intended to promote interagency working and to improve service user experience. (*Appendix 1)*

It is agreed that the home LA is authorised to act on behalf of the LA where the person is currently detained under s.136 in order to comply with legislation in s.13 of the MHA 83.
This applies not only to assessments in health based places of safety but also to police cells or any other place of safety as defined by the MHA. The local Authority where the s.136 is located is still responsible for considering and carrying out MHA assessments'. However good practice would be for the Home Local Authority to be contacted and asked if they have capacity to undertake the assessment and if they agree to completing the assessment confirm they will be acting on behalf of the LA where the s.136 is located. *(Appendix 2)*

It is anticipated that this can only be achieved if there is sufficient AMHP provision left in the home area to staff their service safely. Therefore, this is unlikely to be achieved by Out of hours AMHPs or AMHPs that work within an Emergency duty team as they generally work as the sole AMHP on duty and cannot leave their jurisdiction unattended.
These MHA assessments will continue to be undertaken by an AMHP from the area where the place of safety is ("where the body lies").

It is expected that if requested to undertake an s.136 assessment on a client who is well known to another area any relevant clinical details (history, risk assessments, previous AMHP reports etc) should be proportionately shared between the relevant agencies.

Where indicated consideration should be given to assessing s.136 detentions with one s.12 medic as stated in the Code of Practice if it seems abundantly clear that detention under s.2 or s.3 is a highly unlikely outcome. *(Appendix 3)*

It is expected that all s.136 assessments are undertaken in a timely manner and where practicable balance the desirability of specialist assessment against any possible delay.

Any instances concerning a client having to be conveyed to a place of safety within another Local authority due to a lack of Place of safety resource in their home area should be escalated via local pathways up to management. This will be shared within the Regional South Yorkshire s.136 meeting.

General Notes- "Where the body lies"

It is clear under s.13 (1) of the Act that an LA has the legal responsibility for ensuring that an assessment is carried out on a person in 'their area' **("i.e. where the body lies").**

Where a request for an assessment under the Act is received from a LA not part of this agreement the responsibility for ensuring that a Mental Health Act assessment is carried out remains with the area where the patient is "physically present" at the time of the referral (i.e. where the body lies). However even in these circumstances consideration should be given as to whether it is reasonable

and practical (e.g. ability to release an AMHP to carry out the assessment) for an AMHP from the person's home area to carry out the assessment but in the knowledge that the ultimate responsibility remains with the LA where the person is currently.

Mental Health Act assessments
Contact telephone numbers

Sheffield

- Central AMHP team 01142264778
- Switchboard 01142716310

Rotherham Doncaster (RDaSH)

- Single Point of Access 01924

Barnsley

- Daytime – 01226 772448
- EDT – 01226 787789

Note: all these numbers now operate 24 hours a day, 7 days a week.

Sid Fletcher AMHP Sheffield

Shirley Atkinson AMHP Barnsley

Annika Leyland AMHP Doncaster

Appendix 1

Mental Health Act 2007 21st Edition s.13 (page 117)

Partnership agreements:

There is nothing to prevent LASSAs from entering into agreements under S.75 of the National Health Service Act 2016 for NHS trusts to exercise functions under this section on their behalf: see NHS bodies and local Authority partnership arrangements regulations 2000 (SI 2000/617) reg 6. This allows for AMHPs to be deployed in services which are jointly run with NHS trusts.

Appendix 2

Mental Health Act 1983: Code of Practice 16.28 (page 143)
People detained under s136 are sometimes far from home. Arrangements should be in place so that the Police can take a person to the nearest available health based place of safety, which should admit the person even when the person resides in another area. Local authorities should also have arrangements in place so that the nearest AMHP can attend, although consideration should always be given to whether an AMHP from the persons local authority, with the benefit of local knowledge and understanding of any relevant history, could reasonably travel to assess the person. These arrangements should also ensure that, when a place of safety services an area that includes more than one local authority, the relevant AMHP services work together to ensure continuity of care and timely attendance.

Appendix 3

Royal College of Psychiatrists s.136 guidelines. (Page 46)
It is reasonable to expect that a suitably qualified medical practitioner and an approved mental health professional can attend a place of safety to commence a face-to-face assessment within 3 hours of being requested to do so.