BIRMINGHAM & SOLIHULL PLACE OF SAFETY MOU

MULTI-AGENCY PROTOCOL FOR THOSE ARRESTED UNDER S136 OF THE MENTAL HEALTH ACT 1983 And Those Detained Under s135

AGREED: February 2021

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MOU NAME:
SECTION 136

BRIEF OUTLINE OF THIS POLICY:
To agree the roles and responsibilities of BSMHFT, UHB, Birmingham City Council and West Midlands Police when individuals are detained under s136 of the Mental Health Act 1983 (as amended in 2007).
of the Mental Health Act 1983 (as amended in 2007).
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Parties to the Document: Birmingham City Council, West Midlands Police, West Midlands Ambulance Service*, University Hospitals Birmingham NHS Foundation Tust, Birmingham and Solihull Mental Health NHS Foundation Trust, Solihull City Council, Sandwell and West Birmingham Hospitals NHS Trust, Birmingham Women's and Children's NHS Foundation Trust. *subject to agreement
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CONTENTS:

1 INTRODUCTION

a. This document forms part of the wider plan to improve partnership arrangements between West Midlands Police, Birmingham City Council, Solihull Metropolitan Borough Council, Forward Thinking Birmingham, Birmingham and Solihull Mental Health Foundation Trust, UHB BWC, Sandwell and West Birmingham Hospitals NHS Trust and the Birmingham and Solihull Clinical Commissioning Group.

b. This protocol will support the provision of multi-agency services to individuals who are likely to be patients detained under (s135 / 6) of the Mental Health Act 1983 and has been developed jointly by the above parties including West Midlands Police, taking best practice from around the country. Use of this protocol will ensure compliance with relevant legislation, national guidance and other sources of standards for the NHS and the Police. These are listed in Appendix A.

c. Note: There are aspects of s136 operations which are unique to particular agencies and which do not affect the others. These matters will not be outlined here.

2 EXECUTIVE SUMMARY OF INTENTIONS

a. To ensure efficient, effective and dignified assessment arrangements for ALL detainees who need to be removed to a Place of Safety.

b. To ensure effective assessment by Police Officers and / or the Ambulance Service

c. To ensure removal to the most appropriate location.

d. To ensure the use of a dedicated psychiatric Place of Safety whenever available, exemplifying best practice.

e. To ensure the use of Emergency Departments only where this is consistent with concerns about urgent healthcare requirements.

f. To ensure the use of Police Stations, only in exceptional circumstances and where it is medically safe to do so.

g. To ensure effective multi-agency oversight for Place of Safety arrangements within Birmingham and Solihull.

h. To work across organisational boundaries in achieving these intentions.

3 ABBREVIATIONS

ABD	Acute Behavioural Disturbance
AHP	Allied Healthcare Professional (defined by PACE)
AMHP	Approved Mental Health Professional (defined by MHA)
BSOL CCG	Birmingham and Solihull CCG
BSMHFT	Birmingham and Solihull Mental Health NHS Foundation Trust
BCH	Birmingham Children's Hospital
CAMHS	Child and Adolescent Mental Health Services
CoP	Code of Practice, (either to MHA or PACE, as specified).
D&A	Drugs and Alcohol
DPA	Data Protection Act 1998
ED	Emergency Department
EOC	Emergency Operations Centre
FME	Forensic Medical Examiner (also known as Police Surgeon)
JSOG	Joint Strategic and Operational Group
LD	Learning Disability
MHA	Mental Health Act 1983
NoK	Next of Kin
PACE	Police and Criminal Evidence Act 1984
PoS	Place of Safety
PS	Police Station
RLOC	Reduced Level of Consciousness
RMP	Registered Medical Practitioner
SMBC	Solihull Metropolitan Borough Council
UCOG	Urgent Care Operational Group (who have oversight of this policy)
UHB	UHB University Hospitals Birmingham NHS Foundation Trust
WMAS	West Midlands Ambulance Service
WMP	West Midlands Police

4 OVERSIGHT

4.1 This MOU relates to individuals detained by the Police under S135/6 of the Mental Health Act (MHA) for removal to a Place of Safety (PoS).

4.2 Sections 135(1) and 136 of the 1983 Act provide for the police to detain a person believed to be suffering from a mental disorder in specified circumstances and "remove" them to a designated place of safety. Such designated places of safety include hospitals, police stations and local authority residential care homes. Subsections (2), (3) and (4) provide flexibility for the officer, in certain circumstances, to keep the person at the place at which they have been detained if it is a designated place of safety. Subsection (4) also makes amendments to provide for a police officer to act quickly to protect people by extending the application of section 136 to private property (other than private dwellings) Police can now use s136 in any public or private place, unless it is a "house, flat or room" where someone lives, or any non-communal "yard, garden, garage or outhouse" connected to such a place. Places where S136 **can** be used Include workplaces, railways, police custody and Emergency Departments (ED).

4.3 Section 136 Subsection (1C) Before deciding to remove a person to, or to keep a person at, a place of safety under subsection (1), the constable must, if it is practicable to do so, consult—(a) a registered medical practitioner, (b) a registered nurse, (c) an approved mental health professional, or (d) a person of a description specified in regulations made by the Secretary of State requires police officers to obtain advice from a doctor, nurse, approved mental health professional (or other person specified in any regulations which may be made) before exercising their powers under section 136, unless in the officer's judgment it would not be practicable to do so. An officer might decide it is not practicable to consult if, for example, he or she needs to act without delay in order to keep a person safe from immediate danger. The mental health professional cannot instruct the police officer, only offer advice. Any decision to detain is ultimately that of the police officer.

4.4 It is agreed between all parties (WMP, PLACE of Safety (POS) Staff, WMAS)(MHA CoP 16.30) that those detained, or requiring an assessment, are a joint management responsibility based on the risk assessment tool (High/Medium/Low) from the point of detention to the point of disposal or admission, and it is the responsibility of every organisation to ensure support for the other(s), throughout the period of detention (including conveyance) in accordance with the legislation and guidance.

4.5 Birmingham & Solihull CCG will ensure sufficient Place of Safety, including contingency considerations, are commissioned in healthcare or non-Police Station settings. Although not desirable, Police Stations remain a Place of Safety option - albeit only if the 'exceptional circumstances are met'. Police Cells can no longer be used for children if arrested under the Mental Health Act. In Birmingham, the designated PoS is The Oleaster for adults, and for children it is Parkview Clinic (FTB) (CoP 16.36).

4.6 This MOU will be approved and monitored by a local governance structure, which will also take responsibility for examining the processes in place for other multi-agency tasks, such as transport of persons under the Act and policies in respect of patients who go absent without

leave (CoP 16.35). In Birmingham and Solihull this role is delegated to Joint Strategic Operation Group (JSOG).

4.7 Each ogranisation will designate a Manager to be responsible for the on- going operational, day-to-day oversight of the protocol, as well as being the day-to-day point of contact to resolve challenges with operational implementation of this protocol. From UHB, in-hours this will be the ED Ops Manager/GM, out of hours it will be the Ops On-Call Manager Please refer to the partner escalation policies at appendix M, N and O. Problem solving, where it cannot occur at the time, will be managed in a regular and minuted forum (at least bi-monthly). This will involve attendance by key staff, including the designated NHS Manager and Local Police Mental Health Operational Lead. It will be referred to in this protocol as the 'Multi-agency Group' or 'UCOG'.

4.8 The assessment may be delayed, for example when it is unclear whether a person who is under the influence of drugs and/or alcohol also has a mental disorder, or where the need to administer emergency sedation makes the subsequent assessment impractical until the effects of the medication, drugs and/or alcohol have subsided. There will be joint consideration on the location of individuals who are detained whilst presenting with drug, alcohol or physical aggression issues. West Midlands Police may decide to commit the appropriate number of police resources to ensure the subject is under control at the Place of Safety if the risk assessment evidences that the individual poses an 'unmanageable high risk' and it is considered medically safe to do so by either the FME or attending Psychiatrist (Appendix D).

4.9 Police officers should remain in attendance when a person arrives at a health-based place of safety until a handover is completed which includes a joint assessment of the threat and risk posed by the detainee. Healthcare staff, including ambulance staff, should take responsibility for the person as soon as possible, including preventing the person from absconding before the assessment can be carried out. The police officer should not be expected to remain until the assessment is completed and should be able to leave when the situation is agreed to be safe for the patient and healthcare staff. In ED's, Police will usually remain at all times unless it is confirmed that their attendance is no longer required.

4.10 In accordance with this MOU it is expected that police will use S136 (3) MHA which allows officers to search "if the constable has reasonable grounds for believing that the person – May present a danger to him/herself or others *AND* Is concealing on their person an item that could be used to cause physical injury to him/herself or others. 136C Protective searches (1)Where a warrant is issued under section 135(1) or (2), a constable may search the person to whom the warrant relates if the constable has reasonable grounds for believing that 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.

4.11 Neither section 136 nor S32 PACE permits routine searching of detainees. There will also be an additional security review/confirmation in the presence of BSMHFT/UHB staff to reaffirm the above.

4.12 The security approach will be in accordance with BSMHFT security and search policy, and UHB security and is intended to minimise risk to service users, staff and visitors.

4.13 Where assessment of an individual occurs on private premises, it is only conducted under s135 of the Mental Health Act where a warrant, issued by a Magistrate, has been

obtained. Where assessments occur without warrant, there are no powers to remove an individual to a Place of Safety and this protocol does not apply. If the assessment takes place without warrant and the subject is detained, they are then in the AMHPs lawful custody. Removal is then via S6 of the MHA. Hospital admissions following the necessary application should occur directly from the assessment location, with Police assistance If the detainee is violent and dangerous, where necessary, in order to prevent a breach of the peace or assist with conveying a patient liable to detention under the Mental Health Act.

4.14 Careful planning should be undertaken by any AMHP who is responsible for coordinating an assessment on private premises, especially where there is a possible risk of resistance or aggression. There is often confusion amongst professionals about the powers available to act and a lack of clear communication. The number of professionals and agencies involved dictates that effective planning and communication is key.

5. INITIAL ACTION FOLLOWING DECISION TO DETAIN

5.1 Only Police Officers may detain someone under s135/6 MHA and remove them to a Place of Safety. Following an initial decision to detain, an ambulance should be requested for conveyance to a PoS (it should be organised in advance if detention is considered likely to arise following execution of a warrant under s135). This is not only important in terms of that patient's dignity, it is also important in terms of the skills of Ambulance Service staff in assessing whether other medical risks may be masked by mental ill-health and / or drugs and alcohol, requiring urgent medical assessment in an ED. Street Triage should be contacted for all potential detentions under Section 136 between 1000hours and 0200hours. Please refer to 4.3 above for full details. Police will contact Street Triage to request transport if reasonably practicable to do so.

5.2 The patient must be searched under s136C PACE if the relevant conditions are met. Any items which are considered to pose a risk of harm to others may be seized and they should be retained by the Police Officers until handed to the Place of Safety staff (not to ED staff) or to the Custody Officer at the Police Station. NHS staff should note that the power to search is only a power to search to the extent that is reasonably required for the purpose of discovering the item that the constable believes the person to be concealing. The search extends to the removal of outer coat, jacket and gloves AND a person's mouth. The constable may seize and retain - it says nothing about handing over to non-police agencies this search is limited to a physical 'pat-down', to searches of pockets and bags. Where someone is detained under s136 MHA, they are able to be searched on arrest subject to the criteria of s136C. s136 (5)The power to search conferred by subsection (1) or (3) — (a)does not authorise a constable to require a person to remove any of his or her clothing other than an outer coat, jacket or gloves, but (b) does authorise a search of a person's mouth.

5.3 Police officers can also now search under s136C following arrival at a Place of Safety for anything that may be used to cause harm if a constable has reasonable grounds to believe they possess such a thing.

5.4 Confirmation of search will be requested by BSMHFT staff/UHB Staff/Others and where the grounds for a search are met an additional "security sweep" will be facilitated by BSMHFT staff using a metal detection wand in the presence of the policy. The security sweep approach will

be in accordance with BSMHFT search policy and is intended to minimise risk to service users, staff and visitors.

5.5 Property will also be initially handed to PoS staff/UHB Staff for searching and documenting. Once check and deemed safe this will be returned to service user if considered appropriate to do so whilst in place of safety.

5.6 Police officers can also search someone if reasonable grounds for the search are met at any point after they have executed a search warrant under s135(1) or s135(2) MHA - the power to do so is s136C(1) - this 135 search authority lasts until the end of detention under s135(1) OR until the person detained under s135(2) has arrived back at the place they were being transported to.

5.7 Police officers are authorised to retain possession of anything found during that search, apart from items of legal privilege, which could be used for causing physical injury to the detainee themselves or others and retain it until the end of the period of assessment. Anything found which is prohibited by an offence can be retained indefinitely after being seized under s19 PACE.

5.8 Identification of which PoS will be used should be reached in accordance with Appendix B. Police Officers bear legal responsibility for the health and safety of their detainees until a formal agreed handover to NHS staff is affected.

5.9 Where an ambulance or the Street Triage team are unavailable, Police Officers should still make their initial assessment in accordance with Appendices B and C, with due allowance made by other professionals for their reduced skill base.

5.10 Where Police Officers take a decision to expedite transport themselves, this should be in cases of emergency or where it is necessary in order to safely manage a high risk of violence. This MUST be balanced against whether a patient is presenting with a RED FLAG. The violence may be such that a police vehicle must be used in which case the senior paramedic present must travel in the police vehicle. (Appendix C).

5.11 The guiding principle of this protocol is that, wherever possible, individuals will be removed to a health based, psychiatric PoS, unless they are detained whilst presenting with a RED FLAG. These are outlined in Appendix C and are agreed as criteria for removal to an Emergency Department.

5.12 Section 136A prevents the use of police station as a place of safety in any circumstances where the detainee is under 18 years of age.

5.13 A person is defined as ‘arriving’ when Arrival is at the point where the detainee enters the PoS (s136(2a) (a)(1,2) MHA) Place of Safety or Arrival at police station is the time the person arrives at the station. Disputes into acceptance should be referred to the UCOG if they cannot be resolved by operational supervisors at the time.

5.14 The "permitted period of detention" is 24 hours from the time a person arrives at a place of safety or the time a police officer decides to keep the person at a place of safety. Subsection (1) 136B Extension of detention: The registered medical practitioner who is responsible for the examination of a person detained under section 135 or 136 may, at any time before the expiry of the period of 24 hours mentioned in section 135(3ZA) or (as the case may be) 136(2A), authorise the detention of the person for a further period not exceeding 12 hours (beginning immediately at the end of the period of 24 hours where the

condition of the person detained is such that it would not be practicable for the assessment to be carried out before the end of the period of 24hours" - i.e. intoxication or medical treatment. Where both the place of safety at which the detainee is being held and the intended place of assessment is a police station, authorisation to extend the permitted period of detention will also require the approval of a police officer of the rank of superintendent or above.

5.15 Advance notification of an impending s135 / 6 arrival will be given to the staff who manage the PoS by the Police Service, wherever possible.

- For The Oleaster Unit, the advance number is [redacted]
- For Good Hope ED: [redacted]
- For City Hospital ED, the advance number is [redacted]
- For Heartlands ED [redacted]
- For Queen Elizabeth Hospital ED, the advance numbers are [redacted]

5.16 Full telephone numbers relating to this protocol are contained in Appendix K. Where removal to the Police Station will occur, advance notification will be given via Force Contact Centres, as for other arrests. The Contact Centre will identify a relevant custody station and notify the arresting Officers.

5.17 Place of Safety staff should note that, where an individual has not been removed to The Oleaster, the Custody Officer who detains the person in custody will contact them to let them know which Police Station has been used to detain the individual and to request that they are notified when The Oleaster is in a position to receive the patient on transfer under s136(3).

5.18 Oleaster PoS staff should ensure they record the order in which they are notified of any detentions removed to the Police Station, so that consideration of allowing a transfer can occur in the order in which the arrests were made.

6 CHILD & ADOLESCENT MENTAL HEALTH SERVICES (CAMHS)

6.1 s136 Suite Place of Safety Service Birmingham Provision (PLEASE REFER TO APPENDIX L FOR THE CAMHS PoS SPEC)

This service is based at Parkview Clinic, Moseley, Birmingham B13 8QE and is part of Birmingham Women's and Children's NHS Foundation Trust. The service provides for children and young people who live in Birmingham, age range is up to 18th birthday. A young person aged 18 or over will be taken to The Oleaster Adult Place of Safety.

6.2 Following detention under Section 135/6 of the Mental Health Act, West Midlands Police will:

- Contact the BCH switchboard on Tel: 0121 333 9999
- Ask for the 136 Suite at Parkview, the PoS Coordinator is based on the Ashfield Unit [redacted]
- Following an initial conversation with the PoS Coordinator and where it is reasonably practicable to do so, the Police will attempt convey the child/young person to either the BCH Emergency Department (if medically compromised and 16 or under and local A&E if physically compromised

and aged 16 plus), or to the s136 Suite at Parkview Clinic, Moseley B13 8QE (if medically fit and if the Suite is available).

6.3 It is essential that West Midlands Police follow the process above – contact via the BCH switch – to ensure nursing staff are available to receive the patient on arrival at the 136 Suite, Parkview Clinic.

6.4 Contact Details for CAMHS 136 Suite:

Ashfield Nurse in Charge: 0121 333 9999 [redacted].

7 INITIAL CONVEYANCING

(This protocol should be read in conjunction with the Joint Transport of Patient Policy)

7.1 It will be the responsibility of Police Officers to request an ambulance for transport following detention under s136. It will be the responsibility of the AMHP to register a log and ring back if needed. The Ambulance Service is the preferred method of transport to convey that individual from the location of arrest to the PoS and to undertake any further conveyance requirements should the individual be subsequently transferred).

7.2 Transport following arrest under s136 should be instigated via a 999 call for an emergency ambulance.

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

7.4 In consideration of the journey to ED or the PoS, particular thought should be given to whether it is safe to do so, where the person is agitated.

7.5 Where it is considered that the safety either of the patient, the ambulance staff or the Police Officers would be at risk during transfer, ambulance crews should consider requesting a pre-hospital Doctor via EOC.

7.6 Particular consideration should be given as to whether there is a need for on-going physical restraint by two or more Police Officers and therefore a risk of positional asphyxia or Acute Behavioural Disturbance. Whether or not pharmacological interventions (such as anti- psychotics or Lorazepam, which are only available via a pre-hospital Doctor) are immediately appropriate, is also a relevant consideration.

7.7 Where a pre-hospital doctor is deployed prior to conveyance, Police officers will act in accordance with their training. They may follow advice if it is appropriate to do so.

7.8 Any problems in securing arrangements for conveyance should be escalated to appropriate line managers for discussion with ambulance managers and referred to the UCOG if not resolved. This will allow on-going monitoring of the frequency of ambulance or Police conveyance.

7.9 Where Police Officers take a decision to expedite conveyance themselves, this should be in cases of some urgency or where it is necessary in order to safely manage a risk of

violence or where an ambulance is simply unavailable. These occasions are expected to be rare.

7.10 Reference should be made to West Midlands Ambulance Service policy on Mental Health and the Joint Transport of Patient Policy.

Medication - police officers should not be associated with the administration of medication under the Mental Health Act or Mental Capacity Act, unless unavoidable in circumstances where safety would otherwise be seriously compromised. Officers are briefed to resist becoming involved because restraint techniques in policing and in healthcare significantly differ – officers should 'contain' not 'restrain' wherever this is practical and possible.

8 REMOVAL (OR TRANSFER) TO AN EMERGENCY DEPARTMENT

8.1 It is not the intention of this protocol, to promote the use of Emergency Departments as a Place of Safety. This is recognised as inappropriate (see references in Appendix A). In addition, if the s136 suite at Oleaster is full, police officers are diverted to ED with s136 detainees - not just those who require physical assessment.

8.2 However, a minority of people detained by the Police under s135 / 6 MHA present with physical healthcare requirements in addition to their suspected mental disorder, which can only be addressed in an Emergency Department.

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

8.4 Where such concerns exist or cannot be ruled out by Police Officers, the Police Custody Officer is required to ensure that any person receives appropriate clinical attention, either by calling an ambulance to Police custody or by removing the individual to hospital.

8.5 This protocol seeks to provide a balance against that uninformed assessment, by prior consideration of these issues by the Ambulance Service at the point of arrest (supported where necessary by a pre-hospital Doctor).

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

8.7 It is the responsibility of a police Supervisor to ensure that sufficient Officers are deployed to security duties in support of ED staff, especially so where the RED FLAGS involved include agitated or disturbed behavior.

8.8 In addition, Police Officers will ensure that the following information is supplied to ED staff:

- Name, address of the individual detained.
- Name, address of the individual's next of kin or nearest relative.
- Time the s136 is enacted.
- Circumstances in which the individual was found and arrested.

- Whether the detainee has been to any other Place of Safety prior to arrival.
- Whether or not the individual has been searched by the Police.
- Whether any article or contraband has been retained by the Police.
- Whether they are also suspected of any criminal offence on which the Police will consider taking action, dependent on the assessment conclusion.
- Whether the Police hold any information regarding the possibility that the individual presents a risk of violence or escape to NHS staff.

8.9 Ambulance staff (or any pre-hospital Doctor) will provide appropriate medical information on whether restraint has been used, whether drugs have been administered and any other observed symptomology which will subsequently need to be known. Police will inform staff of which tactics, including restraint has been used and for how long.

8.10 This protocol ensures that only RED FLAGS are removed to Emergency Departments for medical management. By necessity, this will involve initial psychiatric assessment and consideration of capacity and consent issues. This may involve liaison between ED Doctors and the Liaison or Duty Psychiatrist.

8.11 Informing an AMHP should not be delayed pending transfer to a Place of Safety, as it will not necessarily be known upon arrival at ED how long the patient will remain there. It is the responsibility of the assessing organisation to inform the AMHP.

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

8.13 Any time spent at ED needs to be included in the overall24 hours maximum assessment period from the point of arrival at ED.

8.14 Anyone removed to ED and accepted there for assessment / treatment, shall ensure to take such steps as are practicable to ensure that the patient understands their rights whilst detained. It is the duty of the “managers of a hospital” to ensure that s132 MHA is complied with. Patients will be given a leaflet detailing their rights and a verbal statement of patient rights will be communicated to them (see Appendix F for the ‘rights leaflet’)

8.15 If it is possible for the ED staff to manage the physical healthcare requirements, rule out a medical or psychiatric emergency and/or confirm that the person is considered ‘fit for discharge’ then the person may be considered for transfer to a Place of Safety for conclusion of the Mental Health Act assessment.

8.16 If the patient is discharged from ED, but remains in detention under s136 for a MHA assessment elsewhere, it will be the responsibility of the ED staff to ensure the transmission of relevant medical information which may be required by PoS staff or Police Custody Officers. This must not be done verbally, via the arresting Officers. The responsible Emergency Department staff should follow internal protocols for the transmission of relevant medical information relating to the transfer of the patient.

9. REMOVAL (OR TRANSFER) TO A HEALTH BASED PLACE OF SAFETY

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

9.2 In the psychiatric setting, the 'handover period' should include a sufficient period of time for the PoS to co-ordinate their staff and for a Police Officer to provide a comprehensive briefing of relevant information. In most cases, the police should be free to leave within 30 minutes once staff are satisfied they can safely manage the person.

9.3 The Police Service will be able to inform NHS staff of the information listed in para 5.8, where this information is known or easily able to be established:

9.4 Following acceptance at a Health Based PoS, the risk assessment should take place before the rights are administered - this is what happens in police custody and would be a safer option for NHS staff. The explanation of these rights should not be delayed where removal is to Accident & Emergency. Whilst at a PoS hospital managers will facilitate a solicitor if a patient requests one.

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

NHS Managers will have the right to insist upon Police support and it will be given - Police supervising Officers will have the right to insist on the level of that support and this will be monitored within the UCOG group to ensure that retention of police is in line with this policy.

9.6 Risk assessment should be regularly subject to joint-review and the Police should be released, recalled or reinforced, where threats alter.

9.7 Operational staff will comply with this compromise and may refer the MHA form to the UCOG, in the event that they remain dissatisfied.

9.8 To maintain confidence in the support arrangements, the UCOG will ensure effective communication and feedback to all operational staff regarding difficulties referred to them.

9.9 Although it is preferable for the MHA assessment to occur with the AMHP and relevant RMPs together, there will be occasions where this does not occur. If an RMP examines the individual prior to the arrival of an AMHP, the relevant question is to ask, "is this individual mentally disordered within the meaning of the Mental Health Act?"

If “No” - Release from s136 without waiting for an AMHP

If “Yes” - Maintain detention until the arrival of an AMHP for interview.

9.10 This is not the same as asking the doctor(s) to indicate whether someone should be ‘sectioned’ under the Mental Health Act. Individuals may be mentally disordered, but present in such a manner as to require community treatment, rather than hospital admission. This is identified and organised by the AMHP following interview.

9.11 It is desirable for a specialist Consultant Psychiatrist and / or a specialist AMHP to be available to make the assessment if it appears that the detained individual has a learning disability. See Section 8 on LD patients detained under s135/6).

9.12 BSMHFT will ensure that the place of safety is kept clear for 6 hours prior to a warrant being executed. This will be subject to a discussion with the AMHP and the bed manager to confirm the PoS is clear at the commencement of the 6 hours period. Assurance will also be given that the suite will be free post execution until resolution of the assessment. The PoS commitment will be stood down if direct admission to a bed is available or the AMHP confirms a bed is not required.

10 REMOVAL (OR TRANSFER) TO A POLICE STATION

10.1 Detention at a Police Station should only be accepted by the Custody Sergeant where it is potentially considered medically safe to do so and in exceptional circumstances only. Any conditions referred to paragraph 2.6 or the ‘RED FLAGS’ in Appendix C, should lead to immediate transfer to an ED being ordered.

10.2 It is especially important for Custody Officers to consider those factors listed in para 2.6 (above) and Appendix C (below) if conveyance to the Police Station has NOT occurred with the involvement of paramedics. Confirmation should also be sought from the arresting Officer as to whether the Police Station is the first Place of Safety to which the person has been removed and whether or not any paramedics / technicians, doctors or other medical staff have been involved in any management decisions thus far.

10.3 Where detention at the Police Station is accepted, the Custody Sergeant will immediately inform both an RMP and an AMHP.

10.4 The Custody Sergeant will also ensure that the Place of Safety will be informed that an individual arrested under s135/6 has been detained in Police custody. This is in order to ensure that staff at The Oleaster are aware of any additional detentions and that they are then able to notify the Custody Sergeant that a transfer may occur once they are in a position to receive a subsequent patient.

10.5 Any transfer under s136(3) to a subsequent Place of Safety must be authorised by a constable or AMHP or a person authorised by either of them.

10.6 It is the responsibility of the Police to arrange for an identified Appropriate Adult to support the person who has been detained under section 136 if an offence has been

committed, whilst they remain in Police detention. Whilst nothing in law prevents the AMHP undertaking this function, it should be clearly explained to the Custody Sergeant why the AMHP is not considered to be the most appropriate individual in the circumstances.

10.7 The Custody Officer must ensure that anyone who is detained receives appropriate clinical attention from an Approved Healthcare Professional. The AHP may be an FME or Custody Nurse, but it may be necessary to call an ambulance.

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

10.9 The Custody Sergeant/Inspector will monitor the on-going need for the individual to remain detained in Police custody and will expedite all opportunities to remove them to a health-based setting.

10.10 Arresting Officers will still be responsible for initial completion of the MHA monitoring form and for attaching it to the custody record. This form will follow the patient if they are transferred to a Health PoS or to an ED.

10.11 The Custody Sergeant will ensure confirmation of information which should subsequently be shared with NHS professionals, either in Police custody during a MHA assessment or upon transfer to a health-setting. This information is listed in para 5.8 above.

10.12 Where an individual is removed to a Police Station as a PoS, the reason they cannot be accommodated at the main PoS should be recorded on the MHA monitoring form and the matter be referred to the UCOG. This will allow focus on the proportion of instances that each venue is utilised.

10.13 Where an individual's assessment is entirely managed within Police custody, a MHA assessment should occur within 4 hours, unless delayed on medical advice. This is dependent on the co-operation of all agencies to ensure attendance and participation in the assessment and swift identification of all available beds. Assessment taking longer than 4 hours should be referred to the UCOG.

10.14 The Custody Officer will adhere to the following escalation procedure to conclude the assessment or release in a timely fashion:

10.15 Although it is preferable for the MHA assessment to occur with the AMHP and relevant RMPs together, there will be occasions where this does not occur. If an RMP examines the individual prior to the arrival of an AMHP, the Custody Officer should enquire of the Doctor(s), "is this individual mentally disordered within the meaning of the Mental Health Act?"

If "No" - Release from s136 without waiting for an AMHP

If "Yes" - Maintain detention until the arrival of an AMHP for interview.

10.16 This is not the same as asking the doctor(s) to indicate whether someone should be 'sectioned' under the Mental Health Act. Individuals may be mentally

disordered, but present in such a manner as to require community treatment, rather than a hospital admission. This is identified and organised by the AMHP following interview.

11 ASSESSMENT OF AN INDIVIDUAL WITH A LEARNING DISABILITY

11.1 Where it is known, or where it becomes suspected, that an individual removed to any Place of Safety has a learning disability and is over the age of 19, early contact will be made with the Community Learning Disabilities Services. If the patient is brought to a UHB ED, the UHB Vulnerabilities Team must also be informed by ED staff.

11.1 This will ensure that, if an individual is known to Learning Disabilities Services, information is shared at the earliest possible point.

11.2 In cases of suspected co-morbidity, liaison should occur at the earliest point between the initial RMP and LD clinicians to determine who will bear lead clinical responsibility for the assessment and for determination of the subsequent pathway to be followed.

11.3 Specifically with regard to the PoS at The Oleaster Unit, Edgbaston, where it is determined that LD clinicians will undertake or lead the MHA assessment, it will be their responsibility, in conjunction with the AMHP, to ensure that assessment and arrangements necessary for that individual's treatment and on-going care are concluded within the 24 hour legal timeframe, but preferably earlier.

11.4 The number of assessments a person with an LD undergoes will be noted at the UCOG with particular consideration given to efficacy of partnership working in each case and other learning outcomes for the professionals involved.

11.5 It is preferable that assessments or a person with an LD are undertaken by an RMP who is s12(2) approved and a specialist in that area of psychiatry.

11.6 Ultimately, the law only requires that the assessment be conducted by a Registered Medical Practitioner, with reasons as to why a s12(2) Approved Doctor was not utilised being documented. MHA CoP; para 16.46.

11.7 Decisions to delay for a specialist or s12(2) RMP should be balanced against any resulting delays in assessment.

11.8 The reasons for proceeding without resort to a s12(2) RMP or an LD specialist, should be documented.

12 ESCALATION PROCESS

12.1 The Royal College of Psychiatrists recommends a maximum period within which to conclude Mental Health Act assessments. Whilst the law allows 24 hours to do so,

assessment should occur and conclude in most cases within 4 hours. If this does not happen health care staff should report it through their organisation's incident reporting system, or escalation system

12.2 For the purposes of this escalation process 'PoS Guardian means:

- Emergency Department - Senior ED Nurse
- PoS - Senior Psychiatric Nurse
- Police Station - Custody Sergeant

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

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

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

3hrs:	PoS Guardian to contact the AMHP for a situation update.	Further contact will be made with the AMHP at least every 3hrs in the absence of any other communication.
12hrs:	The fact of an on-going s136 detention should be brought to the attention of the appropriate Managers who should then work together to conclude the assessment or make arrangements. Further contact will be made with the AMHP at least every 3hrs in the absence of any other communication.	• Escalate to Director of Operations, Division 3 or the Tactical on-call if out of hours. • PoS – Urgent Care Manager • Police - Duty Inspector • CAMHS PoS - Manager for Place of Safety Tier 4 CAMHS • LD - LD On-Call Manager at Birmingham Community Healthcare Foundation Trust
19hrs:	The fact of an on-going s136 detention should be brought to the attention of the appropriate Senior Managers who should then work together to conclude the assessment or admission / referral arrangements:	• Escalate to the Managing Director, Division 3 or the Tactical on-call if out of hours • PoS - Head of Urgent Care • Police - Force Incident Manager • CAMHS PoS - Manager for Place of Safety Tier 4 CAMHS • LD - LD On-call Manager

		at Birmingham Community Healthcare Foundation Trust
24hrs:	The fact of an on-going s136 detention should be brought to the attention of the appropriate Service Directors, who should then work together to conclude the assessment or admission / referral arrangements. Further contact will be made with the AMHP at least every 2hrs in the absence of any other communication.	• Escalate to the Deputy Chief Operating Officer or the Strategic on-call if out of hours. • PoS - Associate Director • Police - Duty Superintendent Mission Support (Post 24 hrs) • CAMHS PoS - Manager for Place of Safety Tier 4 CAMHS • LD - LD On-call Manager at Birmingham Community Healthcare Foundation Trust

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

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

13 TRANSFER BETWEEN PLACES OF SAFETY

13.1 Initial management in an ED and / or Police Station should be for as short a period as possible and individuals should be transferred to the main PoS as soon as possible. That stated, a transfer should not occur without the authority of an AMHP, a RMP or another healthcare professional who is competent to assess that the transfer will not put the individual's health at risk.

13.2 Transfer can only be undertaken by a Police Officer or an AHMP or by someone authorised by either of them to do so. Even where authority is delegated, the Police Officer or AMHP retain responsibility for conveyance. Nor should the transfer occur without the agreement of the receiving PoS that they are able to accept the individual.

13.3 Transfer of an individual should be undertaken by the Ambulance Service, wherever possible, and organised via the Urgent Care Desk: 01384 215555, although the person remains in the legal custody of the Police Officer or AMHP. Secure Patient Transport is used when the patient is considered a risk to others / themselves. If they are calm or sedated but safe to be transported, regular transport can be used. Reference should be made to consideration of specialist transport.

14 CONCLUSION OF ASSESSMENT

14.1 Where assessment concludes that the individual requires admission to hospital as an informal or detained MHA patient, a bed will be sourced in line with the Bed Management Policy. Removal from the POS is not a police role and should be managed either with agreement within area or commissioned provider for out of area placements. West Midlands Police do not transfer between MHUs. They will transfer between ED and MHU and between Police Stations to ED/MHU.

14.2 Where it has been agreed that the Police should resume other duties, they should not become re-involved in supporting any conveyance unless the risk assessment has altered where specifically the detained has become violent or dangerous. Securing arrangements for admission to hospital remains the responsibility of the AMHP and should be obtained via the Ambulance Service (Tel: 01384 215555).

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

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

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

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

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

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

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

15 CRIMINAL OFENCES / s136 MENTAL HEALTH ACT

15.1 Where an individual is detained by the Police in circumstances where they could either have been arrested for a criminal offence or detained under s136 of the MHA, they

should be arrested and removed to a Police Station unless the offence is so trivial as to be safely set aside for the purposes of prioritising a mental health assessment. This might well occur where the offending was very low-level, possibly 'victimless' and / or where the behaviour it is most likely to be related to their mental health condition.

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

15.3 For offences which are not trivial, including offences of violence against NHS staff prior to or after arrival at the PoS, an arrest will largely depend on the threat and risk posed by a patient and the seriousness of the offence - lodging in a police cell is not automatically the right thing to do i.e. if ABD is a factor, the detainee will need to go to ED.

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

15.5 They should then be considered for removal to an ED prior to detention in Police custody, subject to any advice given by the Ambulance Service.

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

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

16 ESCAPING FROM LAWFUL CUSTODY UNDER s135/S136

16.1 A patient is considered to have escaped from lawful custody if they are if liable to be detained i.e. the application has been made to a MHU but haven't arrived yet, or if the person has arrived at hospital and is detained under s.2/3/4 MHA. The power to retake a patient who 'leaves' whilst detained comes from s18 MHA. Where a patient absents themselves from detention under either s135 or s136, the Police and the AMHP will ensure a co-ordinated approach to recovering the patient. However, it should be noted that AMHPs will only be involved in obtaining a warrant under S135(1), but NOT S135(2). In this case within the detention period of a person detained under s136 there is a power to return the patient to the ward within the prescribed time limit. If entry is needed to a place where a person is living (house, flat or room) or any yard, garden, garage or outhouse connected with that place, a warrant should be sought under s135(2) to enable entry and recovery. In all other places, police can utilize their power under s136(1B) and enter by force if necessary.

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

16.3 There is no power to force entry to premises in order to secure the re-detention of someone who is missing under s18 MHA. Where entry needs to be forced in order to re-detain a patient, this must be done under the terms of a warrant issued under s135(2) of the MHA (see Appendix I). This can be supported by the Street Triage Team where appropriate.

16.4 Where a person is re-detained, Police Officers should then recommence the process of this protocol, calling an ambulance and re-risk assessing the appropriate place to which the patient should be removed. This may or may not be the same location to which they were previously heading to or from which they have absconded.

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

16.6 The overall time for assessment and conclusion of Place of Safety operations, including absences, is 24 hours from the point of arrival at the first Place of Safety.

17 MONITORING

17.1 The Police will ensure provision and the Mental Health service provider will ensure collation of Mental Health Act monitoring forms. These will ensure the basis of overseeing the use of s135 / 6 powers in the area. They are legally required and of critical importance. MHA CoP; para 16.63 and 16.64.

17.2 Completed forms will be sent to the relevant MHA Office, who will scan the forms onto the electronic care record.

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

- Age
- Gender
- Race / ethnicity
- Religion

But also to:

- CAMHS / LD issues
- Number of time the POS was used on a month by month basis
- Number of patient under 18 who used the Oleaster POS
- Number of times the POS was unable to be accessed as it was full
- Average length of time from arrival at the POS to assessment
  - Average length of time from arrival at PoS to release from 136 or application for admission
- Examination of assessment times significantly above the average.

17.4 Analysis should include:

- How many were ‘mentally disordered within the meaning of the MHA’?

- How many under the influence of drugs / alcohol?
- How many were physically aggressive on detention?
- How many and percentage of removals to A&E?
- How many and percentage of removals to Police Stations?
- How was transport to the PoS undertaken?

17.5 Monitoring will be dealt with by the JSOG who will be responsible for audits and monitoring in line with the Act and receive reports / recommendations.

18 APPENDICES

APPENDIX A

REFERENCES

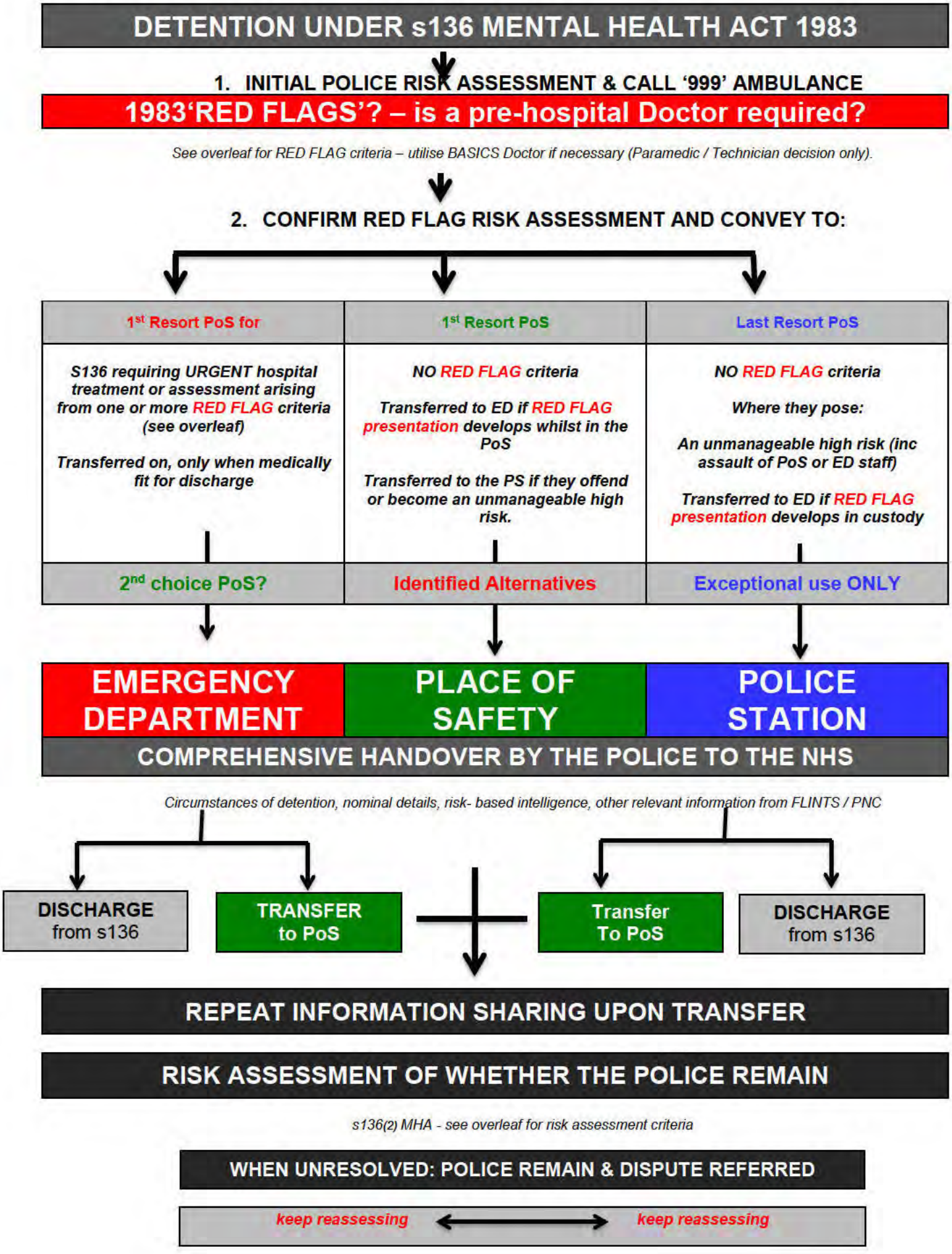
This protocol is developed in compliance with the following legislation:

1 Mental Health Act 1983 (MHA)
2 Code of Practice (CoP) to the MHA, revised 2015
3 Police and Criminal Evidence Act 1984 (PACE).
4 Code of Practice, Code C, to PACE, revised 2008
5 Human Rights Act 1998
6 Data Protection Act 1998
7 Policing and Crime Act 2017

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

8 Royal College of Psychiatry Standards on s136 (2008)
9 Independent Police Complaints Commission of the use of Police cells for detentions under s136 (2008)
10 Academy of Medical Royal Colleges Report on Managing Urgent Mental Health Needs in the Acute Trust (2008)
11 NICHE Guidelines on the Short-Term Management of Disturbed / Violent Behaviour (2005).
12 NPIA Safer Detention Guidance, NPIA (2006)
13 NPIA Guidance on Police Responses to People with Mental Ill-Health or Learning Disabilities (forthcoming, 2010)
14 Home Office Circular 17/2004
15 Home Office Circular 66/1990
16 R v Ashworth Hospital Authority (2005), House of Lords.

APPENDIX B **Operating Flowchart**



APPENDIX C

RED FLAG CRITERIA

RED FLAG CRITERIA Police Officer / Paramedic triggers for conditions requiring Treatment or Assessment in an Emergency Department	
Dangerous Mechanisms: Blows to the body Falls > 4 Feet Injury from edged weapon or projectile Throttling / strangulation Hit by vehicle Occupant of vehicle in a collision Ejected from a moving vehicle Evidence of drug ingestion or overdose	Serious Physical Injuries: Noisy Breathing Not rousable to verbal command Head Injuries: Loss of consciousness at any time Facial swelling Bleeding from nose or ears Deep cuts Suspected broken bones
Attempting self-harm: Head banging Use of edged weapon (to self-harm) Ligatures History of overdose or poisoning Psychiatric Crisis Delusions / Hallucinations / Mania	Acute Behavioural Disturbance- Two or more from: Serious physical resistance / abnormal strength High body temperature Removal of clothing Profuse sweating or hot skin Behavioural confusion / coherence Bizarre behaviour
BASICS Doctors: ONLY AT THE REQUEST OF PARAMEDICS / TECHNICIANS - ACCESSED VIA EOC Where immediate management of RED FLAG conditions necessitates the intervention or skills of a Doctor or where without medical oversight the journey would involve too much risk, ether to the patient, the paramedics or the Police Officers. This should include situations where rapid tranquilisation is considered necessary, in accordance with NICE GUIDELINES 2005.	Conveyance to the nearest ED: Should NOT be undertaken in a Police vehicle UNDER ANY CIRCUMSTANCES where a RED FLAG trigger is involved. This includes remaining in ED until the person is medically fit for discharge to PoS, to Police Station or from s136 detention. It is the responsibility of the Police to outline to ED the LEGAL ASPECTS of detention;

APPENDIX D

RISK ASSESSMENT TOOL, S136(2) MHA

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

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

Where the Police feel that the NHS have insisted upon support inappropriately or where the NHS feel the Police have provided too much or too little support, this should be referred to the MAG for resolution and feedback should be provided by Managers to ALL professionals involved

Appendix E **Mental Health Act Monitoring Form**

s135 / 6 PLACE OF SAFETY

Section A - Arresting Officer to complete.

s135		s136	

INDIVIDUAL'S PERSONAL DETAILS			
Surname		First name	
Date of birth		Gender	Male/Female
Ethnicity		Next of Kin	
Telephone		NoK Telephone	
Address		NoK address	

CIRCUMSTANCES OF DETENTION								
Date of arrest		Time of arrest						
Location								
Circumstances								
Warning markers								
WMAS conveyance?		WMAS call sign						

LEGAL MATTERS AT PoS			
24hrs starts at		Ends at	
1st AMHP informed		Name	
1st RMP informed		Name	
Rights explained	Yes/No	By	
Rights leaflet given	Yes/No	By	

EMERGENCY DEPARTMENT *(if used)*					
Emergency Dept		Arrival at		Transfer at	
Transfer authorised			To		
WMAS transfer	Yes/No	WMAS call sign			

PSYCHIATRIC P9S *(if used)*					
Psychiatric PoS		Arrival at		Transfer at	
Transfer authorised			To		
WMAS transfer	Yes/No	WMAS call sign			

POLICE STATION *(if used)*					
Police Station		Arrival at		Transfer at	
Transfer authorised			To		
WMAS transfer	Yes/No	WMAS call sign			
Appropriate Adult		Relationship			
AA Telephone No		Custody Record No			
Reason for using PS					

Section B – For ED Staff / PoS staff / Police Custody Officer to complete

INITIAL SCREENING			
Drugs	Yes / No / NK	**Alcohol**	Yes / No / NK
Assessment delayed	Yes / No	**By how long**	hrs
Medical oversight	Yes / No	**By whom**	
Physical Injury	Yes / No	**Treatment required**	Yes / No
Restrained	Yes / No	**Known medication**	
Current conditions	Yes / No / NK	**Details**	

JOINT RISK ASSESSMENT	
Police PNC / FLINTS checks done?	Yes / No
Already known to MH Services?	Yes / No
Warning review	
NHS Risk Assessment (see Appendix D)	LOW / MEDIUM / HIGH
Police Risk Assessment (see Appendix D)	LOW / MEDIUM / HIGH
Agreed as to whether the Police remain? (see Appendix D)	Yes / No
Did the Police remain beyond 'handover'	Yes / No (If yes, time of Police Officer release)
Did the Police remain throughout?	Yes / No (If yes, time of Police Officer release)
Has provision of that support been referred?	Yes / No
If so, by whom?	Police / NHS

INDIVIDUALS INVOLVED			
AMHP			
AMHP arrival time		Telephone	
First RMP		Section 12	Yes / No
Second RMP		Section 12	Yes / No
Nearest Relative		Telephone	
Solicitor		Telephone	
Arresting Officer		Police Station	

MHA ASSESSMENT				
1st RMP assessment commenced	Time		Date	
AMHP and RMP(s) present together?	Yes / No			
If not, why not?				
Mentally Disordered within the MHA?	Yes / No			
2nd RMP assessment commenced	Time		Date	
AMHP and RMP(s) present together?	Yes / No			
If not, why not?				
AMHP interview commenced (*if separate*)	Time		Date	
MHA assessment concluded	Time		Date	
Admission to hospital required?	Yes / No			
If yes, state which section MHA / voluntary				
If no, state time of release from s136	Time		Date	
Time taken from first arrival at 1st Pos until released or subject to an MHA application	hours		minutes	

CRIMINAL OFFENCES / SUI	
Any offences during PoS detention	Yes / No
Action taken	
Police recalled because of a prior offence?	Yes / No
Any other SUI during PoS detention	Yes / No

APPENDIX F

LEGAL RIGHTS LEAFLET – S136 MHA

PATIENT INFORMATION	s136 Mental Health Act

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

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

WHY AM I IN HOSPITAL?

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

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

HOW LONG WILL I BE HERE?

You can be kept here (or in another place where you will be safe) for up to 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 specifically trained to help decide whether people need to be admitted to hospital.

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

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

If the doctors and the Approved Mental Health Professional have not seen you by the end of the 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.

PATIENT INFORMATION	s136 Mental Health Act

WHAT HAPPENS NEXT?

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

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

CAN I APPEAL?

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

WILL I BE GIVEN TREATMENT?

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

LETTING YOUR NEAREST RELATIVE KNOW

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

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

CHANGING YOUR NEAREST RELATIVE

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

CODE OF PRACTICE

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

HOW DO I COMPLAIN?

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

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

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

PLEASE ASK HOSPITAL STAFF FOR ANY OTHER INFORMATION

APPENDIX G

LEGAL RIGHTS LEAFLET – S135 MHA

PATIENT INFORMATION	s135 Mental Health Act

ADMISSION OF MENTALLY DISORDERED PERSONS
PATIENTS REMOVED UNDER A MAGISTRATES WARRANT

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

WHY AM I IN HOSPITAL?

You have been brought to this hospital under s135 of the Mental Health Act because an Approved Mental Health Professional thinks that you have a mental disorder and you may need treatment or care.

An Approved Mental Health Professional is someone who has been specifically trained to help decide whether people need to be in hospital.

A Magistrate has issued a warrant saying that you can be brought here and kept here, even if you do not want to come.

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. If these people 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.

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 135.

WILL I BE GIVEN TREATMENT?

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

LETTING YOUR NEAREST RELATIVE KNOW

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

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

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

CHANGING YOUR NEAREST RELATIVE

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

CODE OF PRACTICE

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

HOW DO I COMPLAIN?

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

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

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

PLEASE ASK HOSPITAL STAFF FOR ANY OTHER INFORMATION

APPENDIX H

AUTHORITY TO TRANSPORT

s6 and s137 MENTAL HEALTH ACT

I (name of AMPH / Police Officer):

.....

BEING AN APPROVED MENTAL HEALTH PROFESSIONAL / POLICE OFFICER, BASED AT (professional address):

.....

AUTHORISE THE FOLLOWING PERSON:

.....

TO DETAIN / CONVEY THE FOLLOWING PERSON: INDIVIDUAL'S PERSONAL DETAILS

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

TO (name of hospital):

.....

THIS PATIENT HAVING BEEN DETAINED UNDER THE MENTAL HEALTH ACT 1983 AND BEING LIABLE BY VIRTUE OF s6 or s137, TO BEING DETAINED & CONVEYED.

Signature: ..... Time / Date: .....

APPENDIX I ASSESSMENT ON PRIVATE PREMISES

There are some important considerations for any AMHP planning a Mental Health Act assessment on private premises, with regard to support from the Police:

1. Do I need Police support during the assessment?
2. Is violence, resistance or escape predicted?
3. Are we attending to immediately detain the person under the MHA?
4. If we are going to assess whether to detain, do I need a warrant under s135(1) of the MHA?

POLICE SUPPORT

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

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

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

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

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

N.B: There should be no automatic assumption, where such an individual leaves a premises, that s136 can automatically be used. The Police Officer must be separately satisfied that the criteria for s136 are met, and occasionally they may not be.

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

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

Where either an AMHP or a Police Duty Sergeant / Inspector remains dissatisfied about any aspect in relation to the preparation for an assessment on private premises, they should refer the matter to the UCOG for consideration.

WARRANTS UNDER s135(1) MENTAL HEALTH ACT

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

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

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

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

Only one other thing needs to be shown: that where a warrant is being applied for, despite no attempt to enter having yet been made; or where it is known that access to the premises can be lawfully secured, the reasons for still applying must be documented (CoP MHA: para 10.10).

Accordingly, there is NO requirement to demonstrate:

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

NB - the fact that warrants may be secured in order to provide a contingency should an assessment develop unexpectedly in a way which then necessitates removal to a Place of Safety, is shown by the use of the words “if thought fit”, within s135.

Furthermore, case law has upheld Police Officers’ use of low-level, reasonable force where they have done so in order to safely execute warrants on private premises, for example to briefly control the movements of others in order that the warrant may be executed efficiently. Legal advice to the Police Service has upheld the contention that these cases would apply to the execution of either type of warrant, under s135 and therefore provide additional reasons to consider applying for a warrant.

INTER-AGENCY DECISION MAKING

The AMHP coordinating the assessment should ensure discussion with the Police Duty Sergeant, prior to making requests for Police support and in order to discuss whether a warrant is sought. This should include requests for Police information about anticipated risks - it may be that, following confirmation of certain information, the AMHP is willing to proceed without Police support, confident that it will be safe.

Where an AMHP anticipates aggression and resistance, they should anticipate the Sergeant requesting specific confirmation that MH professionals will be immediately

applying to detain the individual under the MHA; OR that a warrant is being sought. Where there is no intention to apply for a warrant, they should bear in mind the risks and threats in light of the Police powers available, outlined above.

APPENDIX J AWOL UNDER S135/6 OF THE MHA

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

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

WARRANTS UNDER s135(2) OF THE MENTAL HEALTH ACT

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

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

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

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

Only one other thing needs be borne in mind: that where a warrant is being executed by a Police Officer, it is suggested good practice for the Police to be accompanied by someone from the hospital or care team with responsibility for the patient (CoP MHA: para 10.10) .

Several common misconceptions:

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

NB - it is often worth ensuring copies of supporting legal material for the attention of Magistrates, such as this protocol. Magistrates are not always fully aware of the criteria for granting warrants under s135 or the differences between the two warrants available under this section.

INTER-AGENCY DECISION MAKING

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

APPENDIX K TELEPHONE NUMBERS

EMERGENCY DEPARTMENTS	TELEPHONE NUMBERS
Good Hope Emergency Department	(0121) [redacted]
City Hospital Emergency Department	(0121)
Heartlands Hospital Emergency Dept	(0121)
Queen Elizabeth Hospital ED	(0121)
Birmingham Children's Hospital ED	(0121) 333 9500

PLACES OF SAFETY	TELEPHONE NUMBERS
The Oleaster	[redacted]
BCH PoS for CAMHS	(0121) 333 8788

POLICE STATION	TELEPHONE NUMBERS
Birmingham Central Police Station	[redacted]
Sutton Coldfield	
Perry Barr	
Bournville	

BIRMINGHAM CITY COUNCIL	Approved Mental Health Professionals
North (office hours)	0121 303 2480
Central (office hours)	0121 303 2480
South (office hours)	0121 303 2480
Emergency Duty Team (Out of Hours)	0121 464 9001

LEARNING DISABILITIES	TELEPHONE NUMBERS
Phone Number (office hours)	[redacted]
Phone Number (out of hours)	
Fax Number	
SOLIHULL LEARNING DISABILITIES	**TELEPHONE NUMBERS**
Solihull Learning Disability Team (Health)	0300 200 0011
Solihull All Age Disability Team (Social Care)	0121 -704 8007
Solihull EDT	0121 605 6060

WEST MIDLANDS AMBULANCE	TELEPHONE NUMBERS
Non-Emergency number	01384 215555

MHA THE OLEASTER	TELEPHONE NUMBERS
Fax Number for Monitoring Forms	[redacted]

APPENDIX L
Schedule 2 Part 1

SERVICE SPECIFICATION

Service	BCH CAMHS
Commissioner Lead	CLAIRE PAINTAIN
Provider Lead	MARIE CROFTS
Period	

1. Purpose

1.1 Aims

The aim of the service is to provide a safe environment in which to hold, assess and support a child or young person held under sections 135 or 136 of the Mental Health Act. It will be achieved by ensuring the following:

The quality of care offered must be the same, whatever the child or young person's racial, religious or cultural background.
The quality of care offered must be the same, whatever the child or young person's age.
Rapid access to effective interpreting services, trained in the needs of the child or young person's mental health must be available.
It is also essential that a system of clinical supervision be in place to enable staff, that have undergone training, to put that training to efficient use.

1.2 Evidence Base

Section 135 of the Mental Health Act 2007 allows for a warrant to be issued in order to assess a CYP known to have a mental disorder on private premises. This warrant can be sought by an Approved Social Worker (ASW), or the Police; in any event the Police Officer serving the warrant has to be accompanied by an ASW and a doctor. The removal of the individual to a place of safety may also require the co-ordination of Ambulance Services or Police escort.

Section 135 assessments could be undertaken on the private premises where the individual currently is, or it may be appropriate to remove the CYP to a place of safety for assessment.

A place of safety could be the most appropriate place to assess a CYP under section 135 or a CYP held under section 136.

Section 136 of the Mental Health Act 1983, "*allows for the removal to a place of safety of any person found in a place to which the public have access (by payment or otherwise) who appears to a Police Officer to be suffering from mental disorder and to be in immediate need of care or control.*" (DOH).

Under Section 136 of the Mental Health Act (1983) a Police Officer can remove a CYP who appears to have a mental disorder and needs immediate help from a public space to a place of safety. A CYP can be detained at the place of safety for up to 72 hours. Section 44 of the Mental Health Act (2007) amends Section 136 of the 1983 Act to enable a CYP to be
transferred from a place of safety to one or more other places of safety, subject to the overall detention limit of 72 hours. A person may be transferred by either a Police Officer, an Approved Mental Health Professional (AMHP) or someone authorised by either of them.

Section 136 is not an admission section but allows for an assessment to take place at the place of safety, with the stated purpose of enabling examination by a doctor, interview by an AMHP and necessary arrangements to be made for admission if required.
Lord Bradley's review of people with mental health problems or learning disabilities in the criminal justice system (DH 2009) recommends that:

"*All partner organisations involved in the use of Section 136 of the Mental Health Act 2007 should work together to develop an agreed protocol on its use.*

Discussions should immediately commence to identify suitable local mental health facilities as the place of safety, ensuring that the Police Station is no longer used for this purpose." (DH 2009 p48)

There is currently no health sector place of safety in Birmingham. A Police Station is normally the default place of safety when other options have been exhausted. The Independent Police Complaints Commission (IPCC) and Royal College of Psychiatrists (RCP) confirm that a Police Station is poorly suited to managing vulnerable people who have a mental disorder and/or are at risk of harming themselves. It may have the effect of criminalising the individual, has negative impact upon the CYP's experience and the Code of Practice to the Mental Health Act (2008) makes clear that it is only on an exceptional basis that this should now occur.

Local Context
The Department of Health has asked NHS West Midlands to ensure that appropriate services are being commissioned for young people in secure settings across the region. Young people are those aged up to 18.

The Government is committed to ensuring that children with mental health problems get the right help at the right time. Children held in secure settings are especially vulnerable. They are entitled to the same services as children in the wider community and there is focus given to this in the Every Child Matters: Change for Children programme, including the Children's National Service Framework. We must enable these children to receive the services that are appropriate to their needs. The following statements are taken from the Promoting Mental Health for Children Held in Secure Settings, DH, 2007

Places of Safety – Background
Numerous Government reports have recommended that Police Stations are not used as the default location for clients in need of urgent mental health assessment under the Mental Health Act. The Mental Health Act Code of Practice states that "a Police Station should be used as a place of safety only on an exceptional basis". (MHA CoP Para 10.21)

The Inquest into the death of Michael Powell (died in Police custody in Birmingham in 2003) lead to a rule 43 recommendation that Places of Safety need to be established.

In addition, a more recent but still pending adult case is that of MS v UK – a case currently progressing towards the European Courts of Human Rights. This case involves the Mental Health Trust, The Local PCT, the Police service and UK Government. The case relates to detention under s136 beyond the permitted 72-hour period and a subsequent civil claim against the Trust for negligence, for breaches of Articles 3 and 8 of the Convention.

Figures
The data collected by West Midlands Police was based on the number of detentions under s136 over the past 3 years leading to the conclusion that the average detentions for s136 for children under 16 is 5 per year. For those under 17, it is approximately 20 per year.

1.3 General Overview
"Place of safety" means residential accommodation provided by a local social services authority under Part III of the National Assistance Act 1948, a hospital as defined by this Act, a Police Station, an independent hospital or care home for mentally disordered persons or any other suitable place the occupier of which is willing temporarily to receive the patient." (DH 2008)

In practice it is Police Stations and emergency departments that are commonly used in the UK, although the Mental Health Act does allow other options. We expect through this service provision that any CYP under 16 years of age, detained under the mental health act will be managed through an age appropriate service provided by Birmingham Children's Hospital CAMHS Service.

1.4 Objectives
Ultimately the objective of the service is to:

Provide emergency contact details to the Police.
Determine whether you have a past psychiatric history, and whether you are currently detained *determine if you have any current or previous mental health difficulties and if you have been detained by the Police on a Section 136*
To Interview CYP in the most humanistic way as soon as possible after your arrival in the place of safety *to ensure the young person is assessed as quickly as possible following arrival at the place of safety and are*

orientated to the environment on arrival. Wherever possible we will ensure there is a known or responsible adult who accompanies the young person or is contacted as soon as is possible.
To commence face-to-face assessment within 2 hours of their notification that you will be arriving at their place of safety
Contact nearest relative as defined by Mental Health Act
Arrange appropriate psychiatric assessment of your needs
To request support of the crisis resolution/home treatment team to explore intervening in any admission to the acute unit by offering you a choice/alternative to hospitalisation * follow up appointments will be arranged if you are already known to a tier3 team and they will also be made aware of your assessment in place of safety. You may be referred to a tier 3 team following your assessment if admission is not deemed appropriate for you at this time.
Consider any other alternatives to hospital admission
Consider whether it is appropriate to transfer to another place of safety. Arrange admission/transfer to an alternative place of safety or admission ward, where needed, contacting ward and completing Mental Health Act application
Exercise authority to convey you as a detained CYP using the most humane and least threatening means

Psychiatrists
You can expect them to undertake the following on your behalf:
Ensure prompt mental health examination of you, ideally by a Section 12 - approved doctor
Ensure you have a physical healthcare assessment and management, which may involve a junior psychiatrist
Where your assessing psychiatrist is not Section 12 - approved, they should consult with a Section 12 - approved psychiatrist before you are discharged
Provide specialist clinical assessment of your need and assist in development of a care plan.
Make any necessary Mental Health Act recommendation
Identify a hospital admission bed if you need it
Provide a record of assessment, which should be available at time of transfer if you are admitted to hospital
Prescribe any emergency medication you may be deemed to require under common law in emergency if suitably trained staff are available to monitor its effect
Your Psychiatrist should be a member of local review group to monitor outcomes and improve standards with partner agencies.
Your psychiatrist should have active Involvement in local policy, procedures and guidance development

Second medical opinion (preferably general practitioner or Section 12-approved doctor)
You can expect them to undertake the following on your behalf:
Be available so that your individual assessment is completed as quickly as possible
Where possible the person should be Section 12 - approved if he/she does not know you
They should have active Involvement in local policy, procedures and guidance development
Be a Member of local review group to monitor outcomes and improve standards with partner agencies

Psychiatric nursing staff in place of safety
You can expect them to undertake the following on your behalf:
Ensure adequate information on your needs are obtained so that appropriate staffing is available to support your needs when you arrive
Try and obtain additional information, e.g. case notes and name of your care coordinator
Alert approved mental health professional unless Police have done so
Document time of arrival at place of safety, arrival of approved mental health professional, doctors and completion of assessment
Complete initial risk assessment with information from you, Police and ambulance staff
Ensure you have no urgent physical health issues
Advise approved mental health professional of your arrival
Ensure that detailed information from Police/Ambulance Service has been received
Advise the Police when it is safe for them to leave
Ensure there is adequate nurse staffing
Give you information verbally and in writing on your detention under Section 136
Ensure your safety and well-being and safety of others throughout your stay in the place of safety
Complete notes of your assessment and observations in line with standard clinical policy
That they will be experienced to deal with any incidents that may arise
Have access to staff trained in physical intervention
Administer and monitor any effect of medication prescribed for you
To have had training in rapid tranquilisation, life support and use of resuscitation equipment
Have active Involvement in local policy, procedures and guidance development
To be a Member of local review group to monitor outcomes and improve standards with partner agencies

NB. The commissioners expect the above should serve as indicators to inform skill, competencies/confidence training & development of all staff linked to the service

1.5 Expected Outcomes

The commissioners need the following success criteria to be considered as important to feed into routine outcome/data collection
Success Criteria (taken from Bather 2006, CSIP London Success Criteria within section 136 review)

For the Service User
Assessment carried out, and removed to hospital, with least stigma possible
Rapid access to assessment and appropriate care
Least possible use of force or restraint
Understanding of illness and situation from all professionals involved
Maintenance of confidentiality
Clarity about individual rights

For Carers or Family Members
Access to appropriate support from relevant professionals after assessment
Assessment carried out, and removed to hospital, with least stigma possible
Service user detained safely

Kept in touch with services after assessment

Approved Mental Health Professional
Comprehensive recording of and access to relevant information in order to support appropriate decisions about the care and treatment for the service user
Least possible delays to assessment
Appropriate and proportional support in violent or resistant situation

Medical Staff
Service user detained and conveyed to appropriate assessment facilities that is able to deal with any risk and is able to provide appropriate health facilities.
Access to relevant information about service user and situation with a fully comprehensive and documented handover

The Mental Health Act Commission and the Care Quality Commission currently have responsibility for the monitoring of places of safety in health and social care premises.

Local monitoring is essential to ensure the appropriate use of the Section 135/136 and a safe assessment process, initiated quickly and with rapid resolution including, where necessary, transfer to an admission ward or discharge. As commissioners we will work with the West Midlands Police Service to review numbers and anonomised CYP data for those where the Police invoke section 135/136. The provider of the place of safety will be expected to record:

1.6 Service Monitoring, Evaluation and review process

All performance related discussions including service gaps and risks will be escalated via the regular routine contract meetings via the CAMHS Performance Meetings or as an exception meeting depending on the severity of risk. Formal risk management processes will be used by the Provider to record and monitor risks to support service improvement.

Routine monitoring will be provided via a dashboard report included in Appendix A
with frequency of reporting being determined by the quarterly review dates enclosed below:
Reporting of activity should be received one week prior to the meetings, indicated on the below schedule:

Where possible theses dates will be scheduled in advance and may be adjusted in the event of extenuating circumstances to ensure availability of key people; but will convene around this time to ensure discussions around service delivery and performance remain current and can respond quickly to any presenting issues during the period.

2. Scope

2.1 Service Description

Identifying the service or services which would deliver these outcomes

Consideration must be given to the location and the journey to the place of safety in Birmingham. The MHA Code of Practice states that *"the 'preferred' place of safety is in a psychiatric facility."* (DH 2008). It is currently proposed that the under 16 yrs place of safety is Parkview Clinic, 60 Queensbridge Road, Moseley Birmingham B13 8QE.

The Parkview Place of Safety will be the default location for all individuals (under the age of 16) detained under section 136. However, where these options are not available, an A&E department or Police Station would only be used as a last resort.

Physical standards of the section 136 assessment facility

The following guidance is compliant with the National Institute for Health and Clinical Excellence (NICE) guidance on short-term management of disturbed/violent behaviour in CYP psychiatric settings and emergency departments (NICE, 2005).

The provider of the assessment facility must meet these standards.

Security

The psychiatric assessment facility must be a locked facility in order to be able to safely care for those who are disturbed

Levels of staff required to support this facility, **when in use**, are up to three staff trained in physical intervention, which should be available at short notice without compromising staffing levels and hence safety elsewhere. This is in addition to the staff carrying out the assessment

Current staffing ratio is one staff member to co ordinate the care of a young person who presents to the place of safety. There may be a need for extra staff in some cases where a young person requires extra support if they are agitated or require physical intervention. In these cases where available ward staff can be contacted to assist or the assessment if possible can take place on the ward area.

The person's belongings should be recorded and kept in a safe place

Assessment Room

The room must:

Be large enough to accommodate 6 people, to be able to both assess and restrain where necessary the area is able to accommodate up to 6 people

Be well-lit and have an observation window observation panel in the door leading to the room used for assessment

Have good exits, with consideration being given to there being two doors at opposite ends of the room; the doors should open outwards for the safety of staff one exit door out of the assessment room. Doors are not two way opening.

Have fixed, soft, comfortable chairs in a washable fabric; furniture and fittings should be chosen so they cannot be used to cause injury by offering a weapon of opportunity

Have a clock visible to both staff and the detained person

Have no ligature points

Have good communication with others through a phone line with outside dialling phone available in the place of safety nurses office

Have a panic alarm system no alarms are raised by telephone or fire walkie talkie only

Be located near to other staff and be easily accessed by a team trained in physical intervention and the use of resuscitation equipment yes on the ward areas and all nurses in POS have this training. Equipment located in place of safety includes defibrillator, grab bag and bp,pulse and oxygen sats monitor.

Have CCTV to enhance staff protection, in accordance with guidance on the use of CCTV (see guidance from the Mental Health Act Commission (2005) based on Information Commissioner's Office CCTV Code of Practice); CCTV should not be a reason for lower staffing levels and the CCTV screen must be watched CCTV is not available or used in any part of the inpatient service.

Have access to resuscitation equipment including a defibrillator

Supporting Facilities

The CYP may need to remain in the assessment unit for several hours (the Act allows detention for up to 72

hours), although it is envisaged that someone would only be detained for prolonged periods in the most exceptional circumstances. The assessment may be delayed, for example when it is unclear whether a person under the influence of drugs and alcohol also has a mental disorder or where the need to administer emergency sedation makes the subsequent assessment impossible until the effects of the medication have subsided. It may take time to gather the relevant information and a person might be more vulnerable if discharged in the night. The assessment unit should be located in an assessment area that has:

A couch for sleeping or resting and to assist any necessary medical examination
Saliva substance misuse screening or drug urine testing kits
Washing and toileting facilities
Decontamination facilities to remove CS spray and other noxious substances
Provision of beverages and light snacks
A drug cupboard, where the facility is in a healthcare setting
A place for writing up notes and briefing of assessment unit staff by those involved in the detention
If in a hospital, a computer linked to the electronic care system to identify relevant background

information, current status under the Mental Health Act, crisis plans, advanced statements or decisions
It is helpful in all places of safety to have leaflets for CYPs in less commonly used languages and formats available electronically where they are not otherwise immediately available
A telephone with outside dialling arrangements
Facilities for carers and legal representatives, including a separate waiting area for them
Access to photocopying facilities

Smoking in the Place of safety

Many individuals detained under Section 136 will be smokers and being unable to smoke may increase their distress and level of disturbance.

The key aim should be to ensure that their length of stay in the Section 136 suite is kept to a minimum. Due to safety considerations in the assessment period it is unlikely that a safe external space within the suite could be provided to permit smoking. Therefore it is envisaged that those detained will be unable to smoke.

The place of safety service complies with the trust no smoking policy. There are a range of nicotine replacement products available to any young person who is assessed in the place of safety.

2.2 Accessibility/acceptability

Location of the Place of safety

The unit:

Must be accessible to the disabled and should preferably be on the ground floor
As the person may need to rest, it should be in a quiet area
Should have discrete access avoiding public areas
Should be in a secure area, permitting the individual to wander or pace and if appropriate to talk to their carers and friends

In determining the size of the unit, consideration needs to be given to the likelihood of there being more than one person requiring this facility at any given time. Where there may be more than one in the unit at one time, the unit should have lockable sections so that the individuals can be kept apart.

2.3 Whole System Relationships

The provider must work with the commissioner and other stakeholders to agree inter-agency protocols for the use and management of the place of safety. The protocol is referenced in appendix 1. The agencies will include, but are not limited to: Pan Birmingham Child and Adolescent Mental Health Commissioner, Adult Mental Health, West Midlands Police Service, West Midlands Ambulance Service, Local Accident and Emergency Providers, Local Mental Health Services and Voluntary/3rd Sector Providers.

2.4 Interdependencies

This Service relies on developing good relationships and communications with other Services, at both strategic and operational levels. Interdependencies for the service include:

Community Adolescent Mental Health Services (CAMHS)
Specialist Commissioning Team
CAMHS Commissioner
West Midlands Police
Adult mental health service providers
3rd Sector Provision

The service will continue to develop these and other appropriate relationships to ensure effective joint working for children and young people.

Working in collaboration with other providers the service will aim to ensure a smooth transition between care settings and providers with seamless and consistent transfer of care where appropriate, but most importantly upon:

transfer to CAMHS Tier 4 for access to emergency beds where applicable
Discharge/Disposal

2.5 Sub-contractors

The provider shall not sub contract any of its obligations under the terms of this agreement without the prior written consent of the commissioner.

3. Service Delivery

3.1 Service Model

The provision of a safe, efficient, timely and appropriate service to undertake assessment of a YP who has been detained on a section 136/135. Multi-agency services to ensure effective assessment of mental, physical and psychological health and convey to appropriate location. If young person fits criteria then safe transfer to POS where a Mental Health Act assessment will be carried out and the YP 136 Rights read to them. Outcome will be determined from assessment.

3.2. Standards: Safeguarding

The Provider will ensure staff in all areas respond sensitively to the needs of individuals, children and young people, and provide appropriate environments for their care/treatment; ensuring risks are minimised to those using the service. It will ensure that all staff are aware of Safeguarding Adults and Children policies and procedures, as well as ensuring that staff know what to do in the case of suspected abuse or neglect of children or adults.
All staff who are working in the place of safety suite have upto date training in child protection including mandatory training and additional training provided by Birmingham safeguarding children's board.

The Provider will supply the PCT with a copy of the organisational child protection policy and procedures that is compatible with Birmingham Safeguarding Children Board (BSCB) Procedures. The trust child protection policy Is available at all times electronically via the trust website and on all the inpatient wards. Each inpatient ward has a link nurse available and there is a CAMHS specific child protection link in the child protection team.

The Provider will ensure that there are clear procedures for referring concerns about children's welfare in line with Pan Birmingham NHS Child Protection procedures, Birmingham Safeguarding Children Board Child Protection procedures and HM Government Guidance What to do if you're worried a child is being abused and that these are understood by, and accessible to, all staff.

The Provider will ensure that staff receive the appropriate level of safeguarding training, commensurate with their role and responsibilities, in line with RCPCH Intercollegiate Guidance 2006 and The Common Core of Skills and Knowledge for those working with children and families.

The Provider will engage and support with Serious Case Reviews, undertake Internal Management Reviews and implement the recommendations arising from these if so requested by the Local Safeguarding

Children Board.

There must be appropriate governance arrangements and a Designated Senior Manager responsible and accountable for Safeguarding Children within the organisation. The Designated Senior Manager will be available to attend relevant Safeguarding Children meetings as required by the commissioner and other relevant partners including the BSCB.

The Provider will have in place and adhere to safer recruitment procedures that are in line with the commissioner's recruitment procedures, guidance including BSCB Child Protection procedures and Working Together to Safeguard Children. The organisation will implement the requirements of the Vetting and Barring Scheme when these are released.

The Provider will ensure that they can evidence that staff have the appropriate level of up to date (3 yearly) CRB clearance.

3.3 Pathways

We currently use the Adult Birmingham POS Multi-Agency response to include:
West Midlands Ambulance Service
Birmingham Police
Birmingham Childrens Emergency Department
Birmingham CAMHS

4. Referral, Access and Acceptance Criteria

Geographic coverage/boundaries

The service is available to young people aged 0-16 years that are resident, and are registered with a GP, in the Birmingham area.

Location(s) of Service Delivery

Parkivew Clinic
60 Queensbridge Road
Moseley
Birmingham
B13 8QE

Days/Hours of operation

The service will be operational 24 hours a day 365 days of the year.

Referral criteria & sources

Referrals are via West Midlands Police for those CYP detained under Section 135/136 of the MH Act.

The provider will ensure in collaboration with West Midlands Police that robust arrangements are in place for CYP when they fall outside of the scope of the service. These will be detailed in the multi agency generic protocols and service's operational policy.

Exclusion Criteria

This service specification has been exclusively designed for children and young people aged 0-16 years detained under the MH Act 136. The service is provided for young people within Birmingham only anf for young people up until their 16th birthday. Young people above this age will need to go to an adult place of safety located within the adult mental health hospital site

Response time and prioritisation

West Midlands Police and Birmingham Childrens Hospital are working together to provide a safe, efficient, timely, assessment for YP who are detained on a Section 136/135.
Co-ordinate arrival of appropriate professionals within two hours to undertake a Mental Act Assessment and

read 136 Rights to YP.

5. Discharge Criteria & Planning

The discharge planning is dependent on the route that follows following assessment. Please see flow chart which will explain the options and exit routes depending on admission to hospital, further detention in hospital or discharge home.

6. Self-Care and Patient and Carer Information

Information should be age/ culture appropriate and help set user expectations around the service

7. Quality and Performance Standards

The following table identifies the outcome measures and data collection required by the commissioners to be provided in a quarterly report

Activity indicator	Method of measurement	Consequence of breach	Rationale
Number of occasions and place where Section 136 is invoked by the Police	Data reports from Police and from provider	No consequence	*Evidence from London suggests that over 90% of CYPs can be held safely in a health service place of safety, we need to monitor numbers and locations to better understand the service*
Age	Data report from provider	No consequence	*To demonstrate equity of access and outcome. Also the monitoring of historical over represented groups*
Ethnicity		No consequence	
Gender		No consequence	
Duration of contact	Analysis from provider, to include time notified, time arrived at PoS, time of discharge	No consequence	*From point of arrival at PoS or at point team arrive at other PoS to commence assessment*
How many of the CYP that arrive at the POS are refused? Why are they refused?	Screening proforma via initial telephone/pager contact to POS co - ordinators	Possible referral to out-of-hours CAMHS referral process	*Do not meet criteria for POS, have not been detained on a 136, too old*
Mode of transport from public place to place of safety	From provider, from reception report	No consequence	

Time taken for approved mental health professional to arrive	From provider, we would expect providers to assess CYPs within 2hours unless external factors prevent/limit assessments available	We will need to agree with the provider an expected performance level	*CYPs should be seen in a prompt and timely manner*
Time taken for doctor(s) to arrive	Report from provider	We will need to agree with the provider an expected performance level	*It is important that CYPs are assessed promptly.*
Total time spent in place of safety, that is assessment and time to transfer/discharge to identify any potential delays due to conveyance, escort or bed finding issues	We expect regular performance monitoring from the provider of time spent in the facility and reasons for any delays.	No consequence	*We need to understand the amount of time individual CYPs spend in the facility*
Discharges following assessment solely by doctors without Section 12 approval	Report from Provider		
Any serious untoward incident.	Report from provider, identifying different categories of SUI	No consequence	*We need to understand the range of SUIs that occur, management of these will be multidisciplinary and will be reflected in local protocols*
Previous and current psychiatric contacts, whether they were under the care programme approach, whether the individual is currently detained under any mental health legislation and whether the least restrictive option has been considered, including crisis resolution and home treatment team support	Report from provider – no CYP identifiers are required	No Consequence	*In order to ensure the most effective services are commissioned for places of safety and community services we need to understand the past history of CYPs and the level of previous involvement by Mental Health Services*
Whether the individual has been previously detained under Section 136	Report from provider	No consequence	*See above*
Whether drug and/or alcohol consumption was significant	Report from provider		*Alcohol or drug consumption is not an automatic reason for an assessment not being made, or an assessment defaulting to a Police Station. The provider must work with the Police to assess the risk the CYP poses to themselves and others and how this changes over time*

Whether the individual had taken an overdose or harmed themselves and required medical intervention	Report from provider	No consequence	
Use of restraint in initial detention and any injuries sustained in detention	Report from provider		
Absconding and action taken, with outcome	Report from provider		
Any criminal activity, before or at the time of Section 136 detention and whether the individual was charged.			
Obtain the views of all the professional groups involved (Police, doctors, including emergency department staff and forensic physicians, approved mental health professionals, nursing staff, including emergency department nursing staff, forensic nurse practitioners and ambulance staff) to ensure that the procedures are well understood and effective			
Service User experience			
Carer experience			

8. Activity

9. Continual Service Improvement Plan
Additionally it is expected that a Service Improvement plan will be written by the existing provider by February 2011 which will cover some of the following areas:

Data collection/ evidence – focus on practical steps to embed systems for monitoring and improving quality/ type of data collected - working to develop more real-time systems and link to areas of concern raised by young people Audit processes to assess progress and quality of services Identification of new ways of engaging with children and young people Improving coverage of services across Birmingham Developing improvement targets responding to this years baseline data.

APPENDIX M BIRMINGHAM CITY COUNCIL ESCALATION POLICY

STAGE 1 ESCALATION:

FOR DAY TO DAY ISSUES CONTACT THE RELEVENT CONSTITUNECY TEAM MANAGER VIA CONTACT CENTRE: 0121 303 1234

LOCALITY	CONSTITUENCY TEAM	TEAM MANAGER	HEAD OF SERVICE
NORTH	SUTTON	[redacted]	ZAKIA LOUGHEAD
	ERDINGTON		
EAST	HODGE HILL	MAUREEN WATSON	JULIA PARFITT
	YARDLEY	JULIE FLYNN	
SOUTH	EDGBASTON	[redacted]	AFSANEH SABOURI
	NORTHFIELD	SHARON STANLEY	
WEST	PERRY BARR	ANDREA HOUSEN	PAULINE MUGRIDGE
	LADYWOOD	HARBHAJAN RAI	
CENTRAL	SELLY OAK	MARIAN MCDONALD	NATALIE MCFALL
	HALL GREEN	GRAYSON ELLIS	

FOR AMHP ISSUES DAY SERVICES
AMHP LEAD – JOANNE LOWE
[redacted]
FOR AMHP ISSUES OUT OF HOURS
TEAM MANAGER – [redacted]
0121 464 9001 [redacted]
FOR SPECIALIST TEAMS
TEAM MANAGER SAFEGUARDING – DANIELLE PARKER
TEAM MANAGER PRISONS - [redacted]
TEAM MANGER JOINT COMMISSIONING -SHANAZ YOUNIS

STAGE 2 ESCALATION:

STRATEGIC ISSUES SENIOR MANAGEMENT RESPONSIBILITY
HEAD OF SERVICE FOR MENTAL HEALTH – NATALIE McFALL - [redacted]
HEAD OF SERVICE SAFEGUARDING – PAUL HALLAM

STAGE 3 ESCALATION:

SERIOUS INCIDENT REPORTING
ASSISTANT DIRECTOR – JOHN WILLIAMS – [redacted]
ASSISTANT DIRECTOR – BALVINDER KAUR [redacted]

APPENDIX N

Escalation Process BSMHFT

Paula Lloyd-Knight Associate Director for Acute and Urgent Care [redacted]

Dr Dhruba Bagchi CD for Urgent Care [redacted]
Kerry Webb CD for Acute Care [redacted]

South
Clinical Nurse Manager Danni Juttla [redacted]
Wards – Japonica, Tazetta, Melissa, Magnolia, Caffra
South HTT

North
Clinical Nurse Manager – Liz Thurling [redacted]
Wards – George, Eden Male, Eden PICU, Larimar, Endeavour House
Erdington , Sutton HTT & Solihull HTT

Central
Clinical Nurse Manager – Hayley Carolan [redacted]
Wards – saffron, lavender, Mary Seacole 1&2, Newbridge House
Ladywood & Handsworth HTT

Angela Preston [redacted] **service lead**
All liaison psychiatry teams
British Transport Police
Aliya Osmani [redacted] **service lead**
PDU, Bed management, POS, Street Triage

APPENDIX O

FTB Contact List 2020

Escalation process:

Team Manager for queries / information
Lead Nurses or Head of Nursing / on call Manager (out of hours) – first escalation through 0121 333 9999
Associate Director of Nursing / Director of operations / on call manager (out of hours) – second escalation if required through 0121 333 9999
Executive escalation Alex Borg or on call executive 0121 333 9999

Senior Management Team:

Staff Member	Job Title	Contact Number	Email Address
Alex Borg	Director of Mental Health Services	0121 333 9999	[redacted]
Neil Barnett	Divisional Director of Operations	0121 333 9999	
Elaine Kirwan	Deputy Chief Nurse	0121 333 9999	
Jo Hemming	Associate Director of Nursing	[redacted]	
Lisa McGowan	Head of Nursing	[redacted]	
Patricia Tulloch	Senior Clinical Nurse Manager – Core Teams, Oaklands, Finch Road and Pause UoB	[redacted]	
Rachel Coley	Senior Clinical Nurse Manager – Blakesley Centre and Birmingham Road Hubs	[redacted]	

Community Hubs:

Hub Details	Contact Details	Clinical Lead/Job Title	Email Address
Blakesley Centre, 102 Blakesley Road Yardley Birmingham B25 8RN	Hub No: 0121 333 8396 Rachel Coley: [redacted]	Rachel Coley – Senior Clinical Nurse Manager	[redacted]
Finch Road Primary Care Centre, 2 Finch Road, Lozells, Birmingham B19 1HS	Hub: 0121 255 0110 Kay Hill: [redacted]	Kay Hill – Clinical Team Manager	[redacted]
Oaklands Centre Raddlebarn Road Selly Oak Birmingham B29 6JB	Hub: 0121 333 8342 Ruvimbo Chawasarira – [redacted]	Ruvimbo Chawasarira and Shiv Sunger – Clinical Team Managers	[redacted]
Birmingham Road Hub 21-23 Birmingham Road Sutton Coldfield Birmingham B72 1PW	Hub: 0121 333 8085 Adam Beales – [redacted]	Adam Beales – Clinical Team Manager	[redacted]

Urgent Care and Crisis Home Treatment Teams – CAMHS and Adults:

Address Details	Contact Details	Clinical Leads/ Clinical Lead/Job Title	Email Addresses
Parkview Clinic 60 Queensbridge Road Moseley Birmingham B13 8QE	Reception Contact Number – 0121 333 9955	Gurpreet Kaur – Team Manager – [redacted] Paul Allen – Team Manager – [redacted] Louise Lorne – Lead Nurse for Urgent Care –	[redacted]

		[redacted] Holly Lancaster – Lead Nurse for Bed Management – [redacted]	

Specialist Pathways:
Learning Disabilities, Youth Offending, ADHD Lead:

Contact Details	Contact Number	Email Address
Amanda Grimshaw – Lead Nurse for Specialist Services - Works Citywide	[redacted]	[redacted]

Early Intervention:

Contact Details	Contact Number	Email Address
Tim Newbold – Lead Nurse for Early Intervention Pathway	[redacted]	[redacted]

Eating Disorders (SEDS Team):

Contact Details	Contact Number	Email Address
Dan O'Mara – Clinical Team Manager – SEDS Team	[redacted]	[redacted]

This Joint Memorandum of Understanding has been agreed for implementation by the following inter-agency partner leads:

West Midlands Police:

Role:

Signature:

Date signed:

Birmingham and Solihull Mental Health Foundation Trust:

Role:

Signature:

Date signed:

Birmingham City Council:

Role:

Signature:

Date signed:

Solihull Metropolitan Borough Council

Role:

Signature:

Date signed:

West Midlands Ambulance Service:

Role:

Signature:

Date signed:

University Hospitals Birmingham:

Role:

Signature:

Date signed:
