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Police Federation of England & Wales

15-17 Langley Road Surbiton Surrey KT6 6LP
Telephone 020 8335 1000 (6 lines)
Fax 020 8390 8998 (General Secretary's Office only)
e-mail gensec@jcc.polfed.org

From the General Secretary's Office
JF/sg

26 July 2007

JBB CIRCULAR NO : 52/2007

To: The Chairman and Secretary
Joint Branch Board

Dear Colleagues

POLICE OFFICERS BEING USED IN MENTAL HEALTH FACILITIES

The purpose of this Circular is to draw JBBs attention to legal advice we have received in relation to the issue of police officers being used in mental health facilties.

We sought advice in connection with the use of police officers to assist health service staff in the administration of medication to mental health patients, as a force was seeking to introduce a policy dealing with the issue.

This circular is divided into the following sections:

1. an introduction;
2. summary of the legal framework;
3. consideration of what members may be required to do;
4. the key issues;
5. local policies;
6. specific questions.

INTRODUCTION

The use of force is always a highly sensitive issue. The right to bodily integrity is protected in both criminal and civil law. In the context of a person with mental illness, the sensitivities are multiplied. It is possible that Article 3 European

Convention on Human Rights, prohibition of torture, which extends to "degrading treatment" could be engaged and in the event of a patient dying, then Article 2, right to life, is likely to be considered.

The Independent Police Complaints Commission has expressed concern about the police being drawn into the use of force in hospital or other residential settings.

Home Office Circular 17/2004 includes guidance on general principles to inform local protocols between the police and health services on handling potentially violent individuals and includes the recommendation that:

> "18 ..... local protocols should define the precise role, which the police may be called upon to play in assisting mental health authorities in dealing with potentially violent individuals"

Given these sensitivities and concerns and the Home Office guidance, local policies that set out the parameters are to be welcomed. A policy provides an opportunity to clarify the issues of principle in advance of the pressures of an operational incident. There are however some difficult issues involved.

SUMMARY OF THE LEGAL FRAMEWORK

A number of legal provisions are potentially relevant including:

1. the provisions of the Human Rights Act 1998, which incorporates the European Convention on Human Rights into domestic law. Article 2 – Right to life and Article 3 – Prohibition of torture are potentially relevant;

2. the provisions of the criminal and civil law protecting the right to bodily integrity;

3. the provisions of the common law, section 3 (1) Criminal Law Act 1967 and section 117 PACE in relation to the use of force;

4. the Mental Health Act 1983. With limited exceptions not relevant for present purposes the Mental Capacity Act 2005 is not in force. The Mental Health Bill is currently being considered by Parliament.

WHAT WOULD OFFICERS BEING REQUIRED TO DO?

There are broadly two possibilities where police officers are called to assist health service staff in the administration of medication to mental health patients:

(i) that they are asked to undertake police duties (most obviously in relation to prevent crime or make an arrest); or

(ii) that they are asked to assist medical staff administer treatment without consent.

It may be that in practice there is seen to be an overlap between these two possibilities, in that for example, the administration of medication is regarded as the

only way to prevent a crime. It is however useful for present purposes to consider the legal position underpinning the two possibilities separately.

Legal basis of police use of force

Use of force against a person is potentially a criminal offence, in particular under the Offences Against the Person Act 1861, and a civil wrong.

The use of force is however lawful in various circumstances, including:

1. A person may use such force as is reasonable in the circumstances in the prevention of crime or in effecting or assisting in the lawful arrest of offenders or persons unlawfully at large. (Section 3(1) Criminal Law Act 1967)

2. Where any provision of Police and Criminal Evidence Act 1984 confers a power on a constable, and does not provide that the power may only be exercised with the consent of some person, other than a police officer, the officer may use reasonable force, if necessary, in the exercise of the power (Section 117 PACE).

3. At common law, if the use of force is done in self-defence or defence of another, it is lawful provided that no more force is used than is necessary for mere defence.

Thus, officers may be able to justify the use of force in relation to a mental patient by reference to one or more of these provisions, in the same way that any other use of force may be justified.

Administration of medical treatment without consent

Plainly the administration of medical treatment is a matter for doctors but an understanding of the legal position in relation to consent is necessary in order to consider the position of police officers who may be called upon to assist.

The general position is that consent is required for any medical treatment. In very limited circumstances a doctor may give treatment under the doctrine of implied consent or the doctrine of necessity.

If the reason for a patient not being able to give consent is lack of mental capacity and the patient has been detained compulsorily under the Mental Health Act 1983 then section 62 permits a doctor to give urgent treatment (which is not irreversible or hazardous) without the patient's consent for the condition for which the patient was detained. If however the patient has not been compulsorily detained then there is no statutory provision for treatment without consent, and only the common law principles apply. The general rule is that competent adults may refuse treatment.

KEY ISSUES

Against this background two fundamental questions arise in relation to the suggestion that police officers assist with the administration of medication:

(i) Is this capable of amounting to reasonable force in circumstances where an officer is entitled to use reasonable force on normal principles?

(ii) Can force be used by a police officer in circumstances where consent for treatment is not required?

(It is assumed in both cases that the treatment will be administered by a medical professional.)

In relation to the first question, we are advised that rather than a general permission being possible or there being an absolute prohibition, whether the forcible administration of medication is reasonable will depend on the circumstances of a particular case. The following points are emphasised:

(a) it will still be necessary to show as a precondition that the use of reasonable force was lawful; and

(b) that the disquiet of the IPCC is evident from the memorandum set out in the appendix to this circular.

In relation to the second question, we are advised that a police officer has no greater power than any other person. Unless a police duty (to prevent crime etc) is being followed, the involvement of a police officer appears inappropriate. There could be issues as to what an officer's position would be if s/he was wrongly informed that consent was not required. Again, while it has no legal status, the IPPC memorandum is indicative of the likely attitude to such a practice. It could be argued that the involvement of police officers would amount to degrading treatment contrary to Article 3 ECHR and if a patient were to die then it would be necessary to show that no more force than was absolutely necessary had been used either in defence of any person from unlawful violence or in order to effect a lawful arrest or to prevent the escape of a person lawfully detained in order for Article 2 not to be breached.

LOCAL POLICIES

We are not aware of any national guidance that deals with the precise expectations upon police officers. The Home Office guidance suggests there should be local protocols but does not deal with the issues considered above.

There is a Code of Practice issued by the Secretary of State pursuant to Section 118 of the Mental Health Act 1983. Paragraph 2 states:

> "The Code provides guidance to registered medical practitioners, managers and staff of hospitals and mental nursing homes and approved social workers (ASWs) (who have defined responsibilities under the provisions of the Act), on how they should proceed when undertaking duties under the Act. It should also be considered by others working in health and social services (including the independent and voluntary sectors), and by the police."

However, despite the reference to the police, no guidance is included on the role of police officers.

When looking at your local agreements, you should question the necessity of police officers attending medical facilities when provision is made within the Mental Health Act for medical staff to use force where necessary. Given the IPCC view, and its stated intent to look closely at any police intervention in any medical situation, we should be aiming to minimise the amount of contact between police and hospital patients.

We attach for your information a copy of a letter which Gloucestershire has sent to their local health provider.

If your force has a policy, we would be grateful if you could forward this to us as this will enable us to build a picture of what is happening across the country.

SPECIFIC QUESTIONS RAISED

What would be the officer's liability in the event of injury or death of a patient?

This would depend on the precise circumstances of the incident in question. The officer's conduct would need to be considered against the principles considered above. It does however seem likely that there is scope for injury or even death to occur and that the position is complicated. This highlights the need for a sensible policy and it may also mean that officers need training on their powers and obligations.

In relation to any civil claim against the police, the position is the same as with any other such claim. Section 88 Police Act 1996 deals with liability for wrongful acts of constables and provides that the chief officer of police is liable in respect of any unlawful conduct of officers under his direction and control in the performance or purported performance of their functions in the same way as an employer is vicariously liable for the acts of his employees. In practice any claims tend to be brought against the chief officer alone. If however a claim is brought against an individual officer, section 88 also authorises a police authority to pay costs and damages and Home Office guidance stresses that officers who have acted in good faith should be supported.

What legal power applies given that some facilities are privately owned?

As considered above, it is general police powers and duties which apply. It is not considered that the position is affected by private ownership of facilities.

Would an officer who was injured be regarded as acting in the execution of their duty for the purposes of the provisions relevant to an injury award (now contained in the Police Injury Benefit Regulations 2006)?

An injury award is payable to a person who ceases to serve as a police officer and who is permanently disabled as the result of an injury received without default in the execution of his duty as a constable.

An injury which is received while the officer is on duty is treated as received in the execution of duty, so assuming that the officer attended on duty there ought to be no scope for an argument that technically he was not executing the duty of a constable.

The injury would also have to be received without default. Default is likely to require wilful neglect or default.

We trust you will find this legal advice of useful and please do not hesitate to contact us with any queries you may have or comments you may wish to make.

Yours sincerely

JOHN FRANCIS
General Secretary

APPENDIX

Extract from Memorandum from the Independent Police Complaints Commission dated 27th October 2004 to Inquiry by Joint Committee on Mental Health Bill

http://www.ipcc.gov.uk/mental_health_bill_memo.pdf

"8. Use of force by police when in hospital or other institutional settings

The Commission is aware that, from time to time, hospital or residential care staff seek the assistance of the police to deal with violent or threatening behaviour by a patient being treated in that institution. In particular, CS spray has been used in hospital settings; police officers have been required to restrain patients brought to hospital for assessment or treatment for lengthy periods as part of the admission process and police officers also become involved when moving a patient from one facility to another or even to quell a disturbance which erupts in a ward setting. The Commission regards it as generally regrettable when this occurs since the appropriate response to a person's mental health crisis is the employment of highly trained and skilled therapeutic staff who are well-informed as to the cause or causes of the person's disordered behaviour and are able to use physical restraint if this is necessary, but within the context of the person's treatment. It is often entirely inappropriate for police staff with no knowledge of a patient, who are uniformed and carry self-defence weaponry, to become engaged in these types of incidents, particularly in secure unit settings.

9. We would look to the Mental Health Bill, or to regulations made under it, more closely to regulate the management of restraint in psychiatry to ensure the human rights of patients are fully and effectively respected and police officers are not drawn into these events unnecessarily, inappropriately and possibly on occasions unlawfully."

27 July 2007

Our Ref: 070425/mm/src 25th April 2007

Jan Stubbings
Chief Executive to Gloucestershire Primary
Care Trust
1250 Lansdowne Court
Brockworth
Glos
GL3 4AA

Dear Jan

Places of safety for persons detained under section 136 MHA.

For some years now we have in Gloucestershire only had one agreed place of safety where persons detained under the above legislation can be held pending assessment. That place has been one of the three police custody suites at Cheltenham, Gloucester or Stroud.

This situation evolved as other agencies that hold joint responsibility for the care of such individuals withdrew any other potential alternatives. The main reason for the police agreeing to take sole ownership of providing this accommodation was whilst the Health Service moved service provision from Coney Hill to Wotton Lawn. It was meant to be for a twelve-month period only. The fact that it remains the case today some ten years later is an unacceptable position.

I am pleased to say that despite this, much good liaison work has continued both through the Inter Agency User Group and actual working practice in our custody suites. Even to the extent of partner agencies enhancing our ability to support such detainees through cross agency training of our custody staff.

You will I hope, be aware of how the police have supported the recent bid for funding to develop an alternative location for holding such people on site at Wotton Lawn. We hope that the bid will be successful and that this will go a long way towards resolving the issue.

It seems a matter of common agreement amongst practitioners that a Police cell is not the most appropriate of locations for persons detained with mental health issues, who are not criminals, yet can be detained for up to 3 days. Clearly if an individual is under the influence of drink/drugs or is violent, then a cell may well be required in order to allow the effects to reduce before an assessment can take place, that is if

other secure accommodation is not available. I must be frank and say that I believe that in 2007, it is not morally acceptable to have persons who are mentally ill locked up alongside criminals under the care of the police.

However, this moral concern has now been overtaken by the requirements within "The Safer Detention and Handling of Persons in Police Custody", which is the current National Guidelines set out by the Home Office which stipulates that "Police cells are not suitable places for detaining people with mental health problems, and a person's condition can sometimes be exacerbated by being held in such conditions." These are the standards against which we are inspected and against which we will be held to account by the Independent Police Complaints Commission should we suffer harm to any such individual whilst detained in police custody. The Constabulary is required to be compliant with this guidance by September 2008, as is every other Police Force in the country.

Given this situation, I must put you on notice that the temporary agreement with the Constabulary to house all section 136 detainees pending assessment can not continue beyond September 2008.

I acknowledge that this decision will cause pain within your organisation to resolve and may meet resistance in certain quarters, however with this amount of notification and the fact that change is forced upon us, I believe it can be satisfactorily addressed and my staff will assist however possible to ensure any new arrangements work efficiently.

Inaction is not an option from our perspective, therefore I hope that a strategic lead can be identified whom we can work with to assist in effectively bringing about the changes necessary to bring this process of care to where it should be in 2007.

Whilst bringing you this problem, let me also offer assurance of our continuing support around the issue and emphasize our desire to see an effective resolution including working practices that take account of the needs of all involved.

Given the timescales involved, an early response would be greatly appreciated.

Yours sincerely

Mick Matthews
Assistant Chief Constable

Copy Sean Clee, Chief Executive to Gloucestershire Partnership Trust
Linda Folley, Director Working Age Adults & Substance Misuse Services
David Pugh, Programme Manager, Glos Partnership NHS Trust
Roland Dix, Consultant Nurse, Montpellier Unit, Wotton Lawn
Dr Jim Laidlaw, Consultant Psychiatrist, Montpellier Unit
Eddie O'Neil – PCT Lead Commissioner MH Adults of Working Age
Dr. T Brain, Chief Constable