‘MOST APPROPRIATE AGENCY’ (MAA) POLICY		
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West Mercia Police welcome comments and suggestions from the public and staff about the contents and implementation of this policy.
Please e-mail contactus@westmercia.police.uk

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‘Delivering the correct service, by the most ‘Appropriate Agency’ – First Time and Every Time.

1.0 POLICY OUTLINE

This policy applies to all West Mercia Police (WMP) employees where their role requires them to assess or respond to calls for service.

The application of this policy is intended to ensure that everyone, including the most vulnerable members of our community, receive the correct service, by the most ‘Appropriate Agency’ – First Time and Every Time.

This will be achieved by ensuring that West Mercia Police adopt a consistent process when determining the most appropriate response to all calls received by our organisation, including those where we have no statutory role and where we are not the most appropriate agency to meet the needs of the caller.

This policy is underpinned by case law and legislation that specifically defines the parameters of the police role and purpose; providing the legality, jurisdiction and legitimacy in which the police should be operating.

The adoption of this policy will ensure that calls for a statutory policing service are prioritised, in line with our vision and values, priorities and the PCC’s Safer West Mercia Plan.

When assessing the needs and expectations of all callers, West Mercia Police will apply two key questions within their TRIAGE process;

1. Is there a statutory policing role?
2. Are we the most appropriate agency?

Whilst the policy is underpinned by relevant legal precedent and statutory guidance relating to police powers, discretion will always exist for operational commanders. Where West Mercia Police choose to attend an incident where there is no statutory policing role, consideration should be given to the fact that attending officers may not be acting in the lawful execution of their duty. It therefore follows that the decision must be clearly recorded with the rationale and a clear tactical plan as to what is expected of the attending officers.

The duty Superintendent (or the OCCI in their absence) will be the final arbiter where uncertainty exists. This discretion should be considered at all stages of the decision-making process.

2.0 PROCEDURE OUTLINE

This procedure applies to all West Mercia Police employees where their role requires them to assess or respond to calls for service.

The procedure has been introduced in order to ensure that every call for service being made to West Mercia Police is properly assessed against our statutory function and the lawful capability of policing.

The principles contained within this policy are reinforced in numerous stated cases, Approved Professional Practice (APP) documents and HMICFRS publications.

Policing powers are not always appropriate to resolve many of the situations that we are requested to attend. In many cases, a legal precedent has already ruled that the police service is not the most appropriate agency to act.

Our attendance to calls that do not fit within our statutory role or where we are not the most appropriate agency can lead to ineffective service delivery of our core roles, risk to the public, legal challenge and reduced confidence and satisfaction. Rarely does the person in need attain the tangible benefit that they were seeking as a result of our response to an incident that would not ordinarily fall within our statutory role.

Whereas this procedure will be applied to all calls for service, it should be recognised that many of the calls for which this policy will be applied relate to those made from or on behalf of other agencies, who are asking us to perform tasks on their behalf.

In addition, there is a notable increase in calls for service from members of the public who have been unable to contact the public authorities or statutory agencies that they need to support them, or where having made contact, those agencies have advised the person in need to call the police service as an alternative as they were unavailable to respond themselves.

The majority of calls for service that that fall within this procedure are those that relate to “Medical, Health and Social Care”. The police service rarely have the qualifications, training, or experience to respond to these calls effectively and rarely have the legal basis, jurisdiction or legitimacy to act.

Common situations for which this procedure is intended can be summarised as calls where there is no recognised statutory role for the police service, and despite this fact, some public authorities, statutory organisations or those commissioned to provide services on their behalf require the police service to;

- Undertake specific actions in support of their own statutory role, for example “Welfare checks”;
- Take primacy for a response due to their own lack of capacity or availability;
- Assist them to manage an emerging threat, harm or risk or
- Provide an out of hours service on their behalf

Additionally, this procedure is intended to be applied to similar calls from vulnerable members of our community that are;

- Unable to secure the appropriate response from public authorities, statutory organisations or those commissioned to provide services on their behalf who are, or should be, managing their care;
- Advised by other agencies to call the police service due to their own lack of availability.

It is important to reiterate that this procedure has not been implemented to reduce the number of calls for service made to West Mercia Police; neither is it intended to deny attendance to any call where there is a clearly defined and statutory role for the police service, or where the police remain the most appropriate agency in all the circumstances.

Instead, the procedure is in place to ensure a person in need is able to attain the most appropriate care from those qualified to meet their needs; building on the principles and learning from within Working Together; the recognised procedures within established Multi-Agency Safeguarding Hubs (MASH) and taking account of all relevant legal precedent that has clearly defined where the police service have been operating outside of their jurisdiction.

West Mercia Police give an assurance that where any person or organisation wants to access a legitimate policing service for which we have legal authority, training, legitimacy and jurisdiction, the caller will always be afforded an appropriate service.

Where there is no real, immediate and unconditional threat to life or other immediate and avoidable significant harm and the request relates to an incident which would benefit from a joint agency response, agencies will be referred to the standard operating procedures for working together, where the joint response can be planned and agreed within defined joint agency strategy meetings. This engenders partnership working and a clear strategy of deployment and management. To achieve this, the OCC will refer all appropriate calls from partner agencies to the MASH, via the police led Harm Assessment Unit (HAU)[1] .

[1] Refer to “Working agreement between Multi Agency Safeguarding Hubs and West Mercia Police OCC regarding access to services”

This procedure therefore introduces a mandate that the MASH (or PVP/CID led out-of-hours urgent strategy meeting arrangements) is the only available option for ALL statutory partner agencies where they seek to task part or all of the actions needed to resolve a case they are managing. The only permissible exception being where there is a clear statutory policing role (such as the report of a criminal act) or where the incident being report contains an immediate, unconditional, and real threat to life where the agency with primacy wishes to secure the response of one or more of the emergency services.

It is possible that even where there is an immediate, unconditional and real threat to life, the response of another emergency service may be more appropriate and the police service is not required to attend every such incident. (See reference to GMP v Sherratt 2018).

The HAU will only refer an agency back to the OCC where the circumstances of the case contain an immediate, unconditional and real threat to life or where immediate and avoidable significant-harm is identified.

3.0 PURPOSE OF THE PROCEDURE

The type of calls that this procedure is intended to address generally fall under the following headings;

- Medical/Health related calls for service;
- Safe and Well or Welfare checks;
- AWOL mental health patients;
- Patients with full capacity who leave health facilities (A&E, GP etc) unexpectedly;
- Police support to voluntary mental health cases;
- Requested use of Police attendance for security at premises occupied by or attended by partner agencies;
- Requested use of Police for transportation of patients in the care of other agencies and
- Police use of emergency powers to mitigate incidents being managed by other agencies which have escalated

It is inevitable that when police officers are deployed to an incident and their role is not clearly defined, they will view the incident from the perspective of an operational police officer and in their endeavour to achieve a resolution, they will rely on their ‘policing’ powers to enable them to act. Whilst this is done with the best intent, it can often be misplaced, unlawful and increase the risk and harm presented to the person in need. Incidents are often exacerbated by adopting this approach.

Police officers are untrained to conduct medical or mental health assessments, they are unqualified to replicate the in-depth review undertaken by social workers and other medical and mental health professionals and it is not their statutory function.

Policing powers are rarely appropriate in the aforementioned situations as the legislation that underpins these powers was never intended for that purpose. Many stated cases have ruled against the police service who have misused their policing powers in the belief that their intentions justified their actions.

It is therefore important that the OCC avoid inappropriately accepting a duty of care by agreeing to a course of action or by deploying an operational resource to any incident where the statutory policing role is not clearly understood.

During the initial call into the OCC, the details provided by the caller often contain limited information which can tend to persuade the call handler to agree to a particular course of action. It is important that the OCC encourage a full and unbiased disclosure of all relevant information and, having assessed those facts, are clear with all callers whether the police service are accepting a call for service or not. Where appropriate the OCC should be specific as to what role (if any) that we are agreeing to perform.

Where there is any doubt, the call handler should make clear that we are not accepting the call for service until they have sought appropriate advice from their supervisor, OCC Sergeant or the Safeguarding Advice Team. Where we are declining the call, the caller should be advised clearly of our decision and the reasons why. Where appropriate, advice where alternative support can be attained should be given.

Where a decision is made that agrees a police deployment to an incident where the statutory role of policing is not immediately apparent, the person making that decision should clearly include the rationale as to why a deployment is agreed, tactical advice as to what is expected from the attending officers and any tactical parameters that should be applied.

It is imperative that the most vulnerable members of our community are afforded, **the correct service, by the most 'Appropriate Agency' – First Time and Every Time.** The police service cannot and should not undertake the service delivery where there is no identifiable role, training, experience or legislative powers to allow us to do so.

In order to meet our own obligations, the OCC should always know what "statutory policing" role is expected of an operational police resource prior to them being deployed and should only deploy officers where a defined policing

purpose is specifically identified. This should be communicated to attending officers if any doubts exist. In the vast majority of cases this will be obvious.

All calls for service will be assessed and only those where there is an identified statutory policing role or where the call handler has confirmed that we are the most appropriate agency, will an incident be created. In all other situations the call will be closed as a contact record.

A TRIAGE[2] process will be used to aid the decision making.
Triage Flowchart
Triage Matrix

Discretion will always remain for an operational commander to determine where a call for service will be made, even where no policing purpose is obvious. The duty Superintendent or the OCCI in their absence will be the final arbiter.

West Mercia Police will continue to utilise the THRIVE assessment model for those calls for service where an incident has been generated on the basis that the creation of an incident will denote that a police response has been agreed. The THRIVE assessment tool will allow for the appropriate decision making in relation to the grading and allocation of these calls for service; as below;

T: Threat
What is the overall threat posed by the report, not only to the victim, but to the immediate family, children, community and location?

H: Harm
What is the impact of the threat? Consider not just the victim or witnesses, but also the community impact.

R: Risk
What risks are obvious or yet to be determined?
What resources and specialist assets are needed to safeguard the victim or community?

I: Investigation
What is the legality, necessity, proportionality in relation to the offence being reported?

V: Vulnerability
What are individual or community vulnerabilities?
Identify how police and partners best safeguard against harm.

E: Engagement
What is the safest means of engagement for the victim and what is the most effective means?

[2] TRIAGE flowchart and matrix attached

During the THRIVE assessment, there must be an assessment as to whether there is an immediate risk to life or serious harm to an identified person *and* determine who is the most appropriate agency to mitigate that risk.

A real risk is one that is present and continuing. The risk does not have to be a probability but the risk has to be substantial and has to relate to death, serious harm or some other form of degrading or inhumane treatment.

Calls regarding suicidal ideation by people who are within their place of residence is not routinely a matter for the police since there are exceptionally limited powers within the Mental Health Act and the legal precedents that have been defined by the judiciary. Most mental health matters would be best resolved by the primary attendance of Mental Health Services or in their absence the Ambulance Service. Obligations are defined within Section 13 of the Mental Health Act and the police service are not empowered or qualified to fill the void of others where this service is not fulfilled.

In rare and limited circumstances, the police service would ordinarily play a supporting and enabling role, where legislation allows.

The police should apply this high threshold when dealing with all calls for service because it reflects the extent of the police's duty to act. It is imperative that in all cases, we record the risks that we foresee and prioritise the threat anticipated with clear reference to legal precedent where appropriate.

This procedure allows WMP to be clear on its policing propose and service delivery prior to deploying available resources.

Even where a response from the most appropriate agency would be delayed, it is always preferable that a qualified person from the most appropriate statutory agency, in possession of all of the relevant facts, should attend to the person in need – The only exception is where there is an immediate, unconditional and real threat to life..

Where there is an identified statutory role for the police service, our attendance should be agreed on this basis and not as an agreement that we will undertake the functions of other agencies in addition, simply because we are present.

In circumstances where there is a role for more than one agency, the MASH would conclude that a joint agency visit should occur; calls handled by the OCC should not result in any lesser standard of assessment prior to our response.

4.0 IMPLICATIONS CREATED BY THIS PROCEDURE

The procedure seeks to define a consistent relationship between WMP and all other public authorities, statutory partner agencies and those commissioned to provide services on their behalf. Similarly it seeks to present greater transparency for members of our community who are often confused as to the roles they can expect from health and social care providers and from the police service.

Significant investment has been made into the provision of the Multi-Agency Safeguarding Hub (MASH). There is a MASH in each of the 4 counties that form the West Mercia policing area. The MASH are resourced with professionals from all of the primary statutory agencies and each have access to their own data pertaining to the most vulnerable members of our community. This data far exceeds anything accessible to the OCC.

It therefore follows that it is preferable that joint decisions based on the fullest access to relevant information will permit an enriched, rounded and professional judgement when determining the joint strategy and shared response in managing levels of need or vulnerability.

Any agency seeking the support of another, should not have a predetermined task for them or an assumption that they can transfer a duty of care; instead all these organisations should convene a “Strategy meeting” so that all relevant partners can come together, facts can be shared and an informed decision made – with the details recorded as to whether a single agency or joint agency response is agreed upon. A strategy meeting can be convened at short notice and out of normal office hours.

Consequently, partner agencies should therefore only have a need to call the OCC where there is an unforeseen, immediate, unconditional and real threat to life; or where they are reporting an ongoing or imminent breach of the peace; or when reporting that a criminal offence has occurred and they are requesting us to investigate it.

By adopting this approach, the most vulnerable members of our community can be assured of a consistent approach and that decisions relating to their care are based on the most up to date facts by qualified and experienced staff and they are attended to by the most appropriate agency.

Where a police response is agreed within a strategy meeting, it should be clearly defined as to the parameters that exist for the deployment, as it should for the role of all other attending agencies.

Where public authorities, statutory partner agencies and those commissioned to provide services on their behalf conclude that there is a legitimate reason to

request the support from the police service, WMP have introduced a specific Partnership Portal within Single Online Home, allowing submissions of request to the police electronically 24hrs a day. The same process of Triage, Thrive and decide will be undertaken upon receipt of requests using this portal. This will not be seen as an alternative for convening a formal strategy meeting and the requesting partnership will engage where this is considered to be the appropriate means of considering the case.

5.0 LEGAL REFERENCES

The police do not owe a private duty of care in common law towards individual members of the public to protect them from harm. Where the police omit to act, it is unlikely that they will be held to have breached a duty of care. In general terms, if the police do nothing they will not be breaching any common law duty of care.

There are recognised exceptions to this general position.

The police may assume a responsibility to care for a person. Where there is such an assumption the police will be under a duty to care for the person.

Robinson v CC of WYP

When do the Police create or assume a duty of care and how is that duty then discharged?

Taking a phone call?
Passing on a message?
Attending a call for service?
Detaining or arresting a person?
Using other policing powers, such as Stop search, road closures, powers of entry, seizure etc?
Providing transport to a patient on behalf of another agency?
Transporting a person between two locations?
Calling an ambulance on behalf of another person?

Sherratt v Chief Constable of Greater Manchester Police
Webley v St Georgie's Hospital NHS Trust

As a result of these situations (above), legal duties to act can arise for the police where;

a) There is a real and immediate threat to life: Duty under Article 2 European Convention on Human Rights (ECHR);
b) There is a real and immediate threat of really serious harm/torture/inhumane or other conduct within Article 3 ECHR;

c) Common law duties of care or
d) Specific statutory duties.

Article 2

Article 2 ECHR protects the right to life. For present purposes this has the following elements:

a) The duty on the state not to take life.
b) A duty to protect against specific threats to life.
c) The duty to put in place systems and procedures that take positive steps to protect life.

A positive duty to protect against a risk will arise where:

a) The police know or ought to know;
b) Of a real and immediate risk to life or serious injury;
c) To a person or group of persons;
d) Even if that person (or group of persons) is not specifically identified. The fact the person/group is/are known to exist may be enough.

Osman v UK 29 EHRR 245
Öneryildiz v Turkey (2004) 41 EHRR 325, para 71."

Article 3

Article 3 ECHR provides:
"No one shall be subjected to torture or to inhuman or degrading treatment or punishment."
The duties arising under the ECHR are not limited to risks to life. There are similar duties where there is a real and immediate risk of conduct within the terms of Article 3.

What is set out above in relation to Article 2 applies equally to Article 3. Article 3 broadens out the circumstances in which a duty may arise, in particular where the risk is less than death.

Syed v DPP [2010]

In relation to forcing entry to a person's home, the High Court ruled that this provision *did not justify entry where there was a general concern for the welfare of someone within the premises* and therefore officers were not in the execution of their duty when purporting to rely on section 17 of the Police and Criminal Evidence Act 1984 (PACE) to force entry against the wishes of the person who answered the door.

Mr Justice Collins said:

"It is plain that Parliament intended that the right of entry without any warrant should be limited to cases where there was an apprehension that something serious was otherwise likely to occur, or perhaps had occurred, within the house….Concern for welfare is not sufficient to justify an entry within the terms of section 17(1)(e). It is altogether too low a test.

I appreciate and have some sympathy with the problems that face officers in a situation such as was faced by these officers. In a sense they are damned if they do and damned if they do not, because if in fact something serious had happened, or was about to happen, and they did not do anything about it because they took the view that they had no right of entry, no doubt there would have been a degree of ex post facto criticism. But it is important to bear in mind that Parliament set the threshold at the height indicated by section 17(1)(e) because it is a serious matter for a citizen to have his house entered against his will and by force by police officers."

Section 17 PACE 1984

> 17(1) Subject to the following provisions of this section, and without prejudice to any other enactment, a constable may enter and search any premises for the purpose –
>
> e) of saving life or limb or preventing serious damage to property *(see notes iv and vi below).*
>
> *iv) Section 17(1)(e) life and limb refers to humans only but animals can be property.*
>
> *vi) See above for the case of R v Syed which is an important case for any officer using the power under section 17(1)(e).*

Section 3 Criminal Law Act

"A person may use such force as is reasonable in the circumstances in the prevention of crime, or in the effecting or assisting in the lawful arrest of offenders or suspected offenders, or of persons unlawfully at large"

It therefore follows that West Mercia Police should be cognisant of the legal precedent that arises from this advice. The following situations are presented to provide clarity as to how this legal advice should be interpreted by West Mercia Police and to remove any ambiguity in the more prevalent situations that the police service are called upon to attend;

Welfare checks

The police service are routinely contacted by partner agencies and members of our community to carry out a “welfare check” on a person whom they have concerns for, in the belief that police are the most appropriate agency and are responsible or liable for the welfare of identified individuals deemed to be vulnerable or at risk.

‘Welfare Check’, ‘Safe and Well’ check and ‘Concern for Safety’ are all terms to describe a request to ensure the safety and wellbeing of an individual.

It has never been defined what is actually meant or expected by such a request. From a policing perspective it is often considered to involve a confirmation that the person is alive at the time of the visit and provides an opportunity for the person in need to disclose any self-diagnosed vulnerability or request immediate medical or health support.

Neither of these actions fit within the statutory role of the police service. Attending police officers seldom have access to any background medical information relating to the person in need and in any case, they are unqualified to assess medical or health support.

In most cases there is a long history pertaining to the person in need and they are often already under the care of another statutory organisation. The motive for requesting the “Welfare Check” is usually associated with a steady decline in their general well-being and often where other opportunities to support the individual may not have been successfully explored.

The process of conducting a safe and well check is undefined. The assessment can only be a momentary visual confirmation of the way a person presents themselves; it can only be accurate for the time the person may be observed to be alive.

It is impossible for a police officer to truly undertake an assessment of what is presented by any person at that time; a person presenting as lucid and calm does not denote that they are not in mental health crisis and intent on taking their own life. The police service are unqualified to assess this.

The police do not generally owe a duty of care at common law to protect individuals from harm, either harm caused by themselves or others.

- The police *may* owe a duty of care to protect persons from harm where the police have assumed responsibility to care for them, or where the police have created (directly or indirectly) the risk of harm. (Sherratt)

- The police *may* owe responsibility to take reasonable steps to assist where there is a real and immediate risk to the life of a person, or a real and immediate risk of that person being subject to serious harm or other inhumane treatment. The risks of harm where a duty will be placed on the police service will generally, but not always, be from the criminal acts of a third party. (OSMAN)

It therefore follows that the police service should be cognisant where they adopt a duty of care where they have no means to mitigate the risk presented. This is particularly relevant where other agencies have primacy and the lawful options available to meet the needs of the person in need.

This procedure seeks to provide clarity when a concern for welfare request will, and importantly will not, become a police responsibility to respond.

The legal duties of care and liabilities towards an individual cannot be passed to the police unless the requesting agency can fulfil the minimum standards as defined within Webley v St George's hospital, and the police service agree to accept that request.

In such cases where responsibility is not accepted, the duty of care should remain with the partner agency or individual concerned.

This procedure does not seek to avoid the police's responsibility to deal with statutory policing matters.
In respect of the core roles of the police service, it is only where a concern for welfare request that includes one of the following that WMP should consider that it is appropriate to consider a police response;

- Where the use of relevant Policing Powers is necessary;
- The Prevention and Investigation of crime;
- To keep the Kings Peace or
- Where we already have a duty of care – such as to those in our custody

Calls that fall within this definition should not be categorised within our command and control system as a "Concern for welfare" as this is not the primary purpose of the police response. In such cases, the welfare check should be considered incidental to the core policing role; importantly where WMP officers are deployed in these circumstances, it should not be taken as an assumption that we are adopting the duty of care for an individual, where that duty does not already exist.

Where WMP receive a call from any agency to conduct a welfare check AND we do not agree that there is a statutory policing role contained within the circumstances presented, we should clearly and firmly decline the request.

A concern for welfare request can also be initiated by a private individual. Increasingly, partner agencies are declining support to members of the public who have approached them for support and have redirected them to the police service to provide that interim care.

It is imperative that this procedure does not allow a vulnerable member of our community to be passed from one agency to another. Where a call is made by a private individual, and they are unable - due to circumstances beyond their control- to check the welfare of another person, or secure support from another more “appropriate” agency who could do so, WMP should consider what support that they can give.

In accordance with what is set out above, the police will only attend a concern for welfare call for service if it is deemed to:

- Be a genuine emergency – i.e. that an individual is at a real, immediate and unconditional threat of death or serious harm;
- Or it is assessed the individual(s) has been subjected to serious harm or
- The individual(s) is a person within the care of the police service and is facing some harm.

Unless this threshold is reached the police have no duty to take action and should avoid attending “just in case”. It is unlikely that any policing powers will exist to enable the attending officers in any case. (R v Syed). It is also unlikely that our response will deliver any benefit to the person in need.

The below statements provide additional considerations when dealing with a request to conduct a welfare check;

i. A medical emergency?

Guidance from the ambulance service is that where possible callers at the scene of an incident should speak direct to them to enable the ambulance service call handlers to triage their call effectively, and provide the best support and advice. It is therefore entirely appropriate that callers who have mistakenly called the police service for a medical emergency, should be redirected to call the ambulance service themselves.

WMAS are clear that third party reporting is insufficient for them to undertake their triage based assessment and the police service seldom have the requisite information when calling on behalf of another. It therefore follows that unless we have doubts that a person will call the ambulance service themselves, the police service should not routinely call the ambulance service on behalf of a third party.

Accordingly the police will;

Advise the caller they must ring for an ambulance, if practicable, or direct that another person present at the scene should make that call – only where no other options exist should the OCC contact the ambulance service.

No other action will be taken by the police, unless it is mandated for the reasons set out above or where there is another statutory reason why police attendance would be appropriate.

ii. Is a child at risk of significant harm?

Special care is required when assessing risks to children. They are usually vulnerable and special concern must be exercised to ensure children's best interests are protected (in line with the guidance document "Working Together 2018").

Unless there is an immediate, unconditional and real threat to life, the requesting agency should be directed to contact Children Service's (Or their Emergency Duty Team outside of office hours), with the aim of convening a strategy meeting through the MASH.

iii. Is the person suspected to have a mental health problem?

Cases involving mental health issues rarely require the support of police officers to support other mental health professionals.

The exception to this is where it is necessary to use their powers[3] under the Mental Health Act where appropriate - this would of course constitute a statutory policing purpose if the request related to this provision.

Otherwise, it is unlikely that the police service would have any role to play and other agencies would be more appropriate.

iv. Has a crime been committed?

A welfare check request can often be associated with a suspected criminal act and the police have a clear duty to investigate crime. In these circumstances the police will, where appropriate, respond to the request so that any investigation can be managed as efficiently and effectively as possible.

[3] Refer to "Basic considerations with regards to the correct use of powers under Mental Health Act (MHA) and Mental Capacity Act (MCA)".

The policing purpose should be recorded as it should not be assumed that our attendance to investigate a crime would mean that we assume a duty of care to any person associated to that call.

Where another agency should be supporting a person in need, their responsibility does not cease simply because the police are attending to investigate a crime. A clear distinction must be drawn.

v. Is this a missing person report?

Cases involving missing persons are subject to specific policies which will be followed by the OCC when taking the original call.

It is often the case that welfare checks become missing person enquiries once initial actions have been completed.

The missing person's guidance gives clear instructions on what actions are required by reporting agencies or members of the public and when an incident should be designated as a missing person enquiry.

vi. Other advice relating to calls from partner agencies;

A call for service from a partner agency may indicate that the duty of care of the individual concerned is within that partner agency's remit. If so, the partner agency retains that responsibility and should take all necessary steps to ensure their care and welfare.

If this requires a welfare check to be carried out, the partner agency should not consider the police service as a taskable asset to be deployed at their request. Any lack of capacity within a partner agency's ability to carry out a welfare check for a case that they are managing does not make the situation a police matter and in these circumstances the police will not routinely attend.

There are a range of non-health partners who may be unable to carry out a concern for welfare check and in these circumstances the police will consider all the information available before deciding whether there is a need for them to do so.

If the threshold for the police to attend is not met, the partner agency will be informed the police will not be attending, but advised to call back immediately should more information become available or the situation changes in a way that requires the police to re-evaluate their decision. (NDM)

It is important to remind other agencies to bring new relevant information to the police's attention if they believe that it would alter our decision.

vii. Other advice relating to calls from a member of the public requesting a welfare check.

It is important to recognise and distinguish between a general member of the public and a family member who call police for assistance, or expresses concern for a person.

The caller may be a Good Samaritan or well-meaning member of the public acting in good faith or exercising their public spirited duty. It is of the utmost importance to maintain trust and confidence in the ability of the police to meet their needs and to be seen as sympathetic and engaged with our communities.

In the first instance the police will establish all the facts, so far as possible, from the caller and consider if another partner agency or emergency service is best placed to give support and assistance.

If so the caller will be signposted to that partner agency and given sufficient information and contact details to do so themselves.

If due to circumstances beyond their control the caller is unable to gain support from a partner agency and they are unable to do their own welfare check (if appropriate), WMP may take on that responsibility. The decision will depend on the facts known at that time.

In such circumstances the police will create a log and grade and THRIVE for dispatch to resource in the most appropriate way. The caller will be informed the police will be attending to carry out a welfare check and report back to them their findings.

viii. Legal powers relating to welfare checks should aid the decision making process;

Common Law

It is important to note that in the context of welfare checks “Police have no general common law responsibility for ‘safety’ or ‘welfare’ of members of the public”.

The central principle is that police will only respond to requests to carry out a ‘welfare check’ when they engage the core duties of police:

- To prevent and detect crime;
- To keep the Kings’ peace and
- To protect life and property.

The carrying out of this type of check is simply the discharge of the general duty to investigate crime and perform other core policing functions. It is not an assumption of care for the safety of any particular individual.

Police powers do not permit forced entry into a person's home without a warrant (Under Sec 135 MHA).

Section 117 PACE

Power of constable to use reasonable force.

Where any provision of this Act—

(a) confers a power on a constable; and

(b) does not provide that the power may only be exercised with the consent of some person, other than a police officer, the officer may use reasonable force, if necessary, in the exercise of the power.

It is unlikely that this power would be applicable when considering the legal precis relating to Section 3 CLA above.

6.0 PATIENTS LEAVING HOSPITALS OR OTHER HEALTH CARE SETTINGS

There are an increasing number of calls from hospitals or other health care settings who have witnessed a voluntary patient who has attended for treatment and has left prior to being seen by a healthcare professional. It is not unusual that where a patient has to wait in hospital settings for long periods, this results in some of them leaving prior to treatment.

In many cases the initial triage has concluded the patient has full capacity and is free to leave, but the circumstances have resulted in them calling WMP to conduct a welfare check "just in case".

The police do not generally owe a duty of care at common law to protect individuals from harm, either harm caused by themselves or others.

- The police may owe a duty of care to protect persons from harm where the police have assumed responsibility to care for them, or where the police have created (directly or indirectly) the risk of harm. (Sherratt)
- The police may owe responsibility to take reasonable steps to assist where there is a real and immediate risk to the life of a person, or a real and immediate risk of that person being subject to serious harm or other inhumane treatment. The risks of harm where a duty will arise on the police will generally, but not always, be from the criminal acts of a third party. (OSMAN)

Absent without leave (AWOL);

Patients who leave health care facilities prior to being seen are parochially referred to as being “Absent without leave” (AWOL), albeit this title has little bearing as they had no obligation to remain in most cases and would otherwise be referred to as ‘self-discharged.’

It is the responsibility of the hospital to determine why a person entering their establishment voluntarily should be considered at enhanced risk when they leave voluntarily.

The duty of care lies with the hospital and where the hospital deem them to be at risk, it is their responsibility to make contact and return them.

The police service are not a taskable asset to return patients who are free to make their own decisions. In law, everyone is assumed to have capacity unless assessed as not or there is a duty to safeguard- based on age for example.

Patients who are detained under a specific piece of legislation, such as provisions under the Mental Health Act, and abscond from their care do not automatically fall within the responsibility of the police service.

It is a regular occurrence that mental health professionals permit patients detained under provisions of the Mental Health Act to return home or attend appointments unaccompanied, as permitted by Section 17 of that Act. When used appropriately, Section 18 of the Act is created to provide a power for the hospital (or others) to return the patient.

Limited alternative powers exist to forcibly return a patient who has left a mental health hospital in the absence of a warrant issued under Section 135 of the Act. It is the responsibility of the health care professional managing the patient’s care to apply for that warrant from which the police may enforce the detention and the subsequent taking to a place of safety by an ambulance.

Only where a detained person has absconded and meets one or more of the following criteria should the hospital notify WMP;

a. Especially Vulnerable (not simply vulnerable);
b. Dangerous (to themselves or others) or
c. Subject to part 3 of the Act (restricted patients)

Patients who fall within this criteria should be subject of a professional discussion between the hospital manager and WMP to understand the level of risk and jointly agree the appropriate course of action required.

The role of the WMP is to support the hospital to return their patient, not to do so for them.

If a patient does not fit the criteria in a-c above, it is not the role of WMP to support the hospital to return them unless;

d. Following all possible enquiries and efforts by the hospital the Patient cannot be found. In these circumstances the patient should be reported 'missing';
e. The Patient's whereabouts is known but they cannot be returned without the use of a warrant to gain entry to a premises (S135 (2) – The police service have a very specific and defined role in these circumstances (and specifically we should not be utilised to transport the patient after detention).
f. The Patient's behaviour is so violent or aggressive towards hospital staff that they are unable to retake them without Police support.

In the circumstances described at d-f above, WMP will assist in retaking a Patient only in support of a suitably qualified and experienced mental health professional deployed with them

Walking out of Health Care Facilities - Patients who leave hospital unexpectedly;

R*eferences:*
The Royal College of Emergency Medicine – The Patient who Absconds 2018
The Royal College of Emergency Medicine - The MCA in Emergency Medicine 2017
Lord Reed – The Supreme Court 2018 – Police Duty of Care

As stated above, where a patient enters a hospital or other health care facility voluntarily, it should be assumed that they are permitted to leave voluntarily.

It should be assumed that a patient has capacity to leave the emergency department until proven otherwise. All Accident & Emergency (A&E) / Emergency Department (ED) doctors should understand the Mental Capacity Act (MCA) and be trained and be comfortable in assessing a patient's capacity.

Likewise, A&E/ED nurses should be trained to make a brief assessment of a patient's capacity to decide to leave the ED as part of their initial assessment of a patient.

Hospitals owe a duty of care in common law and under provisions of Human Rights legislation to persons within its care and control. There are a great many

previous cases that make clear the duties on hospitals to look after patients and vulnerable persons.

These duties are important as generally they do not end when a person absconds from the care of a hospital. For example, a duty to look after a person who posed a risk of suicide would be futile if the duty ended on that person's escape from hospital. Instead the Duty of Care extends beyond the perimeter of the hospital grounds for example.

The duty to take reasonable steps to protect that person remains, even after she/he has left the hospital. One of the steps that the hospital may wish to take is to contact and engage with the police to assist. That would not, of itself, discharge the hospital's duty.

It is therefore a core component of the hospital's duty towards a patient if they understand the risk associated with them.

The police service should not be required to perform the role of security in a hospital or other health care setting.

The hospital should assess & consider who might represent a risk of absconding and consider how it intends to mitigate those risks.

Being able to predict who might abscond following initial triage allows measures to be put into place to try to prevent absconding and also prompts planning for the eventuality that a patient may abscond.

The hospital should consider the following factors to aid their risk assessment.

A patient who is;

- Verbalising a wish to abscond
- Considered to be a high suicide risk
- Previously absconded Quiet / withdrawn Unaccompanied
- Not from locality
- Not willing to engage with staff
- Intoxication Agitated / angry / distressed
- Frustration in delay to assessment Psychotic symptoms
- Brought to ED against own wishes
- Has external commitments/ stressors Delirium / dementia
- Patient / family lack insight into condition Alcohol or drug dependence

Preventing an absconder

There are several practical steps which may be possible after identifying a patient who has a high risk of absconding, to include;

:

- Placing the patient in a location which facilitates observation.
- Prioritising early clinical assessment if they are a potential risk to themselves.
- Perform a capacity assessment; does this patient at this time have the capacity to make a decision to leave the ED without being seen? Be aware that the patient's capacity to decide this may fluctuate. Please see RCEM guidance on the Mental Capacity Act (MCA).
- Allocating a member of staff to observe the patient and try to engage with them (this may or may not include security staff).
- If a patient wishes to leave, establish why the patient wants to leave and try to address their concerns.
- If the patient is adamant they wish to leave and they have capacity to decide this then they should be managed as per local 'self-discharge' procedures.
- For patients with a high risk of absconding it is recommended that a standard form is used to list a description of the patient's physical features should this be required by the police or hospital security in the eventuality of the patient actually absconding (a local example is given in Appendix 1).

Where a patient tries to abscond;

Security staff can only be asked to restrain or forcibly bring a patient back to the A&E/ED if they lack capacity or if it is felt the patient is mentally ill and requires a Mental Health Act assessment. In an emergency where there has been no chance to assess the patient's capacity but there is a significant risk of harm, a patient may be restrained or brought back by force effectively under common law.

If a patient who lacks capacity requires ongoing restraint to prevent him/her from leaving or, in order to provide emergency treatment deemed to be in their best interests, rapid tranquilisation maybe an option if all other efforts have failed. Emergency Departments should have a protocol for rapid tranquilisation.

If a patient is prevented from leaving the A&E/ED because they do not have the capacity to make an informed decision, the means used to keep them must be proportionate to the risk to the patient.

If a patient has a mental health problem that is diminishing their capacity, then they should be assessed under the Mental Health Act (MHA). In these circumstances, the MHA is more appropriate than the MCA.

Common law powers can be used in areas not covered by MHA or MCA or when there is no opportunity to form a judgement about patient's mental capacity or mental state in situations where urgent intervention is needed to avert serious consequences. This power is short and lasts only until crisis subsides.

This is the same power available to attending police officers, but Section 136 MHA would most likely be preferable when they are in a public place.

What should happen if they do leave unexpectedly?

In order to understand the legal powers that exist for hospital staff to exercise their duty of care, it is necessary to understand what category the patient was in attendance;

A - Did Not Wait / Left without being seen- left before assessment by a decision-making clinician

B - Left Before Treatment – left before treatment but has been assessed by a decision-making clinician

C - Self-Discharge – left A&E/ED after informing staff

D - Absconds – left ED at any time without informing ED staff and is at risk of harm to self or others either through neglect or deliberate means

If a patient absconds who is felt not to have capacity, and is at risk either of self-harm or deterioration of their condition, then departments should activate a search of hospital premises.

Departments should have a policy for when to call security and what it is expected security will do to search for the patient. ED staff should try to contact the patient and relatives by phone.

Before contacting the police service for patients who have absconded from A&E/ED it is recommended that the following criteria should all be present;

• There exists a real and substantial risk to the patient if they are not brought back to the ED for medical assessment and/or treatment.
• The risk is such that action needs to be taken with urgency.
• Efforts to contact the patient by telephone have failed.
• No other person or service is able to facilitate the return of the patient e.g. GP, SW, parent, relative.

• Both the nurse in charge and the senior doctor on duty are in agreement that contacting the police is the correct course of action.

In the case of children (under 18yrs) who have absconded from A&E/ED then the threshold will generally be considered to be lower for calling for help from the police service. Any children who abscond with or without an accompanying adult should be considered a safeguarding concern unless evidence to the contrary exists; local safeguarding procedures should be followed.

The threshold will also be lower for those patients in whom there is reasonable evidence that they lack capacity or who may be considered vulnerable (e.g. those with dementia).

As in the cases referenced above, the police service do not generally owe a duty of care in any of these circumstances.

The defining factor is what is expected if the police service are deployed. It is important to understand that legislation does not cater for this; the police service do not have the power to bring patients back to A&E/ED against their will unless they are under arrest (i.e. have committed a crime).

It is increasingly accepted that A&E is not suited for patients who have been detained under Section 136 MHA (the power that authorises a police officer to remove a person to a place of safety if he believes that person is suffering from a mental illness, for the purpose of them being assessed).

Where officers intend to utilise Section 136 MHA, it is important to determine whether a mental health assessment has already been conducted; it is futile to detain someone under Section 136 who has already in the course of the same hospital attendance been assessed as having capacity.

Some police forces provide a mandatory requirement that any patient being considered for transport to a Section 136 centre must first have a telephone triage – it serves no purpose to transport them simply for the hospital to decline the assessment based on recent prior experience.

Police attendance to a hospital or other health care setting should be a rare event that is only supported following a concise and professional handover from the hospital in which the circumstances, the medical assessment, the mental health assessment and the risk factors are shared and importantly the hospital has shared their preventative measures, their summary of actions to resolve the situation themselves and the reason they want the police service to support them.

It is entirely inappropriate for the A&E/ED to request the police to attend their department to utilise Section 136 and convey their patient to the Section 136 centre, which is often part of the same trust and on the same hospital site.

The A&E department cannot avoid the simple transfer of a patient from their A&E/ED to their mental health professionals where it is appropriate; it would be entirely inappropriate for the police service to be deployed for that purpose and that would not constitute a statutory policing purpose.

7.0 DECISION MAKING ESCALATION WITHIN THE OCC

The OCC has a hierarchy in the same way as all other departments within WMP.

Call Handlers play a vital part in the OCC process but it should be considered that they are often the least experienced staff within that environment and are the least qualified to determine whether a complex case warrants a police response.

It is therefore essential that the Call Handler can escalate the decision making to more senior colleagues.

It is essential that we do not leave our organisation vulnerable to premature decisions being made by less experienced colleagues;

1. Where a statutory policing purpose is evident and it is agreed that we are the most appropriate agency, we should agree to deploy an appropriate resource in line with our usual practice.
2. Where a statutory purpose does not exist, we should strongly and unambiguously decline to deploy a resource.
3. Where there is any doubt, we should strongly and unambiguously decline to deploy a resource (and advise the caller of that decision) but advise the caller that we will escalate the case for a review by a more senior person and will call them back if the decision to decline attendance is overturned

The Duty Superintendent (or in their absence the OCCI) will always have the final decision in the case where agreement cannot be reached and they retain discretion to deploy officers/staff to the call for service even where there is no identifiable policing purpose.

8.0 GOVERNANCE

Initially and in order to embed the practice and positive culture for MAA decision making a bi-monthly meeting will occur. Chaired by Head of Public Contact, attended by PSD and SME’s from Strategic Vulnerability and Safeguarding and OCC staff.

The panel will review a dip sample from the 5 shift pattern, exploring from point of call through to resolution and any MAA determination. Identifying areas for improvement and recognising good practice and additional Continual Professional Development (CPD) matters will be shared with relevant Partners.

- Partners will receive a Thematic report every 6 months with the demand data, determinations and outcomes for wider safeguarding and partnership exploration. Vulnerability Partners Engagement Group (VPEG) will be utilised as a police vehicle to share updates and receive partnership feedback on the policy.
- The Ethics Committee will receive 6 monthly updates and be asked to consider any ethical dilemmas.
- The Strategic Independent Advisory Group (SIAG) and Local Independent Advisory Group (LIAG) may be utilised to address any disproportionately issues that become obvious.
- Operational governance exists with a clear hierarchical escalation processes within OCC.
- A performance framework is in place to correlate decision making with those incidents marked as MAA determinations.
- Governance, training and staff wellbeing will be managed by the Crime and Vulnerability Directorate for the Safeguarding Advice Team.

9.0 ASSESSMENT AND ANALYSIS

The Equality Assessment Analysis is available as a separate document.

10.0 CONSULTATION

Business Lead Consulted - NAME	***Date Consulted***
Chief Officer Consulted – permission to go to Critical Friends - NAME	***Date Consulted***

11.0 DOCUMENT HISTORY

The history and rationale for change to policy will be recorded using the below chart:

Date	**Author / Reviewer**	**Amendment(s) & Rationale**	**Approval / Adoption**

April 2023	Lee Davenport	New Policy	Approved at March 2023 Exec & Governance Boards outside of JNCC Policy approval process

12.0 ASSESSMENT AND ANALYSIS

The Equality Analysis Assessment associated with this document is available on request.

13.0 MONITORING / EVALUATION

The Monitoring and review of this policy is the responsibility of the policy owner.

14.0 DATA PROTECTION IMPACT ASSESSMENT

- Is a DPIA required? Is a DPIA required? **No,** as agreed with Audit, Risk & Compliance 15/04/2023
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