RIGHT CARE RIGHT PERSON

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Risk Rating: High

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Legal Basis

Legislation specific to the subject of this policy document:

- Police And Criminal Evidence 1984 S17(1)(e)
- Children Act 1989
- Children Act 2004 S11, S31(9)
- Mental Health Act 1983 (as amended by the Mental Health Act 2007) S135 & S136
- Mental Capacity Act 2005
- European Convention of Human Rights/ Human Rights Act 1998 (Article 2 and 3)

Other relevant legislation which you must check this document against (required by law)

- Human Rights Act 1998 (in particular A.14 – Prohibition of discrimination)
- Equality Act 2010

- Crime and Disorder Act 1998
- Health and Safety at Work etc. Act 1974 and associated Regulations
- General Data Protection Regulation (GDPR) and Data Protection Act 2018
- Freedom Of Information Act 2000
- The Civil Contingencies Act 2004

Other Related Documents

- Judgment of the High Court in *Syed v DPP [2010]*
- Joint protocol between Norfolk & Suffolk Constabularies and Norfolk & Suffolk NHS Foundation Trust
- College of Policing: Demand Management, Safe and Well Checks and Repeat Callers (March 2021)
- Missing and Absent Persons Policy
- College of Policing Risk APP - Risk | College of Policing
- College of Policing Right Care Right Person – Humberside Police - Right Care Right Person – Humberside Police | College of Policing
- His Majesty's Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS) 2018 report, 'Picking up the Pieces'.
- College of Policing Missing Persons APP: Missing persons | College of Policing
- College of Policing – Code of Ethics
- Norfolk and Suffolk Constabularies' Standards of Professional Behaviour
- College of Policing – Right Care Right Person Toolkit
- NPCC Guidance (July 2025) – Responding to reports from DWP, Utility Companies and similar agencies of missing individuals who may complete suicide or self-harm

1. Statement of Policy

1.1 This policy is Norfolk Constabulary's adoption of Right Care Right Person. It covers calls for welfare checks by the public and other agencies, requests for transportation to hospital on behalf of the Ambulance Service, requests for the return of AWOL patients and those that have absconded from a health facility. This policy also seeks to provide clarity to officers and staff as well as partner agencies as to when and how the police will respond to calls for service in the circumstances covered by this policy.

1.2 This policy has been formally agreed via the approved policy development/review process. It will be maintained by the County Policing Command in conjunction with the Central Policy Unit.

1.3 The Right Care Right Person policy is intended to promote equality, eliminate unlawful discrimination and actively promote good relations regardless of age, disability, gender reassignment, marriage or civil

partnership, pregnancy and maternity, race, religion or belief, sex, sexual orientation, economic or family status.

1.4 Managers have a responsibility to ensure this policy is applied fairly, and unless otherwise stated, all policies and procedures are non-contractual.

2. Applicability

2.1 Unless otherwise stated, this policy/procedure applies to all police officers (including officers of the Special Constabulary) and all members of police staff (including Police Support Volunteers). This policy does not cover Missing and Absent Persons or provisions specific to the Mental Health Act 1983.

2.2 This policy applies solely to Norfolk Constabulary. This is not a joint Norfolk and Suffolk policy.

3. What is Right Care Right Person?

3.1 Right Care Right Person (RCRP) aims to ensure vulnerable people get the right support from the right emergency service. It relates to calls for service about:

- Concern for the welfare of a person (welfare check, concern for safety check, safe and well check)
- People who have walked out of a healthcare setting
- People who are absent without leave (AWOL) from mental health services
- Medical incidents

3.2 RCRP is a national project supported by the College of Policing (CoP) and the National Police Chief's Council who are parties to a National Partnership Agreement alongside the Home Office, Department of Health and Social Care and NHS England. The majority of forces have already adopted and implemented the initiative. The purpose is to ensure that in times of need a vulnerable and/or at-risk individual is provided with the right care by the right person.

3.3 Examples of requests for service not routinely suitable for police attendance (absent of information that triggers the legal duty to respond as set out in the next paragraph), include:

- Checks on individuals who have failed to attend routine appointments at hospital, doctor's surgeries, mental health teams etc.
- Those absent from a place that they should be or are expected to be, but who are not reported or classed as 'missing'. See Missing and Absent Persons policy.
- Requests to check whether an individual has taken their medication.

- Requests for monitoring an individual over a period of time where the reporting agencies' resourcing provision is lessened.
- Requests by alarm monitoring companies, to check on a client who has activated an alarm (not a personal attack or intruder alarm).

3.4 The police will respond to a request for service when there is a legal duty to act or the circumstances giving rise to the request engages one of the core policing duties. In the latter case, this reflects the usual business of policing and is not necessarily to be taken as an assumption of responsibility of care for an individual. The core policing duties are:

1. To prevent and detect crime – it is reasonably believed that a crime has been committed or is about to be committed.
2. To save life and protect property – there is an identifiable real and immediate risk to life or property and/or a vulnerable person or child is suffering or are at risk of suffering immediate and significant harm.
3. To keep the King's peace – attendance of a police officer is necessary to prevent a breach of the peace.
4. To bring offenders to justice.

3.5 The College of Policing APP on Core Planning Principles state that the police have additional duties as prescribed under legislation and common law powers.

3.6 The College of Policing have provided guidance on the thresholds for police intervention which stem from the core duties outlined above, however those that are relevant to this policy are:

- Is there a real and immediate risk to life or serious harm to an identified person?
- Is a child at risk of significant harm?
- Does the person appear to be suffering from a mental disorder and be in immediate need of care or control at any place, other than a dwelling or part of a dwelling such as a garage or garden used in connection with the dwelling?
- Is the person suspected of a crime? Is there a Breach of the Peace? Is there a criminal loss or damage to property? Or is there a suspicion that a crime has taken place?
- Is this a missing person report?

4. Legal Powers

4.1 The police are not legally responsible for all forms of risk. The police should not generally assume, directly or indirectly, responsibility for all forms of risks when they have no legal right or power to do so. Acting without a legal basis or power to act could compromise the safety of members of the public, officers and staff, and reputation by exceeding legal authority. Other

agencies may have more appropriate skills (for example, in risk assessment), resources (for example, ability to provide long-term interventions) and legal powers to manage the risk.

4.2 The police will have a legal duty to act in the following general circumstances:

- Where there is a real and immediate threat to life (Article 2 European Convention of Human Rights)
- Where there is a real and immediate threat of serious harm/torture/inhuman or degrading treatment (Article 3 European Convention of Human Rights)
- Common law duties of care (where the police have assumed responsibility)

<u>Specific statutory duties – Article 2 and 3 of the European Convention of Human Rights</u>

4.3 Article 2 of the European Convention of Human Rights protects the right to life. The duty is not to take life, to protect against specific threats to life and the duty to put in place systems and procedures that take positive steps to protect life.

4.4 In the context of a welfare check, the duty may arise where there is a specific threat to life which will generally arise from the criminal act of a third party but not always. The duty could arise where the risk to life is suicide.

4.5 The duty on the police to act will arise when the police know or ought to know of a real and immediate risk to life to an individual or group of individuals. Even if that individual, or group are not specifically identified, the fact that the individual/group is/are known to exist might be enough to trigger the duty.

4.6 To trigger the Article 2 duty to act the risk must be one of death and it must be real and immediate. “Real and immediate” means that the risk must be present and continuing. Threats are not real and immediate if they are conditional on other events happening or will occur at some point in the non-immediate future.

4.7 Threats or risks that do not give rise to a duty to act under Article 2 may give rise to a duty to act under Article 3 of the European Convention of Human Rights. Article 3 states:

> *“No one shall be subjected to torture or to inhuman or degrading treatment or punishment.”*

4.8 Being subjected to serious violence, sexual assault or other such degrading treatment can come within the scope of the duty to act under Article 3.

4.9 For the duty to arise, the risk of torture or to inhuman or degrading treatment will arise in the circumstances at 4.5 above, save for the real and immediate risk will be of conduct falling within Article 3 and not the risk to life.

4.10 The Article 2 and 3 duties can apply to more than one agency who know, or ought to know, of a real and immediate risk to life (Article 2) or threat of serious harm/torture/inhumane treatment (Article 3). The duty is not restricted to the agency with the most appropriate skill/resource.

4.11 Importantly the failure of one statutory agency to respond, even if they are the most appropriate resource in the circumstances, will not negate the legal liability of the other statutory agencies.

Common Law

4.12 The police do not generally owe a legal duty of care at common law to protect individuals from harm, either created by themselves or others. However, the police may owe a duty of care where the police have assumed responsibility to protect an individual from harm or where the police have created (directly or indirectly) the risk of harm.

4.13 Where the police do not have a legal duty of care towards an individual(s), the duty cannot be imposed upon the police unless the police assume a duty of care i.e., they accept a legal responsibility for the duty of care of the individual(s). In such cases, a duty of care is not assumed by the police, and the duty of care will remain with the individual or partner agency with the legal responsibility to act.

4.14 If the police assume a duty of care to protect an individual from harm, the duty of care must be discharged. For example, once police have agreed to undertake a welfare check, they must do as advised without delay. If advice is given to a family member that the police will search for or ensure the safety of an individual or where the police tell a hospital that they will take responsibility for finding an absconder, the police must do as has been advised without delay.

Children

4.15 There are specific duties on the police to act in support of local authorities in safeguarding children and protecting them from the risk of significant harm. A child is generally to be treated as vulnerable, and vulnerability should form part of the assessment of any real and immediate risk to life or of serious injury. Importantly, it should be remembered that RCRP does not supersede obligations that safeguarding partners, including the police, have as regards children. All safeguarding partners must make arrangements to ensure that their functions are discharged having regard to the need to safeguard and promote the welfare of children.

4.16 In requests for service relating to children, the police should exercise caution. If there is no risk to life or of serious injury but there is a risk to the child of significant harm it has been determined pursuant to this policy that, the police will respond. If the child's location is known attendance will be to

that location. If the location is not known, refer to the Missing and Absent Persons policy.

4.17 There is no absolute legal definition of what would constitute significant harm. Physical abuse, sexual abuse, emotional abuse and neglect are all categories of significant harm. Significant harm has been associated with severe effects on the child, and/or relatively greater difficulty in helping the child overcome the adverse impact of the ill-treatment, which might interrupt, change or damage the child's physical and psychological development.

4.18 The police have additional powers and duties under the Children Act 1989 for the protection of children and to comply with requests from a local authority in carrying out their social care function, however the most appropriate agency to carry out a social care function is Children's Services. Unless there is an immediate risk to life or of serious injury or risk of significant harm to the child then Children's Services remain the most appropriate agency to respond. It is acknowledged that there may be occasions when a joint visit with Children's Services would be appropriate, this is to be assessed on a case-by-case basis and should be led by Children's Services.

4.19 In any call for service concerning a child, consideration must be given to the best interests of the child and, in appropriate cases, the voice of the child. A child's views are a relevant consideration but are unlikely to carry the same weight and reliability as an adult where a dispute arises. The best interests of the child could involve making referrals to MASH or other agencies such as social services.

Power of entry

4.20 Where a duty to act arises and the individual/group at risk is in a property, it may be possible for officers to gain entry using the power in section 17(1)(e) of PACE, which provides:

"1) Subject to the following provisions of this section… a constable may enter and search any premises for the purpose …

(e) of saving life or limb or preventing serious damage to property."

4.21 In *Syed v DPP [2010]* the High Court ruled that section 17(1)(e) *did not justify entry where there was a general concern for the welfare of someone within the premises* and therefore officers were not acting in the execution of their duty when purporting to rely on section 17(1)(e) to force entry against the wishes of the person who answered the door.

4.22 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."

4.23 Officers contemplating use of the power under section 17(1)(e) must ensure that they gather as much information as practicable in the circumstances to support their grounds that entry without a warrant is necessary to save life and limb or preventing serious damage to property. Appendix A provides suggestions (not exhaustive) of some reasonable enquiries in relation to this.

5. Procedure

5.1 To continue to respond appropriately to calls that warrant police attention, we will adopt a robust and timely triage system to clearly identify them. All calls for service will be subject to the following threshold tests for police intervention:

i) Is there a real and immediate risk to life or serious harm to an identified person(s)?

ii) Is it a medical emergency?

iii) Is a child at risk of significant harm?

iv) Is the person suspected to have a mental disorder? And in immediate need of care or control, and in any place, other than a dwelling or part of a dwelling?

v) Has a crime been committed?

vi) Is this a missing person report?

5.2 Appendix B outlines the process followed when a request for service is received.

5.3 RCRP calls for service received into the Control Room should be assessed and managed through the Thrive Risk Assessment (See Appendix C) and via the RCRP Storm call script (See CCR Prioritisation of Demand and Call Grading policy).

5.4 RCRP calls for service received via Switchboard must be transferred to the CCR communications officers for assessment and triage.

5.5 RCRP calls for service must be recorded in a Storm Log (CAD) and the RCRP call script completed, irrespective of whether it is resourced

specifically for RCRP. This ensures that all calls are auditable, retrievable and able to be recalled if required.

5.6 All appeals regarding decisions of non-attendance in relation to RCRP received at Switchboard level must be transferred to the main CCR for triaging and recording (See Escalation section).

5.7 The gathering of information/intelligence and checking of police systems to determine whether the police have a duty of care in the circumstances reported should not be considered as acceptance or an assumption by the police of a duty of care. This should be made explicit to the requesting party in those circumstances.

5.8 Information is key to assessment of risk and triage. As a minimum, it is expected that systems checks are completed on Storm (e.g. previous calls and object markers), LEDS/PNC, NFLMS and Athena (e.g. investigations and intelligence). The extent of the Athena checks will be for the call handler to determine based on their assessment of the circumstances reported.

5.9 If the call for service does not meet the threshold for deployment the caller will be informed of this and signposted, if appropriate, to another agency. These calls should be documented on a grade D (CAD) with a rationale as to why officers will not be deployed and how the caller has been updated and/or signposted to another agency as relevant.

5.10 In any case where it has been determined and communicated that there will be no police attendance, we should ask the caller to contact us if new information comes to light and the situation escalates. This will allow for a reassessment of risk and our response.

5.11 If we have contacted another emergency service on the caller's behalf, we should ask them to contact us if the situation escalates, new information comes to light, or they are unable to respond to the request in a timely manner. This will allow for a reassessment of risk and our response.

5.12 We should make it clear to a caller whether or not the police are deploying to a call for service. Where the police are not attending, no reassurances should be given about further actions as these could amount to an assumption of responsibility for the duty of care of an individual(s) in common law. We should make decisions clear and where unsure about deployment, advice sought from a supervisor via the escalation process.

5.13 When dealing with a welfare check where there is (or was) suggestion of vulnerability or concern, Officers/staff should submit a safeguarding referral and consult with a supervisor as appropriate. This referral will usually be in the form of an Athena 'protecting vulnerable people' (PVP) entry. An API is required, and a relevant risk assessment completed and where necessary, a relevant classification added (i.e. mental health). It is important to remember that a PVP submission WILL NOT automatically initiate contact to achieve Mental Health support, so officers must consider also utilising other methods of referral if required such as the NHS 111 mental health option professionals' line, crisis team, REST/STEAM wellbeing hubs and

the mental health response vehicle. Where a child or children are involved, a CPI should be completed, and consideration should be given to a referral to MASH and/or social services.

6. Suicidal Ideation

6.1 Suicidal Ideation means thoughts about suicide. Callers talking about harming themselves where there is no real and immediate risk to life or of serious injury should be directed to ring NHS 111 mental health option or another suitable mental health service or primary care provider. If the caller or person with suicide ideation is a child a police deployment may be required pending a THRIVE assessment.

6.2 Police should not normally attend calls where people have thoughts of suicide and are not actively making efforts to carry this out. These should be dealt with by a health care professional trained to make medical assessments. It is important to remember that the police do not have mental health act powers within a private residence without a warrant obtained under section 135 of the Mental Health Act 1983 ('MHA 1983').

7. Welfare Checks: Members of the public or other agencies

7.1 A concern for welfare can be initiated by a member of the public. In such cases the police will establish all the facts, so far as possible, from the caller and consider if another partner agency is better placed to give support and assistance. If so, the caller will be signposted to the appropriate 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 or they are unable to do their own welfare check, the police may accept the responsibility to do so. This will depend on the facts known at the time and the assessment of risk.

7.2 In circumstances where the police accept a responsibility to act a duty of care is assumed. The police will create a log and grade and THRIVE for dispatch to resource in the most appropriate way. The caller will be informed that the police will be attending to carry out a welfare check and report back their findings.

7.3 If the call for service does not meet the threshold for deployment, the member of the public will be informed that the police will not be attending, and this will be documented on a Grade D (CAD). The member of public will be advised to call back immediately should more information become available, or the situation escalates to allow the police to re-evaluate their decision. Such re-evaluation may not result in a different outcome, and it should be made clear to the member of the public whether or not the police are responding.

7.4 Where health is a primary driver of the concern, care should be taken to ensure signposting or tasking is made to the right service provider. Staff and officers are reminded that the East of England Ambulance service (EEAST) is an **emergency service**, and they may not be the appropriate

resource to intervene where a condition is not life threatening or would not normally result in serious or life-changing injury.

7.5 A call for service from a partner agency may indicate that the duty of care for the individual concerned is within that partner agency's remit. If the partner agency considers that a welfare check is necessary, it is the partner agency's responsibility to carry it out. An inability to do so should be brought to the attention of their manager. An inability to carry out a welfare check that it considered to be necessary does not automatically shift the duty of care to the police. The police will only act if there is a legal duty to do so.

7.6 If the threshold for police attendance is not met, the partner agency will be informed that the police will not be attending but advised to call back immediately should more information become available, or the situation changes to allow the police to re-evaluate risk and their decision.

7.7 It is important to make sure that other agencies bring relevant information to the police's attention. Queries should be raised if there appear to be gaps in the information provided or if what is reported does not make sense.

8. Welfare Checks: Family

8.1 Often police get reports from family members or guardians of young children with concerns for their child's welfare resultant of breakdowns in relationships between adult parties (e.g. an ex-partner not returning a child as expected following a weekend of having responsibility for them).

8.2 Where there is no information to suggest the child is subject to a real and immediate risk to life or of serious injury or significant harm, it will be appropriate to refer the concerns to the Multi-agency Safeguarding Hub (MASH) or directly into Children's Services (e.g. through contact with the duty social worker etc). If there is a breach of criminal or family court orders, police action should be considered.

8.3 Due regard should be given to Force policies on safeguarding children and young people, and any breach in a legal requirement around childcare arrangements that police may be able to enforce (e.g. to prevent and detect crime).

8.4 Regard should also be given to the legal duties in relation to children at paragraphs 4.15- 4.19 above.

8.5 Refer to Missing and Absent Persons policy for reports of missing children.

<u>Domestic Violence/Honour-based Abuse/Modern Day Slavery considerations</u>

8.6 The police might be contacted by partners, family members or other parties where an individual has fled a situation of abuse or concern, and the caller is seeking to re-establish contact with them by subterfuge. Due care should be given that in discharging our responsibilities we are not exposing the individual to additional risk from domestic violence or honour-based abuse perpetrators. In such situations, care should be given in what is disclosed

to reporting persons, and advice sought from supervisors with appropriate consultation with specialist safeguarding resource as necessary.

9. Welfare Checks: Mental Health professionals

9.1 The police might receive requests for welfare checks from mental health professionals in relation to their patients who, for example, they have been unable to contact by phone or did not attend a pre-arranged appointment. The police do not generally owe a duty of care to mental health patients unless there is an immediate risk to life or of serious harm to them. The police may act under a warrant or Court Order (e.g. a section 135 MHA 1983 warrant).

9.2 Officers and staff are not medically qualified to assess or respond to those suffering from a mental health crisis. The presence of the police can sometimes have a negative impact for those who are living with mental ill health or recovering from crisis, especially when there is no policing reason for their involvement.

9.3 Welfare checks for mentally vulnerable individuals should, in most circumstances, be carried out by mental health professionals, and not police officers or staff.

9.4 For advice and support, staff and officers should consider making use of the NHS 111 mental health professionals' line.

9.5 Requests for attendance at pre-planned section 135 MHA warrants should usually be directed to the following form on the Force website: Request police help with a Mental Health Act Assessment | Norfolk Constabulary or via Single Online Home Live Chat. If it is an emergency, then partners should ring 999.

9.6 Should an assessment be thought necessary under the MHA 1983, then the expectation will be that a section 135 MHA 1983 warrant will have been obtained by the mental health professional in the first instance, or an explanation as to why this is not appropriate or possible. A section 135 MHA 1983 warrant provides police the necessary powers to act lawfully and safely in the interest of all those involved in securing entry to private premises where the patient would not otherwise cooperate. Obtaining these warrants, as well as logistics and transport remains the responsibility of the Approved Mental Health Professional (AMHP) for a warrant obtained under section 135(1) of the MHA 1983 or the care team or relevant ward for a warrant obtained under section 135(2) of the MHA 1983.

10. Welfare Checks: Alarm Monitoring Companies

10.1 The police might be contacted by alarm monitoring companies (e.g. a care alarm activation at a remotely monitored care home or flat) to request that a welfare check is undertaken. These requests should normally be signposted to care staff, next of kin contacts or the Ambulance Service (where there might be a medical need) unless there is a specific identified

need for police attendance (e.g., crime in progress, core policing duty or real and immediate risk to life or of serious harm, significant harm to a child).

10.2 Refer to the Security Systems (Police Response to) policy. This details how CCR should respond to a request from an Alarm Monitoring Company, or request for service due to audible or visual alarms (including CCTV and Doorbell cameras).

11. Welfare Checks: Requests from DWP, Utility Companies, and Similar Agencies and the Report Fraud exception

11.1 In July 2025 the NPCC issued guidance to police forces relating to reports from DWP, utility companies and similar agencies that their customers are missing because of suicidal or self-harm concerns.

11.2 In responding to these calls the NPCC proposes that the police consider the following:

i) Has the reporting agency checked the home address and conducted reasonable enquiries to confirm the person is missing from home? If yes, the police should deal under the missing person policy. If not, the reporting agency should check the home address and conduct reasonable enquiries or contact mental health services to report their concerns.

ii) If a medical or mental health emergency the ambulance service should be contacted by the reporting agency.

11.3 The police will respond to a request for service when there is a legal duty to act or the circumstances giving rise to the request engages one of the core policing duties (see 3.4 and 4.1 – 4.11).

11.4 **Exception:** Where a concern for welfare is submitted by **Report Fraud** (formerly Action Fraud), it must be accepted without challenge. Report Fraud do not have the capacity or resources to make further enquiries and should not be asked to so do. The Constabulary retains responsibility for determining the appropriate response and applying the threshold test for intervention (See 5.1). The call handler must:

i) record the information on CAD

ii) provide the CAD reference number to the informant

iii) refer the matter to a supervisor to review

12. Joint visits

12.1 On occasion it may be considered appropriate for the police to accompany another agency to conduct a welfare or other health check, but this will need to be assessed on a case-by-case basis. It is for the requesting agency to provide the relevant information/intelligence to support the need for the presence of the police although consideration should be given as to whether there might be relevant information on police systems. Where police will not attend, the requesting agency will be updated accordingly

and as soon as practicable. The rationale for the decision should be recorded on a CAD.

13. Requests from the Ambulance Service and Hospitals

13.1 Where the Ambulance Service request assistance with entry to a property, these will be redirected to Norfolk Fire and Rescue Service (NFRS) in accordance with the NFRS and Ambulance Memorandum of Understanding (MOU) unless the request engages one of the core policing duties. NFRS have powers of entry regarding life at risk.

13.2 Walk outs, absconders and requests for transportation are considered below. All other requests from the Ambulance Service and/or healthcare providers should be dealt with according to the flowchart in Appendix B and with reference to THRIVE risk assessment.

14. Walk-outs from healthcare settings

14.1 The police might receive reports of persons walking out of a hospital emergency department, GP Surgery, Mental Health establishments as well as any other NHS facility where a patient may have attended for treatment, whether medical or psychological. The police do not generally owe a duty of care to return people in this situation unless there is an immediate risk to life or of serious harm.

14.2 The police do not have the power to bring patients back to a health care facility against their will unless they are under arrest (i.e. have committed a crime) or have been placed under a relevant section for treatment that conveys a power to return.

14.3 It should be assumed that a patient has capacity to leave a health care facility unless proven otherwise. Staff and officers should obtain information of a patient's likely state of mental capacity from the caller, when a subject is being reported as leaving a site. Mental capacity is decision specific. The healthcare provider should be asked in respect of what decision the patient lacks capacity. Information from the health care facility is key to any assessment.

14.4 Health facilities have a duty of care under common law and generally these duties do not end when a patient leaves the care of a hospital or other health facility unexpectedly.

14.5 All Emergency Department (ED) doctors should understand the Mental Capacity Act 2005 (MCA) and be trained to assess a patient's capacity.

14.6 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.

14.7 Under Article 2 ECHR, the hospital and the police have a duty to protect individuals from a specific threat to their life. Consequently, where there is

a real and immediate risk to life both agencies have a duty to locate the missing patient.

14.8 Under Article 3 ECHR, the hospital and the police have a duty to protect a person from torture, inhuman or degrading treatment or punishment. Consequently, where a patient is likely to suffer a prolonged period of exacerbated pain or distress, both agencies have a duty to search for the missing person.

15. Prevention of Absconding – Emergency Departments – Role of Partners

15.1 Practical steps which may be possible after identifying a patient who has a high risk of absconding include:

i) Placing the patient in a location which facilitates observation.

ii) Prioritising early clinical assessment if they are a potential risk to themselves.

iii) Perform a capacity assessment; does this patient at this time have the capacity to decide to leave the ED without being seen? Be aware that the patient's capacity to decide this may fluctuate. See Royal College of Emergency Medicine (RCEM) guidance on the Mental Capacity Act (MCA).

iv) Allocating a member of staff to observe the patient and try to engage with them (this may or may not include security staff).

15.2 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' policy.

15.3 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 absconding.

15.4 Security staff can only be asked to restrain or forcibly bring a patient back to the 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.

16. Partnership Approach

16.1 When there is critical concern for someone's safety, they should always be reported missing to the police immediately and the reason for concern should be thoroughly explained to enable an appropriate level of response.

16.2 Where the concern for someone's safety is not critical, the professionals in contact with any person who is not where they are supposed or expected to be should make initial inquiries to ascertain their whereabouts. These procedures will need to be detailed and agreed locally but should include:

- Checking the person's care plan or other relevant information
- Calling the person's mobile phone as well as any other contact numbers
- Contacting appropriate next of kin
- Searching the immediate area
- Informing other staff members
- Speaking to other patients or service users to establish any recent events that may be relevant
- Check CCTV recordings to check for possible sightings or signs that they have left the premises
- Recording the actions that have been taken, people who have been spoken to, and the rationale for any decisions about risk and when to escalate to another agency or not
- Checking the person's home address if appropriate

16.3 If appropriate, the missing person's next of kin or other family members should be informed of the incident. Staff should listen to any concerns from them about their loved one as this may help to inform the risk assessment. From this point onwards they should be kept updated and involved with the investigation where possible.

16.4 If the person cannot be found the incident should be reported to the police if there is now critical concern for their safety, if they are detained under the Mental Health Act, or if the person has not returned home and there is concern that they will either not return or suffer serious harm while away.

17. AWOL (Absent Without Leave) Sectioned Patients

17.1 Individuals might be reported to police as AWOL. An individual is AWOL if they are a sectioned patient and they either:

i) escape from a hospital, or

ii) fail to return from authorised leave, or

iii) breach the conditions of their leave or

iv) fail to return to hospital after a Community Treatment Order (CTO) has been revoked

17.2 In these circumstances, police powers exist to detain and return the individual to the hospital facility under section 18 of the MHA 1983, however this power does not include a power of entry. A warrant obtained under section 135(2) of the MHA 1983 would be required under these

circumstances. If access is not an issue, as someone with authority has provided consent to access to the property lawfully, a warrant under section 135(2) of the MHA 1983 would not be required as the power under section 18 of the MHA 1983 could be exercised.

17.3 The police do not generally owe a duty of care to an AWOL individual unless there is a real and immediate risk to life or of serious harm. The relevant hospital retains the legal responsibility to return an AWOL patient. All staff authorised by the mental health hospital establishment to return a patient back to the hospital have the same powers as the police under section 18 of the Mental Health Act 1983. This includes:

- Any Approved Mental Health Professional (AMHP)
- Any officer on the staff of the hospital
- Any person authorised in writing by the responsible clinician or the managers of the hospital

17.4 Mental Health services must tell the police if an AWOL patient is one of the following:

1. Dangerous
2. Especially Vulnerable (not just vulnerable)
3. Subject to Part III of the MHA (placed in hospital by the courts)

17.5 The policing response will be dependent upon the degree of risk posed, by the assessment above, and the enquiries already conducted by the staff responsible for them.

17.6 Part III of the MHA 1983 includes but not limited to:

- A hospital order (section 37 MHA 1983) and restriction order (section 41 MHA 1983) imposed by the Crown Court
- A hospital and limitation direction (section 45A MHA 1983) imposed by the Crown Court alongside a sentence of imprisonment
- A transfer from prison (sections 47/49 MHA 1983 for serving prisoners, sections 48/49 MHA 1983 for those on remand or civil or immigration detainees)

17.7 Particular care should be given to cases involving children. Consideration should be given to passing information to the local authority that the child has attended hospital but left before treatment. These circumstances may indicate issues at home.

17.8 If a patient has been given leave under section 17 MHA 1983 or has their Community Treatment Order revoked, the police will not provide assistance unless the following apply:

a) Following all reasonable enquiries and efforts by the hospital the patient cannot be found. In these circumstances the patient should be reported 'missing'.

b) The patient's whereabouts is known but they cannot be returned without the use of a warrant to gain entry to a premises (section 135 (2) MHA 1983). If the agency has obtained a warrant, the police will attend to assist them if the patient's refusal is current and live.

c) The patient is violent or aggressive towards hospital staff, and they are unable to retake them without police support.

18. Requests to transport to Hospital on behalf of the Ambulance Service

18.1 Requests might be made for the police to transport individuals to hospital on behalf of the Ambulance Service. The police are not equipped or trained to transport persons either in a mental health crisis or in need of emergency healthcare treatment to a hospital or other medical facility. The Ambulance Service is the appropriate agency to transport patients.

18.2 The Ambulance Service have in place clear and comprehensive procedures for the clinical assessment, treatment and support of a patient before and during transportation, and Ambulance staff have the skills, training and equipment to meet those procedures. Those procedures are in place because of the risks inherent in moving an injured or unwell patient. It is not the responsibility of the police to backfill gaps in the Ambulance Service. The police should only act where there is a real and immediate risk to life or of serious injury.

18.3 Officers **SHOULD NOT** routinely transport patients. If a patient is in need of transport, it is recommended that officers contact the Ambulance Service via 999 or 111 for triaging and where possible obtain their grading and expected local attendance time.

18.4 Those detained under the provisions of the MHA 1983 must be transported by the Ambulance Service rather than police vehicles unless exceptional circumstances apply (such as removing an individual from the immediate area of a dangerous environment such as a fast road, or excessive delays or where there is a critical medical need and it is in the patient's best interest and no other suitable resource is nearby to assist).

18.5 Prior authorisation from the CCR Inspector must be obtained before any agreement or commencement of patient transport. Retrospective authorisation should only be sought in exceptional circumstances where it was not practicable to obtain prior approval. In the event the CCR Inspector is unavailable, a CCR Supervisor may authorise; if both are unavailable, the Duty Inspector may authorise.

18.6 The CCR Inspector must document their consideration regarding the estimated local time of Ambulance arrival before making their decision. Note the local ambulance service is commissioned to attend within 30 minutes.

18.7 The CCR Inspector must record the reason for either authorising or refusing each request to transport by completing the dedicated STORM Call Script 'AMB – AUT' on CAD. There will be occasions that more than one transport decision is required on a single CAD.

18.8 If the patient has been triaged either at scene or on the phone by a medical clinician from the Ambulance Service or other suitably qualified healthcare professional and deemed suitable prior to transport by police the following details must be detailed on the CAD:

- Name of clinician triaging
- Ambulance CAD reference
- Time of decision being made
- The suitability of the patient to be transported by Police

18.9 If the patient is not deemed suitable to transport to hospital by police, the authority to transport should be refused.

18.10 Appropriate steps should be taken to ensure the safe transport of a transportee including by taking steps to reduce the risk a transportee poses to themselves. Any injury or harm caused during transportation should be reported to the end destination to enable appropriate medical interventions. Injuries must also be reported to the CCR Inspector who will consider if the injury amounts to 'Serious Injury' defined as any fracture, deep cut or lacerations or an injury causing damage to an internal organ or impairment of any bodily function. The organisation has a statutory obligation to review and where appropriate refer all Death and Serious Injury to the IOPC (as defined under section 12 Police Reform Act 2002).

18.11 Officers should ensure that if they transport to an Emergency Department (ED), a formal handover is completed with ED staff upon arrival to the hospital to include any transference of risks. For a section 136 MHA 1983 detention, a Detention Monitoring and Joint Risk Assessment Handover Form should be completed and officers should remain. For voluntary attenders for mental health reasons, a Voluntary Mental Health Attendance at Hospital (person accompanied by Police) form should be completed and signed by the ED Floor Coordinator. Both forms can be obtained from the reception desk in ED and copies should be uploaded onto the corresponding API. Handovers should be recorded appropriately when leaving a person with someone else, such as a Mental Health Practitioner.

18.12 If the request is to transport a detained person from one of the Police Investigation Centres, then the same above process should be followed. The Ambulance service remain the most suitable and best trained resource to transport a person in medical need, even those with a mental health need to hospital.

19. Escalation Policy

19.1 In the event of a disagreement between the caller and police, the requesting person/agency in the first instance can ask to speak to the CCR supervisor. If an agreement is not reached the matter should be escalated to the CCR Inspector and then, if required, to the on-duty Cadre/Silver Commander. Contact should then be made with the requesting agency, communicating the rationale.

19.2 All appeals regardless of outcomes must be recorded on a CAD and tagged *#RCRPAppeals.* This is for audit and training purposes.

19.3 Partners and professionals will have the opportunity to escalate slower-time issues through the RCRP partnership boards co-ordinated by the police and the integrated care board which operate at both a strategic and an operational level. If the strategic level group identify issues that need national attention, this can be raised at the RCRP Tactical Board led by the National Police Chief's Council RCRP Lead.

19.4 In the event of a complaint, a CCR supervisor should review in the first instance and where possible resolve dissatisfaction; Say Sorry, Fix it. Formal complaints should be reviewed in line with the standards of Professional behaviour and investigated proportionately, informing PSD as appropriate.

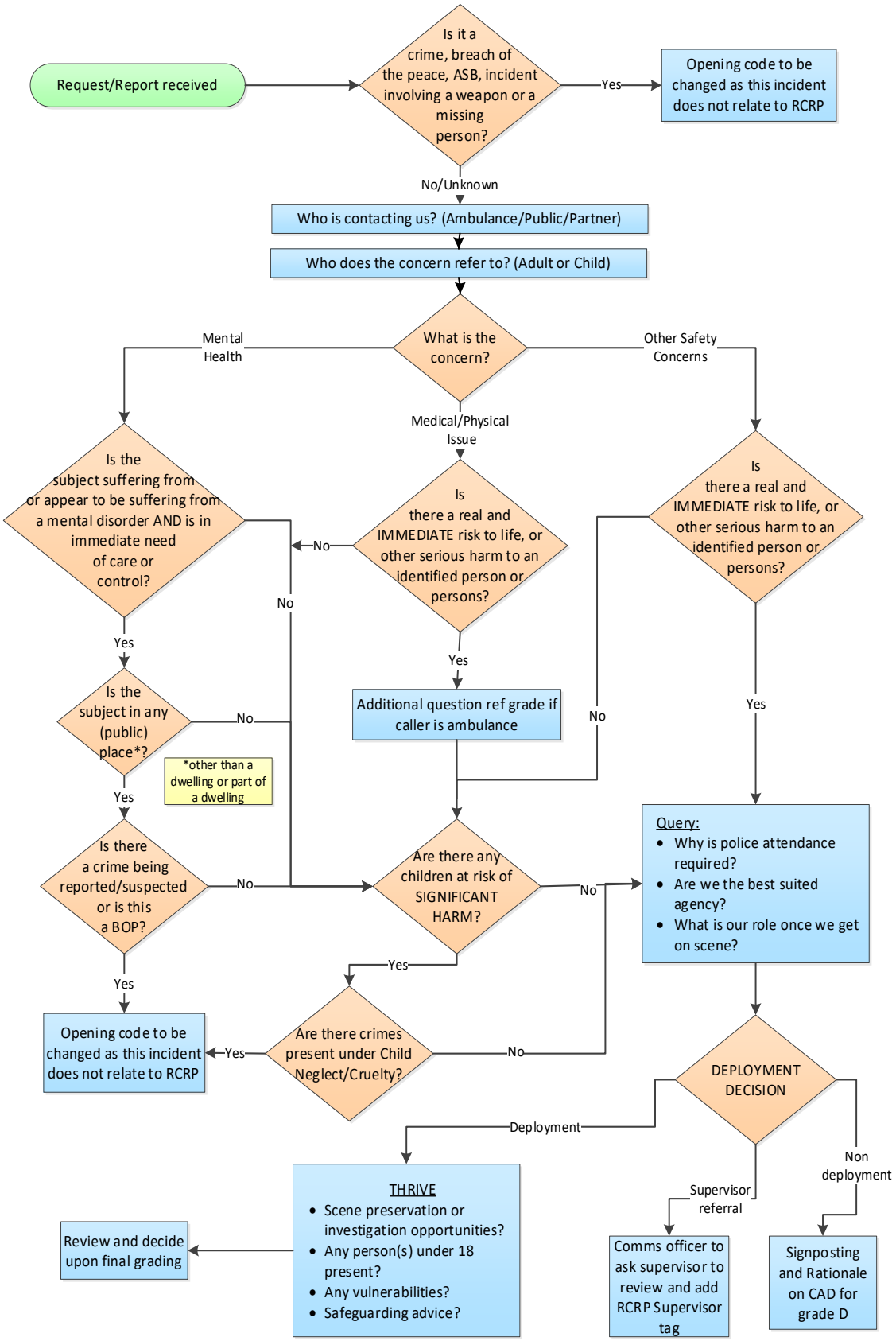
Appendix A – Factors for consideration when assessing whether a section 17(1)(e) PACE entry is necessary.

This might include, but is not restricted to:

- Speaking with occupants or nearby neighbours.
- Contacting known family members or associates.
- Checking security of premises and signs of disturbance/sounds of distress.
- Checking with local hospitals/ambulance service for recent admissions.
- Observation through apertures.
- Presence of vehicles used or owned.
- Using known telephone numbers or other means of contact.
- Checking recent use of social media.
- Checking for signs of, or lack of, activity (e.g., mail or deliveries left on display, checking of bins, signs of infestation/smells etc.).
- Checking any information on subjects' disabilities that may frustrate ability to contact and communication with subject.
- Consideration of any views known or expressed previously by the individual themselves.

If the decision is to not utilise the power under section 17 (1)(e), the officer should consult with their supervisor. Decisions should be documented on logs in line with NDM.

Appendix B – Flowchart for requests



Appendix C – THRIVE

What THREAT has been identified? To Who / What?
TO PERSON – Violence with weapons
TO PERSON – Violence without weapons
TO PERSON – Verbal threats/Stalking/Harassment/Electronic Communications
TO PERSON – Through Personal Circumstances/Vulnerability/RTC/Health–refer to RCRP
TO PROPERTY – Damage/Loss/Environmental
COMMUNITY TENSION / CONFIDENCE IN POLICING / BOP / PUBLIC DISORDER
OTHER – Advice, Intel Report, Organised Events, Lawful Protest
NO T/H/R

If the Threat has been carried out, how serious could the outcomes be?
HIGH
Threat to Life/Life changing injuries (Homicide/Suicide/T2K/Rape/SSO/RTC)
Very high value/widespread loss or damage to property/environment (relative to the callers circumstances)
MEDIUM > HIGH
Serious Physical/mental injuries that require medical treatment but from which recovery will be prolonged (GBH/Self-harm/ TTK/Serious Sexual Offence/RTC)
High value/widespread loss or damage to property/environment (relative to the callers circumstances)
MEDIUM > LOW
Physical/mental injuries that require medical treatment but from which a full recovery is likely
Mid-value/localised loss or damage to property/environment (relative to the callers circumstances)
LOW > None
Minor/temporary physical/mental injuries that don't require medical treatment
Low/no value loss or damage to property/environment (relative to the callers circumstances)

What is the Immediacy of the Threat occurring?
HIGH - Almost Certain/Ongoing/Crime in Action (likely Grade A Response)
MEDIUM > HIGH - the incident has recently occurred and/or the likelihood of the incident occurring is reducing but could escalate without notice, or Golden Hour Principles apply (likely Grade B1 Response)
MEDIUM > LOW - the incident has occurred or the likelihood of the offence taking place is reducing and unlikely to escalate without notice (likely Grade B2/C/Diary/ non-attendance/ advice / signposting)
LOW > No - the incident has occurred and/or it is possible but unlikely that the incident will occur (likely Grade B2/C/ Diary/ non attendance / advice / signposting)

Is there an opportunity for a Police Investigation?
Known Offender / Suspect / CCTV / Crimes in Progress or Recently Discovered / Golden Hour Principles
Identifiable Property / Injury Level / Forensic Evidence / Repeat Victim / Series of Similar Offences- is there a crime series or potential pre cursor to crime?
Not Applicable

Is the victim a **REPEAT VICTIM** within the last 12 months?
Consider previous calls and any incidents not already reported

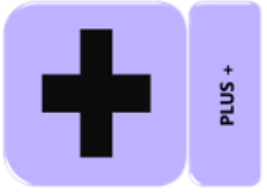
"A person is vulnerable if as a result of their situation or circumstances they are unable to take care of or protect themselves or others from harm or exploitation"

Repeat Victimisation / Coercion and Control / Personal or Family Circumstances / Health & Disability
Discrimination factors / Economic Circumstances
Not Applicable

Consider Vulnerability of the person reporting in addition to any other parties involved

Manage caller's expectations. If signposting, detail which department or agency most suitable to deal.

Signposted / Another Agency /Another Police Department
Hard to reach group
Self-Service / Website
Police Deployment Required
Not Applicable



What additional support / advice has been provided?

Crime Prevention Advice
Preservation of Evidence
Escalation – do you need to escalate to Oscar 1/2/3/4 or Duty Sgt
Not Applicable