

Protecting
your NHS



Memorandum of Understanding
between the
Association of Chief
Police Officers (ACPO)
and the
NHS Security Management Service



NHS

Security Management Service

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1. STATEMENT OF INTENT

- 1.1 This document records a shared understanding of the common interest between the NHS Security Management Service (NHS SMS) and the Association of Chief Police Officers (ACPO) in prevention, detection and investigation work and application of sanctions in respect of security matters within the NHS.
- 1.2 It provides a framework for the exchange of information to achieve this and is intended to facilitate good working relationships between all parties and develop clear lines of communication. It establishes guidelines to:
- *facilitate effective lines of communication by promoting clear understanding of the NHS SMS and police responsibilities, working procedures and respective legal constraints*
 - *assist the police and the NHS Local Security Management Specialist to cooperate at an operational level*
 - *facilitate effective exchange of information, investigation of offences and joint working practices with the objective of maximising the prevention and detection opportunities for all forms of crime against NHS staff and property.*
- 1.3 This Memorandum of Understanding (MoU) does not cover fraud work as it is not part of the NHS SMS remit. There is a separate MoU between ACPO and the NHS Counter Fraud Service for that work.

2. INTRODUCTION

- 2.1 It is recognised that assaults on NHS staff are unacceptable. Lord Irvine, in an address to magistrates, stated that:
- “The criminal justice system needs to act as an effective deterrent for those who might consider attacking NHS staff.”*
- 2.2 Theft of and damage to NHS property is also unacceptable; every occasion when this occurs involves financial loss to the NHS, diverting funds from their intended purpose of patient care and impacting on the ability of health bodies to provide healthcare services.
- 2.3 The NHS SMS fully supports the work of the police in tackling offences in relation to the illegal use and supply of controlled drugs and will work with the police to address illegal use of drugs where this impacts on healthcare delivery.

- 2.4 In an organisation which is the largest employer in Europe, the development of a proactive working relationship with the police in relation to security matters is essential.

3. **BACKGROUND**

- 3.1 In December 2003, the Secretary of State for Health launched a new strategy for security management work in the NHS, developed by the NHS SMS – a body with policy and operational responsibility for the management of security in the NHS (*Statutory Instrument 3039/2002*) and a remit defined as ‘protecting people and property so that the highest standards of clinical care can be made available for patients’ (www.cfsms.nhs.uk).

- 3.2 The aim of the NHS SMS is to ‘protect the NHS so that it can better protect the public’s health’ (*A Professional Approach to Managing Security in the NHS*, NHS CFSMS, 2003).

- 3.3 The current priority areas of action for the NHS SMS are:

- **tackling violence against staff and professionals working in the NHS**
- **ensuring the security of property and assets**
- **ensuring the security of drugs, prescription forms and hazardous materials**
- **ensuring the security of maternity and paediatric wards.**

- 3.4 In addition to the four main strands, the NHS SMS strategy is to work both proactively and reactively to tackle security management issues across the NHS through a range of generic actions:

1. Creating a **pro-security culture**
2. **Deterring** those who may be minded to breach security
3. **Preventing** security incidents or breaches from occurring
4. **Detecting** security incidents or breaches
5. **Investigating** security incidents or breaches
6. Applying **sanctions** against those responsible for security incidents or breaches
7. Seeking **redress** through criminal and civil justice systems from those responsible for security incidents or breaches.

- 3.5 The remit of the NHS SMS is primarily to protect NHS staff and resources and does not extend to cover service-users (patients). However, the NHS SMS accepts that the NHS has a duty of care towards persons using NHS services and property, particularly if they are young or vulnerable service-users (patients).

- 3.6 The NHS SMS Legal Protection Unit (LPU) provides legal services and support in relation to security matters. The LPU is directed, by legislation, to work with healthcare bodies, the police and the Crown Prosecution Service (CPS) to increase the rate of prosecutions and to provide cost-effective advice on available sanctions against individuals who are violent or verbally abusive towards NHS staff and professionals. In order for the LPU to comply with its legal obligations, it will be necessary for it to cooperate closely with the police.

4. NHS LOCAL SECURITY MANAGEMENT SPECIALIST

- 4.1 A key part of the NHS SMS strategy is the requirement for a Security Management Director (SMD) and a Local Security Management Specialist (LSMS) within each health body. The responsibility of the SMD is to promote and lead on security matters at board level.
- 4.2 The role of the LSMS is to ensure that security management work is delivered locally, but to consistent high standards across the NHS, defined within a national legal framework. It is also to provide professional skills and expertise in four main strands of security management work. All health bodies are required to nominate an LSMS who will undertake training with the NHS SMS. The LSMS will only take up post when they have successfully passed the NHS SMS propriety-checking process and successfully completed the Accredited Security Management Specialist training course, which is accredited by the University of Portsmouth.
- 4.3 The network of LSMSs across the NHS will provide a channel for exchanging information and ensuring that knowledge and expertise is shared for the benefit of the NHS. The NHS SMS will facilitate this dialogue and continue to work towards improved standards and consistency across the NHS. The LSMS will be supported by the NHS SMS and particularly by the Area Security Management Specialists (ASMSs) to ensure that consistent, professional and comprehensive operational support is provided on a regional basis.
- 4.4 The ASMSs are employed by the NHS SMS and their primary function is to support the LSMS and SMD in the delivery of the NHS SMS strategy and compliance with Secretary of State Directions through the implementation of policy and guidance supplied by the NHS SMS.

4.5 The NHS SMS has policy and operational responsibility for all NHS health bodies in England. This remit covers all health bodies that provide or deliver services for the NHS, including:

- *Acute Trusts*
- *Mental Health and Learning Disability Trusts*
- *Ambulance Trusts*
- *Primary Care Trusts*
- *GP practices*
- *community pharmacies*
- *NHS dental surgeries*
- *NHS optical services*
- *NHS walk-in centres*
- *NHS out-of-hours facilities.*

5. LSMS/POLICE CONTACT POINTS/LIAISON

5.1 ACPO will ensure that all police forces in England designate a divisional/area single point of contact (SPOC) at strategic, divisional and operational level to facilitate good working relationships with NHS health bodies in their force area. At a strategic level, this would normally be the ACPO officer with responsibility for operational matters. On a more local basis, the Commander at Division, Operational Command Unit (OCU) or Basic Command Unit (BCU) will be the point of contact with the individual health body. (This contact will be referred to throughout this document as the local commander.)

5.2 The LSMS will be the first liaison point and, in principle, the SPOC or lead at an operational police level in matters of security at a health body, both day-to-day and post-incident.

5.3 An appropriate designated police officer should be invited to attend security meetings within the health body.

5.4 The SMD or the designated LSMS will be the SPOC within the health body at a commander level, when dealing with security matters.

5.5 Regular liaison through the nominated routes will:

- *provide a consistent approach*
- *encourage liaison*
- *maintain effective contact in specific cases*
- *allow for advice or guidance to be given in relation to specific cases*
- *enable discussions about the levels of involvement of the organisations involved*
- *provide an avenue for the provision of mutual NHS and police expertise and access to appropriate channels of information*

- *enable the NHS SMS to be kept informed of progress of cases being investigated by the police*
- *ensure that a national standard approach is adhered to*
- *develop the concept of mutual support in tackling crime within the NHS.*

6. POLICE/LSMS RESPONSE TO INCIDENTS

- 6.1 It is recognised that each police force follows its own procedures for incident grading and response. Police forces should ensure that an appropriate response is given to NHS health bodies, taking account of the information provided, and share with the health body the local force policy on incident grading. The police should take account of the clinical condition of an assailant in making any decision to arrest.
- 6.1.1 **Incidents of violence** – to be treated as a priority where appropriate. Offenders should not be considered eligible for a caution at the scene of the incident. Particular priority should be given to cases where an assailant has been detained.
- 6.1.2 **Theft of or damage to NHS property and assets** – standard response expected in line with force incident grading procedure.
- 6.1.3 **Drug/alcohol-related incidents** – an appropriate response in line with the force policy (also see section 21).
- 6.1.4 **Paediatric and maternity** – incidents of infant abduction and issues of child protection to be treated as a priority. Health bodies with maternity units are required to carry out abduction drills, assessing and documenting results. It is recommended that abduction drills are conducted in close liaison with the local police force(s).
- 6.2 The LSMS will ensure that all crime that affects the health body, its staff or those service-users (patients) for whom they have a duty of care, or that is committed on health body premises and brought to their attention, is reported to the police.
- 6.3 The LSMS and police will liaise and share information on crime and crime-reporting where it relates to NHS staff or property.
- 6.4 The police will respond where possible to non-criminal security breaches e.g. trespass at a health body premises. It is recognised that the police have no powers to deal with these issues and that a response to such calls may be a low priority.

7. LEGAL ISSUES

- 7.1 The legal frameworks for sharing information for the purpose of criminal investigation are shown at Appendix 1.
- 7.2 The Crime and Disorder Act places responsibilities on some health bodies to participate in crime and disorder reduction partnerships. The LSMS should be invited to attend community partnership working groups which relate to tackling violence and crime reduction in the area in which the health body is located.
- 7.3 Secretary of State Directions are secondary legislation and provide authority for the NHS SMS to issue guidance and policy for all health bodies in matters relating to security and tackling violence.
(Secretary of State Directions can be found at www.cfsms.nhs.uk.)
- 7.4 Responsibilities under Section 136 of the Mental Health Act 1983 define and agree a place of safety for persons detained under this Act. All health bodies and police forces should negotiate and develop appropriate local policy to meet the requirements of this legislation, including the designated place of safety.
- 7.5 There is a legal requirement for the police to be involved in an order to execute a Section 135 warrant under the Mental Health Act 1983. The request for police assistance is the responsibility of the Approved Social Worker (ASW) and will be based on risk assessment. If a patient under section of the Mental Health Act 1983 is missing and found to be staying at other premises and is refusing to return to the ward, it is the responsibility of the hospital to obtain a Section 135(2) warrant, which will enable the patient to be taken from the premises (using proportionate force if necessary) and returned to the ward. Local policies must indicate the procedure for sharing risk-related information in order to obtain police assistance.

8. INVESTIGATION

- 8.1 It is the responsibility of the police to investigate criminal activity within the community; however, the new role of the LSMS, in addition to leading on and managing all security-related work in their health body, will be to provide support as required to the police during investigations which involve crime in an NHS healthcare setting.
- 8.2 Accredited LSMSs are trained investigators. Part of their role is to pursue investigations into security-related matters and incidents involving violence against NHS staff. This includes pursuing a range of sanctions against offenders – in particular, where the incident could be considered low-level crime, such as common assault. Where the police do not undertake a criminal investigation for whatever reason and an accredited LSMS is in post and they can progress an

investigation into a criminal matter, this should be with the full knowledge and support of the SMD and the local police force. It is the intention that, where an accredited LSMS is in post, they will investigate all cases of assault on staff up to Actual Bodily Harm, where the police have not already arrested or charged a person(s) for relevant offences connected to that incident.

- 8.3 The LSMS will undertake, manage or oversee investigation work on behalf of the NHS health body in relation to security matters including violence against NHS staff. They will act as a liaison point with the local police to ensure that all such incidents can be properly investigated, that evidence is provided to support the identification and prosecution of offenders and that the recurrence of incidents is prevented.
- 8.4 Where the LSMS investigation uncovers a criminal matter, it is recognised that policing priorities may impact on the ability of the local police force to progress such an investigation. The LSMS, with the support of the NHS SMS, will progress these investigations where they consider it necessary, with the full knowledge of the police.
- 8.5 All criminal investigations undertaken by the LSMS will be carried out in compliance with the Police and Criminal Evidence Act 1984 (PACE), the Criminal Procedure and Investigations Act 1996, the Regulation of Investigatory Powers Act 2000 (RIPA), Secretary of State Directions and all relevant Codes of Practice and in recognition of the overriding considerations of the European Convention on Human Rights (ECHR).
- 8.6 Where appropriate, the NHS SMS Legal Protection Unit (LPU) will support investigations conducted by LSMSs and provide legal guidance during the process where the SMD has authorised the investigation.
- 8.7 Where investigation of criminal offences may impact upon NHS service delivery, patient care will always be a factor in deciding on appropriate action and should be balanced with the needs of the investigation. Where an investigation requires the seizure of NHS property or the non-use of an area of NHS property, liaison must take place between the SMD or LSMS and the commander of the local policing area to ensure that patient care is the priority and that evidence is protected and preserved wherever possible.
- 8.8 LSMSs have been trained and have received guidance on protecting a scene of crime and, when available, will be responsible for assisting with this process as required.
- 8.9 The NHS SMS and NHS health body will always consider each case on its merits in relation to sanctions. The NHS will not necessarily wait for the outcome of criminal or civil proceedings before taking

disciplinary action in cases where this action will protect NHS staff and property. Care will always be taken, when undertaking parallel sanctions, not to compromise any criminal investigation.

9. PROSECUTION POLICY

- 9.1 It is the responsibility of the police to investigate suspected or alleged criminal offences and it is the responsibility of the CPS to deal with prosecution of offenders on behalf of the crown. Where action is not taken by the police, the NHS SMS may pursue a case, as the policy of the NHS SMS is to consider prosecution in all cases of violence against NHS staff. Where sufficient evidence exists to pursue prosecution, it is the intention of the NHS SMS to support the police in progressing these cases or to undertake private criminal prosecutions.
- 9.2 The police will progress all cases of violence against NHS staff and will not formally caution assailants without obtaining the views of the victim as laid down in the code for crown prosecutors and Home Office circular 30/2005.
- 9.3 Violence against NHS staff is unacceptable and, when this occurs whilst staff are undertaking their duties, it should be considered an aggravating factor to the offence as laid down by the code for crown prosecutors. Aggravating factors include, for example, offences committed:
- *on hospital/medical premises*
 - *when the victim is serving the public.*

For sentencing purposes, it is essential that the case officer, whether that is a police officer or an LSMS, includes in the case summary the fact that the NHS member of staff was on duty or that the incident was linked to their role within the NHS. The impact of the offence on the resources available for the delivery of NHS care – such as the need for replacement staff because someone has been injured, or cancelled treatments resulting from an assault, theft or criminal damage – should also be recorded in the case summary. Where such information is available, claims for compensation should be made to the court to help demonstrate the financial costs of such criminal activity.

- 9.4 Professional responsibilities and/or the clinical needs of a service-user (patient) may require that continued contact between the service-user (patient) and member of NHS staff is unavoidable during the investigation process. In such circumstances, the case officer must ensure that the reasons for continued contact are clearly highlighted in the case summary. If, at any point, it is considered that continued contact will affect the prosecution process, the NHS health body must

be promptly notified by the investigating officer and appropriate action taken by the clinical team.

- 9.5 In addition to investigating offences of violence, it is the responsibility of the police and the policy of the NHS SMS to pursue prosecution for other criminal offences, e.g. theft, burglary, damage and arson relating to NHS property, with a view to instigating sanctions and seeking redress. In appropriate circumstances, where the police are unable to progress such investigations, the LSMS may undertake the investigation, subject to legal advice from the LPU.

10. REFERRAL OF CASES TO THE POLICE

- 10.1 Where cases are progressed by the LSMS, early contact should be made with the police if police involvement is likely (e.g. powers of arrest or search are needed). If there is sufficient evidence to substantiate a criminal allegation, this should be presented to the police for progression to arrest, charge or summons. The referral should be made in the form of an evidential package containing appropriate Manual of Guidance (MG) forms. The evidential package should generally contain the following:

- *a chronological summary of the allegations*
- *full name(s) and personal details (where known)*
- *all available details of any other parties suspected of involvement in the alleged offences, including reasons for those suspicions.*

It should also contain full details of investigations already undertaken:

- *full details of all witnesses*
- *copies of all witness statements*
- *copies of all documentary exhibits and lists*
- *a schedule of all other relevant information*
- *the name and contact details of the LSMS with responsibility for the case*
- *the name and details of the LPU contact dealing with the case.*

The handover of investigation material should always be to the SPOC at a senior local commander level within the local police force and agreements on the process of handover in such cases should be made at a local policing level.

- 10.2 Original documentation will be provided to the police on acceptance of a case for investigation/progression. The NHS health body will retain a copy file.
- 10.3 Where appropriate, the information will be supplied on official MG series forms.

- 10.4 Where the NHS SMS has reason to proceed with a case that is not being progressed by the police, the police will return all original case files, papers and exhibits to the NHS health body.
- 10.5 Where a police investigation is not taken forward for prosecution, the LPU will review the case and may progress it through private criminal or civil proceedings, in conjunction with the NHS health body. In these circumstances, the LPU will need to review all the case papers in order for an appropriate decision to be made. There may be occasions when certain relevant case papers, statements and other materials are in the possession of the police or the CPS; a request by the LPU or NHS health body will be required for the release of those items. The police will deal with any requests for case papers, statements and other materials promptly and in line with statutory and common law privacy legislation and current guidance.
- 10.6 In most cases progressed by the LPU, consent will have been obtained for the release of a statement and exhibits referred to in it. Where this is not the case, the police should do the following when dealing with the third party disclosure:
- *contact the witness, explaining that their statement has been requested**
 - *ask the witness if they have any objections to the third party disclosure*
 - *provide the third party with the witness's address and details, provided that the witness has no objections to these details being provided and wishes to communicate with the third party*
 - *advise a witness who refuses to consent to the disclosure of a witness statement or address that their refusal may in certain circumstances be overruled, if disclosure is required in the interests of justice (this should be done with appropriate legal advice)*
 - *exercise discretion as to whether or not to disclose the statement if the witness cannot be traced or contacted.*
- *Where it is not appropriate for the police to contact the witness directly, the party seeking disclosure should be invited to send a letter to the witness via the police, who can then forward this to the witness with accompanying CPS advice where necessary.
- 10.7 If an offender has been cautioned by the police, the LPU may still require access to the relevant cautioning documents/information (e.g. name/address of the offender) when reviewing a case to determine whether or not to consider other sanctions against an individual, e.g. civil action. In such circumstances, the relevant documents should be disclosed to the LPU so that a proper review of the case can take place.

10.8 If a member of NHS staff suffers injuries as a result of a violent crime, they may wish to pursue legal action to claim compensation. Under Section 33(2) of the Supreme Court Act 1981, a potential plaintiff in an action in respect of personal injuries or an actual plaintiff in such a case (Section 34) may apply for the disclosure of any document 'relevant to an issue arising or likely to arise out of the claim'. These provisions have now been incorporated into the Civil Procedural Rules. Where a request for the supply of witness statements and other relevant documents (e.g. formal cautions) in respect of criminal proceedings has been made, to which Sections 33–35 of the Supreme Court Act apply, such requests should be complied with by the police unless there is reason to believe that disclosure would be injurious to the public interest.

11. PROVISION OF STATEMENTS OF EVIDENCE

11.1 The police will normally be responsible for obtaining statements of evidence in all criminal cases involving NHS staff and property, unless agreement is reached that the LSMS will obtain statements.

11.2 Where necessary, the accredited LSMS can help the officer in the case to obtain witness statements by arranging contact between the officer in the case and the relevant NHS member of staff.

11.3 LSMSs are trained in investigative interviewing and the taking of statements in accordance with PACE and PEACE standards. If required, in certain agreed circumstances, they can obtain witness statements from both NHS staff and service-users (patients) in support of a police criminal investigation, but only with agreement from the officer in the case.

11.4 Where the police are unable to progress a criminal investigation relating to offences involving NHS staff and property, the LSMS may conduct an investigation and obtain statements of evidence as required for that investigation and to support private criminal or civil proceedings undertaken by the LPU.

11.5 Where the police require statements from clinical staff in relation to a service-user (patient), the LSMS will help the officer in the case obtain those statements.

12. PROTOCOLS FOR EVIDENCE-GATHERING

- 12.1 Preservation of evidence at the scene of a crime will always be secondary to the preservation of life. Both the NHS staff and the police must undertake a cooperative approach to ensure that the requirements of both parties are met. Where the protection of a scene of serious crime is required and this has a serious impact on healthcare provision, the decision on how to progress should be made jointly between the local commander and the SMD or delegated person.
- 12.2 The LSMS will provide support and guidance to NHS staff on the requirements of protecting a scene of crime and will gather information for police in relation to who was present at the time of the offence, in order to help the officer in the case obtain witness statements.

13. EXCHANGE OF INFORMATION

- 13.1 All LSMSs are permitted to supply non-personal data and information to the police at the discretion of the SMD. The LSMS will ensure that all crime is reported to the police where it affects the health body, its staff or those service-users (patients) for whom they have a duty of care, or where it is committed on health body premises and brought to their attention.
- 13.2 Regular meetings between the police and health body should take place – the SMD and LSMS will meet on a regular basis with their counterparts in the local police force(s). The LSMS should meet with the local inspector and beat officer and the SMD should meet with the local commander. Meeting frequency and schedules should be agreed at local level.
- 13.3 Post-incident reviews should take place. The LSMS and the officer in the case should ensure that a post-incident review is conducted for all serious incidents involving the police. Procedures to facilitate this should be agreed at local level. Reviews should be conducted with a view to establishing good practice and identifying areas of failure in process or procedure.
- 13.4 Disclosure of urgent information should comply with legislation and should be facilitated where it is in the public interest.
- 13.5 It is recommended that crime statistics relating to health body premises are made available by the police for review at meetings between the health body and the police, to facilitate discussions about effective local strategies for tackling crime.

- 13.6 Protocols for any exchange of information should be agreed based on a formal written system, with the exception of emergency situations (see Appendix 1).

14. NOTIFICATION OF PROCEEDINGS

- 14.1 The police officer in the case will notify the LSMS of the progress and outcome of all investigations involving NHS staff or property.

15. COURT APPEARANCES

- 15.1 The LSMS will ensure that support is provided to NHS staff who are victims of or witnesses to a crime within their health body when a case is progressed to court. This support will be through personal contact, the individual's line manager, liaison with human resources, occupational health and welfare departments and victim and witness support services.

16. POWERS TO ARREST AND DETAIN

- 16.1 NHS staff have powers to make arrests under common law, Section 3 of the Criminal Law Act (1967) and Section 110 of the Serious and Organised Crime and Police Act 2005 and powers to detain under the Mental Health Act (1983) and the Mental Capacity Act (2005). All NHS staff should be advised not to exercise their citizens' power of arrest during the course of their normal business duties, with the exception of those staff specifically trained to do so, e.g. security officers.

17. POWERS TO RESTRAIN

17.1 The law

- 17.1.1 In all cases, the clinical needs of the service-user (patient) and others must be taken into account. Any forcible intervention must be considered absolutely necessary on the basis of risk assessment and must be proportionate to the perceived or actual harm likely to result if no such intervention is made.

- 17.1.2 NHS staff have a duty of care to protect the public and a responsibility under health and safety legislation to maintain a safe environment. The Human Rights Act (Article 2:1) indicates a positive obligation to preserve life and Article 2:2 allows the use of no more force than is absolutely necessary. Section 3 of the Criminal Law Act 1967 and common law allow all citizens the right to use force that is reasonable to defend themselves or others or to prevent the recurrence of a crime. Restraint may be necessary in all such circumstances.

17.1.3 NHS staff must consider the best interests of the service-user (patient). Staff may be required to use the common law doctrine of necessity to prevent damage to property or harm to themselves, the service-user (patient) or others. The proportionate use of reasonable force may be required in such circumstances.

17.2 Mental health issues

17.2.1 NHS staff may be required to restrain a service-user (patient) under statutory authority, e.g. the Mental Health Act 1983, Mental Capacity Act 2005, Children's Act 1989, compulsory care or treatment orders – in such circumstances, the force used must be absolutely necessary and proportionate to the perceived or actual threat of harm to the service-user (patient), staff or others.

17.2.2 NHS staff must only use a forceful intervention if alternative action or inaction would result in a greater risk. Local joint working protocols must be in place to allow prompt police support when required.

17.2.3 The role of security personnel with regard to use of force must be clearly defined in local joint working protocols.

17.2.4 Police will not restrain service-users (patients) for the purpose of clinical intervention, e.g. enforced administration of medication. Police will attend and intervene to prevent a breach of the peace or to prevent a crime.

17.3 Use of incapacitant spray

17.3.1 In exceptional circumstances, incapacitant spray may be used on NHS premises. The decision to use incapacitant spray will be at the discretion of the officer, based on risk assessment.

17.3.2 Where it is necessary to use incapacitant spray on NHS premises, the police will ensure that guidance on decontamination is provided to all NHS staff affected. In the event of the use of an incapacitant spray, the officer should issue a clear verbal warning to persons in the vicinity to minimise the risk of contamination and the officer should guide NHS staff through the decontamination process.

17.3.3 Where an incapacitant spray has been used and the affected person is being transferred by ambulance, police must inform the ambulance staff and provide advice on decontamination procedures.

17.3.4 Where an incapacitant spray has been used and the affected person is being brought to NHS premises, advance warning should be given by the police to the receiving health body whenever possible.

17.4 Communication

- 17.4.1 When possible, notice should be given by the police that they are bringing an individual who is in police custody to an NHS health body for treatment. NHS staff should give consideration to the need for prompt treatment based on clinical need and risk assessment.
- 17.4.2 In the event that the person in police custody is handcuffed for security or personal safety reasons, handcuffs should only be removed with mutual consent of clinical staff and the escorting officer, based on clinical need and risk assessment.
- 17.4.3 Persons in police custody should not be routinely de-arrested in NHS premises. De-arrest should only be considered in consultation with the NHS staff if the person has a specific clinical need or is admitted as an in-patient, and the decision should be based on risk assessment.

17.5 Use of restraint devices

- 17.5.1 In exceptional circumstances, some NHS staff may use handcuffs or restraining belts to safely manage service-users (patients) or others when absolutely necessary. Locally-agreed protocols must be in place to closely monitor and manage such practices.

18. ENTRY AND SEARCH

- 18.1 NHS staff do not have powers to search people, property or premises in connection with alleged criminal offences without the permission of the individual or owner.
- 18.2 Warrants to search premises for evidence under relevant legislation can be issued by a magistrate or crown court judge where appropriate. A warrant authorises a police officer to enter specified premises and to search for and seize permitted articles as specified in the warrant.
- 18.3 Such a warrant may authorise specified persons to accompany any police officer who is executing it; these may include an LSMS or other NHS staff.
- 18.4 Section 18 of PACE provides a constable with the power to enter and search premises occupied or controlled by a person who is under arrest for an indictable offence, if they have reasonable grounds for suspecting that there are on the premises other items subject to legal privilege that relate –
 - a) to that offence, or
 - b) to some other indictable offence which is connected with or similar to that offence.

18.5 This power can only be exercised by a police officer who has been authorised in writing by a police inspector. No LSMS or NHS security staff can be authorised to enter with the police under this provision.

18.6 For searching within a mental health setting, please refer to Section 35 of this document.

19. MISSING PATIENTS

19.1 The police will respond to reports of missing patients in accordance with national ACPO guidance on the management and investigation of missing persons.

19.2 In the case of missing persons who are detained under the Mental Health Act 1983, the police will deal with these incidents in accordance with national ACPO guidance on the management and investigation of missing persons.

20. INFANT ABDUCTION FROM NHS PREMISES

20.1 Where there is any potential for an infant abduction from NHS premises, protocols in line with NHS national policies *Safe and Sound – Security in NHS Maternity Units* and *Safe and sound? A questioning framework for risk assessment in NHS maternity units* should be agreed between the health body and the local police and put in place to meet the needs of both parties.

21. HANDLING OF DRUGS

21.1 Certain authorised NHS staff, where required as part of their duties, have authority to be in possession of controlled drugs for the purposes of healthcare delivery.

21.2 Otherwise, in accordance with the Misuse of Drugs Act 1971, NHS staff have no authority to be in possession of controlled drugs except when:

- *knowing or suspecting it to be a controlled drug, they take possession of it for the purpose of preventing another from committing or continuing to commit an offence in connection with that drug and, as soon as possible after taking possession of it, take all such steps as are reasonably open to them to destroy the drug or to deliver it into the custody of a person lawfully entitled to take custody of it; or*

- *knowing or suspecting it to be a controlled drug, they take possession of it for the purpose of delivering it into the custody of a person lawfully entitled to take custody of it and, as soon as possible after taking possession of it, take all such steps as are reasonably open to them to deliver it into the custody of such a person.*

21.3 The local police force should enter into a local agreement with the NHS health body on action in relation to disposal of illegal drugs in line with legislation. A local policy should be developed with the police in relation to disposal in line with legislation. Where appropriate and through agreement, a police force may provide NHS health bodies with locked, securely fixed, tamper-proof drugs boxes to which only the police have keys.

21.4 NHS staff who take possession of controlled drugs in the course of their work must ensure that drugs are either handed to an on-duty police officer as soon as possible, or placed within the secure box without delay and the police notified immediately.

22. HAZARDOUS MATERIALS

22.1 Some health bodies handle hazardous materials. Within the context of this MoU, hazardous materials are those which have been specifically identified by the Home Office or ACPO as having the potential to be used by terrorists to manufacture improvised chemical, biological, radiological or nuclear devices to be used to attack the civil population.

22.2 The security of such materials is of high importance. Health bodies that possess these types of materials are required to take all reasonable steps to protect them from theft, loss and accidental or criminal damage. Health bodies that handle these materials have nominated safety officers within their specialist discipline, e.g. radiation safety officer or nominated person within microbiology laboratories.

22.3 All police forces have a Counter Terrorist Security Advisor (CTSA) who is qualified to give advice on security requirements concerning these hazardous materials. The CTSA should be the single point of contact for the police on such matters. The LSMS should be the single point of contact within health bodies.

- 22.4 Regular liaison between the nominated single points of contact will:
- *ensure that a national standard approach is adhered to*
 - *provide a consistent approach to adoption and improvement of security measures*
 - *provide an avenue for the provision of mutual NHS and police expertise and access to appropriate channels of information*
 - *maintain effective contact in specific cases where there has been a significant breach of security affecting hazardous materials.*

23. CRIME AND DISORDER PARTNERSHIPS

- 23.1 The police and all NHS health bodies should take a cooperative approach to initiatives in crime reduction by actively participating in crime and disorder partnerships.

24. PATIENTS ADMITTED TO HOSPITAL WHERE A POLICE PRESENCE IS REQUIRED

- 24.1 In cases where a patient who is in custody or requires police protection is admitted as an in-patient, there should be prior consultation between the health body and the senior police officer and action agreed in line with the risk assessment. A joint formal risk assessment by the healthcare body and the police should be carried out in such circumstances, to determine if police protection and/or other security measures are required.

25. INTELLIGENCE-SHARING

- 25.1 It is recommended that the LSMS and the local beat officer share intelligence in accordance with agreed protocols and guidance. This should not contravene any other legislation which prohibits data-sharing between police forces and the NHS.

26. POLICE INVOLVEMENT IN VIOLENT PATIENT SCHEMES

- 26.1 The police may become involved, in consultation with their local health body, in supporting the delivery of violent patient schemes and in the sharing of information in line with legislation relating to violent patient registers.

27. PROVISION OF TRAINING FOR POLICE OFFICERS

- 27.1 The NHS SMS will offer presentations and awareness sessions for senior officers and local officers on the work of the NHS SMS.
- 27.2 Where possible, the police will introduce the work of the NHS SMS and the role of the LSMS and SMD to their officers through crime and disorder inputs in foundation training and through local force training initiatives.

28. USE OF FIREARMS ON NHS PREMISES

- 28.1 The response to any firearms incident on NHS premises will accord with the ACPO manual of guidance on police use of firearms.

29. MEDIA ISSUES AND RESPONSIBILITIES

- 29.1 Where investigations that involve NHS staff, property, premises or service-users (patients) are progressed, neither the police nor the NHS health body will provide a media statement without prior consultation with the other party. Pre-agreed press releases will be issued wherever possible.

30. SURVEILLANCE

- 30.1 Any directed surveillance carried out on NHS premises must comply with RIPA.
- 30.2 Where practicable, the health body should be consulted when police surveillance operations on their premises are planned, in order to prevent the operation being compromised.

**31. MULTI-AGENCY ISSUES/CRIME REDUCTION PARTNERSHIPS/
COMMUNITY SAFETY PARTNERSHIPS/CHILD PROTECTION**

- 31.1 There may be a requirement for cooperative working between health bodies, the police and other agencies. Any referrals should be in accordance with national policy and the multi-agency public protection arrangements guidance.

32. DEATH IN A HEALTHCARE SETTING

32.1 Criminal investigation into alleged cases of negligence where a death has occurred in a healthcare setting will require cooperation and liaison between the police and the health body. Where a death has occurred in a healthcare setting that the police wish or are required to investigate, the initial points of contact should be the Chief Executive Officer of the health body and the local commander or senior investigating officer.

33. RECONCILIATION OF DISAGREEMENT

33.1 Any disagreements will normally be resolved amicably at local level. A protocol should be developed for dealing with disputes between police staff and NHS staff. This will normally be at the post-incident stage, where an incident debrief will cover all the relevant issues.

33.2 If issues are not resolved through post-incident debrief, they will be escalated through official channels to either the SMD or local commander.

33.3 Ultimately, the issue could be referred to the ACPO operations lead and the Chief Executive of the health body.

34. AMBULANCE SERVICE

34.1 The ambulance service is involved in work as an emergency service which brings NHS ambulance staff into contact with police officers in operational situations and requires close working relationships. It is therefore appropriate that there is mutual understanding and cooperation in an operational environment and that, through liaison, agreements can be reached in relation to operational matters, for example:

- *securing premises*
- *flagging systems for risk addresses*
- *firearms situations*
- *managing crime scenes.*

34.2 Where ambulance staff are required to attend planned police firearms operations, the emergency planning officer or LSMS should be involved in the development of an operational order with the police. Where the security level of the firearms operation prohibits NHS ambulance staff from being involved, consideration should always be given to information of value and the support that the ambulance service can provide in an operational planning situation. The operational order should include arrangements for communication and

meeting points and provide an opportunity for the ambulance service to be involved in post-incident debrief.

- 34.3 If ambulance service staff become aware of the presence of firearms at a location, they will report the situation to the police immediately if safe to do so.
- 34.4 If a decision by police to impound ambulance service vehicles or seize equipment or other ambulance service property at the scene of a crime is required, the decision must be made at SMD and local commander level. (See paragraph 8.7.)
- 34.5 The ambulance service often covers wide geographical areas which cover a number of police force boundaries. When liaising on how all of the above can best be managed, the aim should be to get cooperation and consistency between all police forces and ambulance services involved.

35. MENTAL HEALTH

- 35.1 Criminal law has equal application both inside and outside mental health units. It should be assumed that all mental health service-users (patients) have capacity in law for responsibility for their actions. Such persons should be treated similarly to other persons suspected of having committed or been witness to a criminal offence.
- 35.2 It is recognised that mental illness may be a negative factor in prosecution. To enable a better-informed prosecution decision to be made, mental health professionals should be prepared to disclose confidential patient information to the police as required.
- 35.3 Assaults and other acts of violence committed against NHS staff by persons suffering from mental illness may only amount to a common assault; however, positive action against the offender by the police may assist with the future risk management of the individual and therefore the police should seek the views of the consultant in charge or responsible medical officer (RMO)¹ prior to deciding how to deal with the matter and what action to take. This will enable the best treatment and management to be determined. It is also important in maintaining the confidence of NHS staff who work in the mental health environment.
- 35.4 Some incidents will not require the arrest of the service-user (patient) at the time unless it is necessary for them to be arrested to prevent the incident from continuing or any person from being injured or for the preservation of forensic evidence.

¹ Responsible medical officer only applies to formally detained patients.

- 35.5 In cases where the service-user (patient) is not arrested, the police should make arrangements with the Mental Health Trust for them to be interviewed. The trust should facilitate this process by means of the consultant/responsible medical officer (RMO) assessing the service-user (patient) to determine whether they are fit to undergo this process. The consultant/RMO's assessment should be forwarded in writing to the police custody officer/forensic medical examiner (i.e. the police doctor). This will assist the police custody officer/forensic medical examiner in deciding whether the service-user (patient) is fit to be detained at a police station.
- 35.6 To comply with the PACE Codes of Practice, the Mental Health Trust should arrange for an independent 'appropriate adult' to accompany the service-user (patient) when they are to be interviewed by the police and ensure the service-user (patient) has been given the opportunity to have legal representation at the interview.
- 35.7 If there is sufficient evidence for criminal charges to be preferred, the court may ask the consultant/RMO for a report on the service-user (patient)'s fitness to answer the charges and stand trial.
- 35.8 Where it is appropriate for the service-user (patient) to remain within the mental health unit whilst investigations continue, there should be close liaison between the police and the clinical team with responsibility for the service-user (patient) to effectively manage the preparation of reports as necessary. Professional responsibilities and/or the clinical needs of the service-user (patient) may mean that continued contact is unavoidable during the investigation process. In such circumstances, the case officer must ensure that the reasons for continued contact are clearly highlighted in the case summary. If at any point it is considered that continued contact will affect the prosecution process, the Mental Health Trust must be promptly notified by the investigating officer and appropriate action taken by the clinical team.
- 35.9 Within the mental health and learning disability setting, appropriately trained NHS staff can undertake lawful searches of both service-users (patients) and visitors. However, this must be an action that is both proportionate and justifiable in relation to the assessed risk and for which consent has been sought. The justification for searching will usually be the risk of harm to the individual or others, reasonable grounds for suspecting criminal activity that would compromise the safety of others, e.g. weapons, or a wider social problem, such as a chronic substance misuse problem in the clinical area.
- 35.10 All mental health and learning disability services should have in place a local policy that relates to all aspects of personal and environmental searching. The policy should include action where consent is denied and it must be based on a necessary and proportionate response to

the actual or perceived risk, and support staff who are required to undertake this action. It should also outline the role of the LSMS in relation to any local agreement with the police service as regards their involvement should a search uncover evidence of serious criminal activity or where a need arises to preserve evidence or to store, return or dispose of any discovered items.

- 35.11 There are three high-security hospital facilities in England; these hospitals treat patients described under the Mental Health Act 1983 as 'posing a grave and immediate danger'. For protocols concerning police action in relation to high-security facilities, see Appendix 2.

36. REVIEW OF THIS AGREEMENT

- 36.1 This Memorandum of Understanding will be reviewed each year by representatives of the NHS Security Management Service and the Association of Chief Police Officers and amended if necessary.

APPENDICES

APPENDIX 1 – Exchange of information protocol

APPENDIX 2 – Security in high-security Mental Health Trusts

APPENDIX 3 – Local joint working protocol guidance

APPENDIX 4 – Glossary of terms

Protocol for the exchange of information relating to security matters between the NHS and the police

1. Objective of the protocol

This protocol is intended to facilitate the exchange of data between the Police Service and the National Health Service (NHS) and its Security Management Service (NHS SMS), to enable them to undertake their duties. It is not intended to provide a conduit for the general provision of NHS data, whether personal or otherwise.

Personal data relating specifically to medical/clinical records can only be disclosed with the express written permission of the data subject or on the order of the courts.

Disclosure of data shall only be made in accordance with legislation – the Data Protection Act 1998, ECHR Directives and the Crime and Disorder Act 1998.

2. Exemption to non-disclosure

Disclosure of data may be made where it is for the prevention or detection of crime, or the apprehension or prosecution of offenders, and where failure to disclose would be likely to prejudice those objectives. Disclosure of information will only be made in relation to identified cases and any decision to disclose will be made on a case-by-case basis.

Any requests for information whose purpose is the prevention or detection of crime should specify as clearly as possible how failure to disclose would prejudice the stated objective. The request should make clear:

- *why it is envisaged that the provision of the information would prevent crime and/or*
- *why apprehension or prosecution of an offender is necessary to detect a criminal offence and how the information will assist in the investigation, e.g. why proceedings might fail without the information.*

Provision of personal data with the written consent of the person to whom the data refers will be considered.

3. Use of data

Personal data disclosed must be relevant to an investigation and should only be used for the lawful purpose(s) specified in the request and shall not be further processed in a manner incompatible with that purpose.

4. Data quality

Information discovered to be inaccurate or inadequate for the purposes will be notified to the data owner who will be responsible for correcting the data and notifying all other recipients of the data who must ensure that the correction is made.

5. Review and weeding of data

Retention of disclosed information should be for the minimum period needed to achieve the objective of its disclosure, after which time the data will be returned to the originator or destroyed as agreed.

6. Security

Agencies to which data is disclosed under the terms of this protocol must ensure that data is kept secure at all times and that only those persons with a duty to deal with the data for the purpose of the disclosure request are permitted access to it.

High-security hospitals

There are three high-security hospitals: Ashworth – Merseycare Health NHS Trust, Broadmoor – West London Mental Health NHS Trust and Rampton – Nottinghamshire Health Care NHS Trust. These hospitals treat patients described under the Mental Health Act 1983 as ‘posing a grave and immediate danger’. In a prison setting, some of these patients would be classed as category A prisoners. The requirements for the security of high-security hospitals are set out in the Secretary of State’s Safety and Security Directions November 2000.

It is because of the nature of these hospitals and the patients they care for that there need to be specific protocols between the police and the trusts in regard to a high-security hospital.

There should be an annual meeting between the trust Chief Executive and the Chief Constable to review the protocol.

The protocol should provide for:

- *a police response to any escape or attempted escape*
- *a police response to a siege or hostage situation*
- *a police response to acts of concerted indiscipline which threaten the security of the hospital*
- *a police response to criminal offences committed within the hospital.*

The normal contact arrangements should be between the Director of Security for the high-security hospital and a nominated senior police officer of at least Superintendent rank.

Guidelines for the development of a local joint working protocol between a police service and healthcare body

1. Planning

- *Identify the partners that need to be involved – police, Primary Care Trust, Acute Trust, social services and ambulance services.*
- *Consider the boundaries of each service; is one or more police force required to cover one NHS trust and be involved in the work?*
- *Agree the purpose of the protocol – what does it set out to achieve?*
- *Plan to review the purpose on completion of the protocol.*
- *Involve the relevant personnel – for example, senior police officer, local police beat officer, senior trust, social services and ambulance service staff, frontline staff from health and social services.*
- *Agree a process for the protocol development – regular meetings, consultation group and a launch date.*
- *Agree the implementation and review process.*

2. Content

Contents of a protocol will vary from area to area in accordance with the services provided. The following provides guidance on content areas; these should be considered for inclusion in any protocol, but this is not an exhaustive list. The Memorandum of Understanding between the Association of Chief Police Officers (ACPO) and NHS Security Management Service (NHS SMS) should be referred to when developing the areas relevant to the local service need.

2.1 Introduction

- *Identify the background of the protocol.*
- *Identify the partners involved.*
- *Provide contact details for all relevant personnel.*
- *Explain the role of the Security Management Director (SMD) and Local Security Management Specialist (LSMS).*
- *Include frequency and membership of local police liaison meetings.*

2.2 Criminal activity

Include action that the police and health body will take in respect of criminal activity in a healthcare setting, for example:

- *theft*
- *damage to property, including arson*
- *drug-related incidents*
- *alcohol-related incidents*
- *harassment*
- *threats of violence*
- *assault*
- *target hardening.*

Also include:

- *the role of the LSMS in the investigation process*
- *responsibilities in relation to crime scene management and, where appropriate, securing of premises*
- *the process for reporting crime and the need to follow local and national incident reporting procedures*
- *the role of the NHS SMS Legal Protection Unit*
- *prosecution procedures in mental health and learning disability settings where appropriate.*

2.3 Information-sharing

This should include:

- *the process of sharing information to manage risk and pursue prosecution*
- *the process of sharing intelligence between the local police officer and the LSMS as part of a crime reduction strategy*
- *the protection and gathering of evidence post-incident*
- *responsibilities for taking statements*
- *the process for notification of progress and outcomes of investigations*
- *arrangements for witness support through the police, LSMS and health body*
- *the process of information sharing and systems of 'flagging' high-risk addresses where appropriate.*

2.4 Restraint

This should include:

- *a clear indication of the roles and responsibilities of health and social care staff and the police in regard to restraint*
- *guidelines for the use of incapacitant spray, the Tasar and use of firearms.*

2.5 Search procedures

This should include:

- *clear identification of the roles and responsibilities of health and social care staff and the police – including searching for drugs and weapons*
- *where appropriate, arrangements for searching in mental health, learning disability and high-security settings.*

2.6 Mental Health Act

This should include:

- *the arrangements for requesting police support in Mental Health Act assessments, including Section 135/2*
- *procedures for assessment of patients detained by police officers under Section 136.*

A pro forma for sharing risk-related information between social services, healthcare staff and the police is recommended.

2.7 Missing persons

This should include:

- *the reporting procedures for missing persons*
- *the identified actions to be taken in the event of a high-risk missing person who may be a danger to themselves or others*
- *arrangements for the return of a missing person, including those circumstances where the police may not assist*
- *defined responsibilities of social care, healthcare and police staff in relation to patients detained under the Mental Health Act*
- *arrangements for sharing information between agencies regarding escaped prisoners or absconders from secure units.*

A pro forma for sharing risk-related information between social services, prison services, healthcare staff and the police is recommended.

2.8 Death in care

This should include:

- *defined procedures for notifying the police of deaths in care*
- *the identified actions to be taken in the event of a sudden death, and an explanation of the need to preserve evidence.*

2.9 Hostage situations

This should include:

- the identified actions to be taken in the event of a hostage situation.

2.10 Disturbance

This should include:

- the identified actions to be taken in the event of serious disturbances/riot situations in a healthcare setting.

2.11 Major incidents

This should include:

- the procedure for evacuation of premises where the support of the police and other emergency services is required
- the arrangements for and organisation of emergency planning exercises.

2.12 Infant abduction

This should include:

- identified actions to be taken by the police and NHS staff in the event of an infant abduction if the health body has maternity/paediatric services.

2.13 Handling drugs and hazardous substances

This should include:

- policies and procedures for handling drugs and hazardous substances.

2.14 Surveillance

This should include:

- agreed arrangements to be made when police surveillance is undertaken on health body premises.

2.15 Press releases

This should include:

- agreed arrangements to be made when a press release is required
- identification of the process required and the personnel who would collaborate to agree the content of a press release.

2.16 Training initiatives

This should include:

- methods of disseminating the content of the protocol to all personnel
- agreement on any shared training initiatives.

Training should promote understanding of the roles and responsibilities of the police and healthcare professionals.

2.17 Reconciliation and review

This should include:

- procedures for reconciliation
- review date for the protocol.

APPENDIX 4

Glossary of terms

BCU	Basic command unit
CPIA	Criminal Procedure and Investigations Act
CPS	Crown Prosecution Service
ECHR	European Convention on Human Rights
LPU	Legal Protection Unit
LSMS	Local Security Management Specialist
OCU	Operational command unit
PACE	Police and Criminal Evidence Act 1984
PEACE	Preparation & planning, engage & explain, account, closure, evaluation
RIPA	Regulation of Investigatory Powers Act 2000
RMO	Responsible medical officer
SMD	Security Management Director