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BRIEFING PAPER
Number 08088, 2 July 2018

Mental Health Units (Use of Force) Bill 2017-19: Committee Stage Report

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Summary

This House of Commons Library briefing provides information on key provisions in the *Mental Health Units (Use of Force) Bill 2017-19*.

Steve Reed MP presented the Bill on 19 July 2017, having come second in the Private Members' Bill ballot. This briefing has been prepared in advance of the Bill's Report Stage and Third Reading on 6 July 2018.

The Bill makes provision about the oversight and management of use of force in relation to patients in mental health units and similar settings. It applies to England only.

The Bill would introduce statutory requirements in relation to the use of force in mental health units; and require service providers to keep a record of any use of force, have a written policy for the use of force, commit to a reduction in the use of force, and provide patients with information about their rights.

In the case of death or serious injuries following the use of force, the Bill would require mental health units to have regard to all relevant NHS and Care Quality Commission (CQC) guidance. This would have the effect of putting NHS England's Serious Incident Framework on a statutory footing.

The Bill also places a new duty on the Secretary of State to produce an annual report on the use of force at mental health units. At present, data on this is not routinely published.

In addition to provisions on the use of force in mental health units, the Bill also includes provisions on the use of body cameras worn by police officers who attend mental health units for any reason.

Steve Reed MP introduced the Bill after a constituent, Olaseni Lewis, died in a mental health unit. The patient had been physically restrained by police officers. Mr Reed said:

> Seni Lewis was a young man from Thornton Heath with his whole life ahead of him. But he died after his parents took him to hospital for help when he showed signs of mental ill health. Instead of receiving the care and understanding he needed, he was subject to severe physical restraint by 11 police officers until he stopped breathing. I want Parliament to pass Seni's Law to make sure the serious mistakes that led to Seni's death can never happen to anyone else.[1]

The Bill had its Second Reading on 3 November 2017, and received broad, cross-party support. Some of the issues raised for further consideration included specific requirements on police with regards to wearing body cameras, and the quality of data collected by mental health units.

The Bill was considered over two sittings of the Public Bill Committee on 28 March 2018 and 25 April 2018. The majority of amendments were proposed by Steve Reed following discussions with the Government. As a result, there was little in the way of significant disagreement in Committee and there were no divisions. The main points of debate surrounded how to ensure that investigations of deaths following the use of force were independent, and that families of those who died had sufficient access to legal aid.

[1] Steve Reed MP, Steve launches Seni's law to protect mental health patients, 21 July 2017

1. Background: use of force

1.1 Use of force in mental health units

Mental Health Act 1983: Code of Practice

The *Mental Health Act 1983: Code of Practice* (the Code) provides statutory guidance for registered medical practitioners and other professionals in relation to the medical treatment of patients suffering from mental disorder.

It provides guidance on restrictive interventions for people receiving treatment for a mental disorder in a hospital, which are defined as follows:

> Restrictive interventions are deliberate acts on the part of other person(s) that restrict a patient's movement, liberty and/or freedom to act independently in order to:
>
> - take immediate control of a dangerous situation where there is a real possibility of harm to the person or others if no action is undertaken, and
> - end or reduce significantly the danger to the patient or others.[2]

The guidance applies to all people receiving treatment for a mental disorder, whether or not they are detained under the *Mental Health Act*.

The Code states that when restrictive interventions are required, they should:

- be used for no longer than necessary to prevent harm to the person or to others
- be a proportionate response to that harm, and
- be the least restrictive option.[3]

It also states that service providers should have programmes in place to reduce the use of restrictive interventions.

The Code requires that all hospitals should have a policy on training for staff who may be exposed to violence or aggression in their work or who may need to be involved in the application of a restrictive intervention.[4]

The Code's section on physical restraint says that if physical restraint is necessary, patients should not be deliberately restrained in a way that impacts on their airway, breathing or circulation. Full account should

2 Department of Health, *Mental Health Act 1983* Code of Practice, January 2015, para 26.36
3 *Ibid.*, para 26.37
4 *Ibid.*, para 26.175

also be taken of their physical health, and staff should constantly monitor their airway and physical health throughout the intervention.[5]

The Code also states that where physical restraint has been used, staff should record the decision and the reasons for it, including details about how the intervention was implemented and the patient's response.[6]

Positive and Safe programme

In April 2014 the Department of Health launched the *Positive and Safe* programme, which aims to reduce use of restrictive interventions across all health and adult social care.

As part of this, the Department published new guidelines on ending the deliberate use of face-down restraint for people receiving care. *Positive and Proactive care: Reducing the need for restrictive interventions,* provides non-statutory guidance for adult health and social care staff to develop a culture where restrictive interventions are only ever used as a last resort, and only then for the shortest possible time.

The guidance is intended to inform the Care Quality Commission's (CQC) programme of regular monitoring and inspection against CQC standards.

It also identified key actions that aim to better meet people's needs and enhance their quality of life, reducing the need for restrictive interventions:

a. Staff must not deliberately restrain people in a way that impacts on their airway, breathing or circulation, such as face down restraint on any surface, not just on the floor.

b. If restrictive intervention is used it must not include the deliberate application of pain.

c. If a restrictive intervention has to be used, it must always represent the least restrictive option to meet the immediate need.

d. Staff must not use seclusion other than for people detained under the Mental Health Act 1983.

e. People who use services, families and carers must be involved in planning, reviewing and evaluating all aspects of care and support.

f. Individualised support plans, incorporating behaviour support plans, must be implemented for all people who use services who are known to be at risk of being exposed to restrictive interventions.

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5 *Ibid.*, para 26.71

6 *Ibid.*, para 26.72

The guidance specifically states that face-down restraint should not be used:

> People must not be deliberately restrained in a way that impacts on their airway, breathing or circulation. The mouth and/or nose must never be covered and techniques should not incur pressure to the neck region, rib cage and/or abdomen. There must be no planned or intentional restraint of a person in a prone/face down position on any surface, not just the floor.[7]

Positive and proactive care also introduced new monitoring and governance mechanisms to hold services to account for making these improvements. It was accompanied by an investment of £1.2 million in staff training to help avoid the use of restrictive interventions.[8]

The Department stated that increasing concerns about restrictive interventions in health and care settings had led to the guidance, including those set out in *Transforming Care: a national response to Winterbourne View Hospital* (December 2012) and the Mind report *Mental Health Crisis Care: physical restraint in crisis* (June 2013).

In February 2017, the then Health Minister Nicola Blackwood gave an update on the implementation of Positive and Safe:

> Since the Coalition Government published Positive and Proactive Care: reducing the need for restrictive interventions in April 2014, the Department, with its partners, has taken a number of steps to implement its recommendations.
>
> These include the development of the Positive and Safe Champions Network to promote good practice in the reduction of restrictive interventions; the inclusion of information about the number and type of restraints in the Mental Health Services Dataset and the development of core standards for the training of staff in techniques of prevention and management of violence and aggression.
>
> The Department of Health and the Department for Education are working to produce, for consultation, new guidance on minimising the use of restraint on children and young people who have autism, learning disabilities or mental health issues, and whose behaviour challenges, in health and care settings and in special schools.
>
> Positive and Proactive Care introduced a requirement that services develop Restrictive Intervention Reduction Plans. These plans along with organisations' relative use of restraint in comparison with other organisations, form a key focus of the Care Quality Commission's (CQC) inspections. We expect the CQC to use its regulatory powers to ensure that services minimise the use

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7 Department of Health, Positive and Proactive Care: reducing the need for restrictive interventions, April 2014, para 70

8 Department of Health, New drive to end deliberate face down restraint, 3 April 2014

> of restraint and other restrictive interventions, including face down restraint.[9]

The consultation on restraint and restrictive intervention for children and young people with learning disabilities, autism spectrum disorders and mental health issues ran from 29 November 2017 to 24 January 2018.

NICE guidance

The National Institute of Health and Care Excellence (NICE) produces national guidance and quality standards to improve health and care services. NICE guidelines are not mandatory, but provide evidence-based recommendations.

The NICE guidelines on *Violence and aggression: short-term management in mental health, health and community settings* (May 2015) recommend ways to reduce the use of restrictive interventions, such as through staff training and de-escalation techniques. The guidelines state that a restrictive intervention should only be used if de-escalation techniques and other preventative strategies have failed and there is a risk of harm to the service user or other people if no action is taken. They also state that sufficient numbers of trained staff, including a doctor trained in resuscitation, should be immediately available.[10]

The NICE guidelines advise against face-down restraint, but do say it can be used if necessary, unlike the Department of Health's *Positive and Proactive Care* guidance.

The NICE quality standard on *Violent and aggressive behaviours in people with mental health problems* (June 2017) states that restrictive interventions should only be used if other preventive strategies have failed. They should be used for no longer than necessary and de-escalation should continuously be attempted.

The quality standard also recommends that people who use mental health services who have been violent or aggressive should be supported to identify successful de-escalation techniques and make advance statements about the use of restrictive interventions. If a restrictive intervention is used, the patient's physical health should be monitored during and after physical restraint.

1.2 Patient ethnicity

There are references in the Bill to recording patients' ethnicity and ensuring that staff have training in the provisions of the *Equality Act 2010*.

Concerns have been raised in Parliament and among stakeholder groups about the disproportionate use of physical restraint on people

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9 PQ 63005 [on mental health services: restraint techniques], 10 February 2017

10 NICE guideline, Violence and aggression: short-term management in mental health, health and community settings, p30-31, 28 May 2015

from certain minority ethnic groups, particularly from African and Caribbean communities.

The Bill's sponsor, Steve Reed MP, has previously called for an inquiry into what he called the "institutional racism" in the mental health system:

> **Steve Reed MP:**
>
> [...] Young black men who use mental health services are more likely than other people to be subject to detention, extreme forms of medication and severe physical restraint, and, in extreme cases, this has led to death, including that of my constituent Seni Lewis. Too many black people with mental ill health are afraid to seek treatment from a service they fear will not treat them fairly. Will the Prime Minister meet me and some of the affected families to discuss the need for an inquiry into institutional racism in the mental health service?
>
> **The Prime Minister:**
>
> [..]
>
> It is precisely because of concern about how various people were being treated within our public services that last year I introduced a racial audit of the disparity of treatment within public services. As Home Secretary, I saw this when I looked at the way that people, particularly black people with mental health issues, were being dealt with by the police and in various forms of detention. That is exactly the sort of issue that we are looking at. I am very happy for the hon. Member for Croydon North (Mr Reed) to write to me with the details of the particular issue that he set out.[11]

In October 2017, the Cabinet Office published the Race Disparity Audit, which found that Black Caribbean adults were the most likely to have been detained under the *Mental Health Act*[12], but did not make specific reference to the use of force in mental health settings.

The Home Affairs Select Committee had previously published a report on *Policing and mental health* in February 2015. The report highlighted concerns that the black community more commonly reported the use of force:

> There are real concerns that black and ethnic minority people are disproportionately detained under s. 136 (of the *Mental Health Act 1983*). Matilda MacAttram of Black Mental Health UK said there was still a feeling in the black community that the young black men are presumed to be dangerous based on their physical appearance, and this perception determines how they are labelled and the treatment they receive. At events organised by the Centre for Mental Health to hear views on experiences of detention under s. 136, black people more commonly reported the use of force and that force was used at an earlier stage during contact with the police. Deborah Coles of INQUEST, agreed that

11 HC Deb 1 March 2017 c291

12 Cabinet Office, Race Disparity Audit, October 2017, page 49

> there was a prevailing assumption that people with mental health illness would be dangerous, and that is doubled if the person is from the African Caribbean community. She said the answer was largely to do with training.[13]

The charity INQUEST, which provides expertise on state related deaths and their investigation, published a report in 2015 which stated:

> The lack of publicly-available data is particularly concerning in relation to ethnicity where…there have been significant questions raised about an over-representation of black people in mental health settings and the coercive use of force that features in some of their deaths.[14]

Mind's report on *Mental health crisis care: physical restraint in crisis* (June 2013) and its guidance on Restraint in mental health services also raise concerns about inequalities in mental health care for people from some black and minority ethnic groups.

13 Home Affairs Select Committee, *Policing and Mental Health*, 6 February 2015, HC 202 2013-14, para 71

14 Inquest, Deaths in mental health detention, February 2015

2. Background: police body cameras

Background on the introduction of Body Worn Video (BWV) can be found in the Parliamentary Office of Science and Technology's POST Brief No 14, Body-Worn Video in UK Policing (September 2015).

No specific legislation was required to allow police officers to wear body cameras. The Government's general view is that "the decision to procure and deploy BWV cameras is a matter for Police and Crime Commissioners and chief officers."[15] However, the operation of body worn cameras takes place within a broader legal framework including the *Data Protection Act 1998*, the *European Convention on Human Rights*, and the *Protection of Freedoms Act 2012*. This framework is described in detail in the College of Policing guidance, *Body Worn Video*, but a broad outline is given below.

The Data Protection Act

The *Data Protection Act 1998* (DPA) regulates the processing of personal data, and this includes any recorded image that captures an identifiable individual. The person or organisation holding the data (known as the "data controller") must comply with the eight data protection principles which the Act sets out. These include the principle that personal data should be processed "fairly and lawfully", that it must be obtained only for "one or more specified and lawful purpose", and that it should not be further processed in a manner which is incompatible with that purpose. Further detail is given in Commons Library Briefing Paper 0830, *Data protection: access to personal information*

The College of Policing gives guidance on how the DPA applies to BWV, including that forces wishing to use body-worn video should:

- Publicise this before they start doing so;
- Clearly label devices;
- Announce "where possible/practicable" to the subjects of an encounter that video and audio recording is taking place;
- Begin recordings at the start of any deployment to an incident and continue uninterrupted until the incident is concluded. [16]

The European Convention on Human Rights

The College of Policing guidance on BWV discusses the relevance of article 6 (the right to a fair trial) and article 8 (the right to respect for family and private life) of the European Convention on Human Rights. The guidance stresses that the use of BWV "must be in accordance with the law and proportionate." Case law has established that, for the

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[15] See for example Written Question 8878 [on Police: Cameras] 12 September 2017

[16] College of Policing, *Body Worn Video*, 2014 pp7-8

purposes of the ECHR, police users have sufficient powers in common law to justify the use of BWV. However, its use "must always be justifiable, on a case-by-case basis." The guidance continues:

> In principle, the use of BWV is justifiable for preventing and detecting crime. BWV can collect valuable evidence for use in criminal prosecutions and provides a record to promote integrity and confidence in policing, and objective evidence of controversial events and interactions. It offers protection for the police and for citizens. However, a court may closely scrutinise this justification and it is essential that forces do not retain BWV recordings where there is no clear evidence of an offence, unless some other good reason exists for their retention.[17]

Protection of Freedoms Act 2012 and the Surveillance Camera Code of Practice

Part 2 of the *Protection of Freedoms Act 2012* deals with the regulation of CCTV and other surveillance camera technology and introduces the *Surveillance Camera Code of Practice*. A police force must consider the code and its twelve guiding principles. These include the following:

- the use of surveillance cameras must always be for a "specified purpose which is in pursuit of a legitimate aim"
- their use must "take into account its effect on individuals and their privacy, with regular reviews to ensure its use remains justified"
- there must be as much transparency in the use of a surveillance camera system as possible, including a published contact point for access to information and complaints.

Police and Criminal Evidence Act 1984 (PACE)

Whilst PACE would not cover general operational use of BWV, there are circumstances where it would apply. Section 64A of PACE allows a person to be photographed with or without their consent elsewhere than in a police station in various circumstances, for example if they have been arrested by a constable for an offence, or if they have been issued with a fixed penalty notice. PACE Code D, *(Code of Practice for the Identification of Persons by Police Officers*) would have to be followed if material from BWV is to be used to assist with PACE Code D.

[17] College of Policing, *Body Worn Video*, 2014, p9

3. Second Reading debate

The Bill had its Second Reading on 3 November 2017. Steve Reed introduced the Bill by highlighting the case of Olaseni Lewis, who died in 2010 following the use of force at a mental health unit:

> Seni Lewis was a young graduate embarking on his life, aged 23, and living with his parents in Thornton Heath, when he suffered his first ever mental health episode. His parents recognised what was happening and took him to their local hospital. Seni ended up in the Bethlem Royal mental health hospital in Croydon. His parents stayed with him all day, but had to leave at 8 o'clock in the evening. Seni became very agitated when he realised they had gone, and he tried to leave, too. According to the coroner, the staff lacked the training to deal with him, and although there are no allegations that he attacked anyone, they called the police. Eleven police officers took Seni into a seclusion room and, using pain compliance techniques—the kind used against violent criminals—they took it in turns to hold him face down on the floor for 30 minutes in total. His hands were cuffed behind his back, and his legs were in restraints. They held him like that until he could no longer breathe, and he suffered a heart attack. He went into a coma, and four days later Seni was dead.
>
> [...]
>
> I dedicate this Bill to Seni Lewis. This is Seni's Law.[18]

Steve Reed highlighted the 46 deaths of mental health patients following the use of restraint between 2000 and 2014, and the 9,000 uses of face-down restraint in the past year. He also noted significant variation in the use of force between mental health providers, with some restraining 5% of patients and others restraining over 50%. The intention of the Bill was summed up as follows:

> The Bill will make sure that every mental health provider has a policy in place governing the use of force, including a clear deliverable plan for reducing its use, and ensuring that staff are properly trained in equalities and the de-escalation techniques needed to avoid the use of force. It will speed up justice and allow learning to take place by making sure that any non-natural death in a mental health unit automatically triggers an independent investigation, and making sure that recommendations from investigations and inquests are taken into account when improving mental health services in ways that currently do not happen.[19]

There was broad support from across the House for the intentions of the debate, in contributions from Labour, Conservative and Liberal Democrat MPs.

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18 HC Deb 3 November 2017, cc1089-1092

19 HC Deb 3 November 2017, c1091

Some issues were raised for further discussion in Committee, including the scope of training for mental health units staff, as raised by Will Quince:

> I support what the Bill is seeking to achieve on training, especially as set out in clause 5(1). In many ways, it strikes me as remarkable that frontline staff would not already be given such programmes, but this is a good way of ensuring that staff, particularly new staff, are aware of best practice and guidance on the use of force. I suggest, however, that the Committee looks at whether the provision should be wider than just induction, so that existing members of staff are also given this training. In any workplace environment, it is incredibly important for people to be given refreshers to ensure that training remains fresh and at the front of their mind.[20]

Further contributions by Will Quince, and contributions by James Heappey, Kevin Foster and Sheryll Murray, also discussed the potential for amending clauses related to when exactly police should be required to turn on body worn cameras following a call to a mental health unit.

The Parliamentary Under Secretary of State for Mental Health and Inequalities, Jackie Doyle-Price, confirmed that the Government supported the principles in the Bill, but that the right mechanisms and processes for implementing it would need to be explored further in Committee. The Minister also raised concerns about points raised by other contributors about a potential outright ban on the use of some types of force:

> Members have expressed views on the use of restraint, particularly prone restraint, with some of them suggesting that that type of restraint should be banned altogether. I was at Broadmoor yesterday, and I was told about a man who had experienced a head injury and needed stitches. Because of the challenges of his behaviour and mental health condition, prone restraint was used. I am not condoning the use of prone restraint in that situation or in any other, but I will say some words of caution. We need to understand restraint and define it clearly before introducing an outright ban. The guidance says that prone restraint should be used only as a last resort, and we must be careful not to put staff at risk by introducing a blanket ban without understanding more about the circumstances in which that type of restraint might be necessary.[21]

MPs agreed that the Bill should be read a second time, without a division.

[20] HC Deb 3 November 2017, c1122
[21] HC Deb 3 November 2017, c1135

4. Public Bill Committee

The Bill was considered over two sittings of the Public Bill Committee on 28 March 2018 and 25 April 2018. The final Committee sitting was postponed several times whilst waiting for the Commons to pass a Money Resolution for the Bill.

Report Stage and Third Reading are scheduled to take place on 6 July 2018.

The majority of amendments were proposed by the Bill's sponsor, Steve Reed, following discussions with the Department of Health and Social Care. As a result, there was little in the way of significant disagreement in Committee, and there were no divisions. The main points of debate surrounded how to ensure that investigations of deaths following the use of force were independent, and that families of those who died had sufficient access to legal aid.

The Committee consisted of the following members:

- Ms Karen Buck (Chair on 28 March 2018); James Gray (Chair on 25 April 2018)
- Edward Argar (Charnwood) (Con)
- Luciana Berger (Liverpool, Wavertree) (Lab/Co-op)
- Jackie Doyle-Price (Parliamentary Under-Secretary of State for Health)
- Kevin Foster (Torbay) (Con)
- Helen Hayes (Dulwich and West Norwood) (Lab)
- Caroline Lucas (Brighton, Pavilion) (Green)
- Shabana Mahmood (Birmingham, Ladywood) (Lab)
- Tom Pursglove (Corby) (Con)
- Will Quince (Colchester) (Con)
- Mr Steve Reed (Croydon North) (Lab/Co-op)
- Paula Sherriff (Dewsbury) (Lab)
- Gareth Snell (Stoke-on-Trent Central) (Lab/Co-op)
- Maggie Throup (Erewash) (Con)
- Mrs Anne-Marie Trevelyan (Berwick-upon-Tweed) (Con)
- Mike Wood (Dudley South) (Con)
- Mr William Wragg (Hazel Grove) (Con)
- Daniel Zeichner (Cambridge) (Lab)

Transcripts of the Committee's sittings are available on the Mental Health Units (Use of Force) Bill 2017-19 page of the Parliament website.

5. Committee Stage: detailed consideration of the Bill

The clause numbers refer to those from the Bill as first introduced in the House of Commons, Bill 8 of 2017-19.

As set out above, the majority of amendments were proposed by the Bill's sponsor, Steve Reed, following discussions with the Department of Health and Social Care. As a result, there was little in the way of significant disagreement in Committee, and there were no divisions.

5.1 Use of force in mental health units: Clauses 1–12

Clause 1: key definitions

Clause 1 of the Bill sets out key definitions in relation to the Bill's provisions, such as 'mental health disorder', which has the same meaning as under the *Mental Health Act 1983*; a 'mental health unit', 'patient' and 'use of force'.

Steve Reed moved amendments 2-6 which altered the definitions for 'mental health unit', 'patient' and 'use of force'. Some of the changes were intended to standardise language with other guidance, and others simplified definitions, but some were more substantive.

The Bill as introduced defined a mental health unit as 'a hospital, independent hospital, care home or registered establishment, in England, that provides treatment for mental health disorders.' Amendments 2 and 3 removed "care homes or registered establishments" from the definition, and clarified that independent hospitals were only within scope of the Bill when they provided at least some NHS care.

Amendment 6 sought to change the definition of 'use of force' to no longer cover instances where a person 'threatens' to use force. It also included isolation as a type of force, alongside physical, mechanical and chemical restraint.

Amendment 5 removed the definition of responsible manager from the Bill, and was considered alongside amendments to clause 2, requiring a unit to appoint a 'responsible person' (see below).

The Parliamentary Under Secretary of State for Mental Health and Inequalities, Jackie Doyle-Price, confirmed that the Government supported these amendments, which "make the language in the Bill

consistent with the 2015 code of practice under the Mental Health Act 1983, and with broader guidance."[22]

Clause 1, as amended, was ordered to stand part of the Bill.

New Clause 7: interpretation

Further definitions – on terms related to the NHS and mental health unit employees – were set out in New Clause 7, moved by Steve Reed, which was ordered to stand part of the Bill.

In the Bill introduced at Report Stage, NC7 stands as clause 13.

Clause 2: responsible person

Clause 2 of the Bill as introduced would have required a person operating a mental health unit to be a registered manager. Currently, in order to be registered as a provider of health or social care under the *Health and Social Care Act 2008*, the provider must appoint a registered manager. This clause would have brought mental health units within the ambit of section 13 of the 2008 Act.

However, Steve Reed moved amendment 7, which sought to replace the registered manager with a 'responsible person' who must be:

a) employed by the relevant health organisation, and

b) of an appropriate level of seniority

Health organisations that run multiple units would only be required to have a single responsible person. Steve Reed set out the rationale for this change:

> The change in language avoids confusion with existing Care Quality Commission regulations that use the phrase "registered manager", but the intention remains the same. By introducing the legal concept of a responsible person for mental health units, the Bill increases accountability and leadership.[23]

This was moved alongside amendments 11 and 60, which replaced references in clauses 3 and 7 to registered managers with references to responsible persons. The Government supported the amendments.

Clause 2, as amended, was ordered to stand part of the Bill.

Clause 3: policy on use of force

Clause 3 of the Bill would require responsible persons for mental health units to have a written, published policy on the use of force on patients, and to commit to an overall reduction in the use of force. The policy would be subject to regular review and republication if amended. In preparing the policy the responsible person would be required to consult with the police in the local area and 'other persons' as considered appropriate.

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22 PBC Deb 28 March 2018, c6

23 PBC Deb 28 March 2018, c7

At present, the *Mental Health Act 1983* Code of Practice states that health and social care providers should have policies on restrictive interventions, including how restrictive interventions used by the provider should be authorised, initiated, applied, reviewed, and discontinued; as well as how the patient should be supported throughout the application of the restrictive intervention. The policy should also set out local recording and reporting mechanisms around the use of restrictive interventions.[24]

The Code of Practice is statutory for registered medical practitioners and other professionals in relation to the medical treatment of patients suffering from mental disorder. The Bill would place on a legislative basis similar requirements for providers to have a policy on the use of force

Steve Reed moved amendments 8-10 and 12-17, which proposed a number of changes:

- Changing the description of a unit's policy to specifically cover staff who would be using use force on patients;
- Requiring a responsible person in charge of multiple units to have a single policy for all units;
- Introducing a duty to consult with 'any persons that the responsible person considers appropriate', and removing a specific reference to consulting the police that was included in the Bill as first introduced;
- Stating that policies on the use of force by staff can be revised, but substantial revisions require the responsible person to carry out further consultations;
- When first introduced, the Bill stated that the policy must set out what steps would be taken to 'minimise and reduce' the use of force. Amendment 14 changed this simply to 'reduce';
- Removing a requirement for a responsible person to 'take all reasonable steps' to use force only in accordance with the policy. This is because later amendments would require adherence with the policy through statutory guidance.

Luciana Berger welcomed the amendments, highlighting the use of force policy already in place with Mersey Care NHS Foundation Trust, but noting there were different approaches with trusts across the country, which clause 3 hoped to standardise.[25]

The Mental Health Minister, Jackie Doyle-Price, confirmed that the Government supported these amendments.

Clause 3, as amended, was ordered to stand part of the Bill.

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[24] Mental Health Act 1983 Code of Practice, January 2015, para 26.7
[25] PBC Deb 28 March 2018, c9

Clause 4: information about use of force

Clause 4 of the Bill as introduced would have required mental health units to provide patients with information about their rights in relation to the use of force. The Secretary of State would have been required to make regulations prescribing the information to be provided. This information would have included:

- The registered manager's policy for the use of force;
- The person to whom any complaint about the use of force would be made; and
- Details of organisations from which the patient could get free independent advice on the use of force.

Steve Reed moved amendments 84 and 19 which removed the requirement for the Secretary of State to prescribe the information to be provided; and removed specific references to the responsible person's policy for the use of force, how to complain, and independent advice organisations. This was instead intended to be addressed in the Secretary of State's statutory guidance, set out in clause 6.

Amendment 84 proposed instead that a registered manager must publish information about the rights of patients, consulting any relevant persons prior to publication. Patients, and anyone appropriate who is with them, such as family or carers, must be provided with this information as soon as reasonably practical after they are admitted to the unit.

These were considered alongside amendments 20-23, also moved by Steve Reed. These changed the drafting of the original Bill, but continued to emphasise that information should be in a form that patients are able to understand. Amendment 24, moved by Steve Reed, stated that the information must be kept under review, and any substantial changes would require them to consult again with any relevant persons.

Steve Reed also moved amendment 85, which set out conditions under which responsible persons were not required to provide this information to patients or people with them. The conditions were if the patient refused, didn't want the information to go to another person, or if the responsible person thought it would cause distress to the patient or any people with them. Steve Reed raised concerns that this could be seen as a loophole to prevent patients receiving information about their rights. The Mental Health Minister, Jackie Doyle-Price, replied:

> On the specific concern that amendment 85 might cause a loophole, I must emphasise that the exception is not about letting any unit off, but about recognising when it might be appropriate so that information will not cause further unintended distress and ensuring that patients' interests are protected. Different patients will require different approaches, and a one-size-fits-all approach does not count.

> When the measure is set alongside the other provisions in the Bill, we are satisfied that we have the right balance between protecting the rights of patients and empowering them—and empowering their carers and relatives to look after them—while having appropriate safeguards to prevent further distress. I support the amendments.[26]

All the amendments were agreed to. Clause 4, as amended, was ordered to stand part of the Bill.

Clause 5: training in appropriate use of force

Clause 5 of the Bill requires that responsible persons must have a training programme for all front-line staff. This would include training in avoiding discrimination and techniques for avoiding and reducing the use of force.

The *Mental Health Act 1983* Code of Practice currently requires that all hospitals have a policy on training for staff who may be exposed to violence or aggression in their work or who may need to be involved in the application of a restrictive intervention.[27] It also states that staff should only use restrictive interventions for which they have received training.[28]

Steve Reed moved amendment 86, which provided a more detailed list of topics to be included in staff training. The full list of topics is:

- how to involve patients in the planning, development and delivery of care and treatment in the mental health unit;
- showing respect for patients' past and present wishes and feelings;
- showing respect for diversity generally;
- avoiding unlawful discrimination, harassment and victimisation;
- the use of techniques for avoiding or reducing the use of force;
- the risks associated with the use of force;
- the impact of trauma (whether historic or otherwise) on a patient's mental and physical health;
- the impact of any use of force on a patient's mental and physical health;
- the impact of any use of force on a patient's development,
- how to ensure the safety of patients and the public; and
- the principal legal or ethical issues associated with the use of force.

Amendment 87, moved by Steve Reed, proposed removing the definition of staff from clause 5, and referred instead to the slightly modified definition in new clause 7. The Bill as introduced defined staff as people that the responsible person "might reasonably expect to use

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26 PBC Deb 28 March 2018, c14

27 *Mental Health Act 1983* Code of Practice, January 2015, para 26.175

28 *Mental Health Act 1983* Code of Practice, January 2015, para 26.65

force, or authorise the use of force' on a patient." The new definition covered those authorised to use force on a patient, those who could authorise the use of force, and those who had a general authority function with regard to the use of force. This is a broader definition which also covers more senior staff, as well as frontline staff. It also removed volunteers from the definition. The new definition means volunteers would not be required to receive training, as they would not be expected to be involved in the use of force.

Helen Hayes questioned whether the training would cover specific challenges arising from the use of restraint on patients with autism. In response, Jackie Doyle-Price acknowledged that the Government would need to ensure any guidance covered this issue.

Steve Reed specifically highlighted the intended impact of training focusing on reducing discrimination:

> We only have to look at pictures of the faces of people who have died in state custody, including in mental health custody, to see how severe the risk of unconscious bias in the system is. A much higher proportion of those faces will be of young black men than the proportion present in the population as a whole. In order to ensure that staff will not be acting out of prejudice against people who enter a publicly funded health service for treatment on equal terms with everyone else, it is important that staff are trained to be fully aware of the risks of unconscious bias and racism in that service.
>
> Putting anti-discrimination training into legislation is a move towards ending such unlawful discrimination, as is the overall aim of the Bill, and towards exposing the use of force to much closer scrutiny by standardising data recording across the whole country, so that it is possible to compare performance in mental health units on the same basis in different parts of the country.[29]

Amendments 86 and 87 were agreed to. Clause 5, as amended, was ordered to stand part of the Bill.

Clause 6: guidance about functions under the Act

Clause 6 of the Bill as introduced would have required the Care Quality Commission (CQC) to publish guidance for responsible persons about the exercise of functions introduced by the Bill.

Steve Reed moved amendments 28-34, which would require the Secretary of State, rather than the CQC, to produce this guidance. The amendments would also put the guidance on a statutory basis, would require the Secretary of State to consult persons they consider appropriate, and require the guidance to be kept under review.

The Mental Health Minister, Jackie Doyle-Price, argued that the duty to consult would ensure that the guidance would be well received within

[29] PBC Deb 28 March 2018, c17

the health sector, and confirmed that the Government backed the amendments.

Clause 6, as amended, was ordered to stand part of the Bill.

New Clause 3: delegation of responsible person's functions

NC3, moved by Steve Reed, was debated alongside clause 6. This set out that a responsible person could delegate their functions under the Bill, but that they retained responsibility for those functions.

NC3 was ordered to stand part of the Bill.

In the Bill introduced at Report Stage, NC3 stands as clause 11.

Clause 7: recording the use of force

Clause 7 of the Bill as introduced would have required responsible persons to keep a record of any use of force on a patient in a mental health unit for at least 10 years. The Secretary of State would also have had to prescribe, in regulations, the information to be contained in the record, including: the type of force used; death of, or any serious injury sustained by the patient where use of force was a contributing factor; and all efforts made to avoid the need to use restraint on the patient.

This record would also have included the gender, age and ethnicity of the patient, and other known protected characteristics, as defined by the *Equality Act 2010*.

Data is currently not routinely published on the use of force and on patients' ethnicity. See section 1.2 for further comment on patient ethnicity and the use of force.

Steve Reed moved the following amendments to clause 7: 37-41, 43-46, 48-54, 56, 57, 59-62, 64-68, 88-92, 94 and 95, which were all agreed to.

These amendments removed a requirement on the Secretary of State to set out in regulations the information to be recorded, and instead set this out on the face of the Bill. The responsible person for the mental health unit would be required to record:

- The patient's name and NHS number;
- The patient's mental disorder (if known);
- Whether the patient has a learning disability or autistic spectrum disorders;
- The patient's relevant characteristics;
- The place, date and duration of the use of force;
- The name and job title of the member of staff who used force;
- Anyone using force not employed by the mental health unit;
- The reason for the use of force;
- The type or types of force used;
- A description of how force was used;

- A description of the outcome of the use of force;
- Whether the patient died or suffered any serious injury;
- Any efforts made to avoid the use of force;
- Whether these types of force form part of the patient's care plan.

'Relevant characteristics' are defined in the Bill as age, disability, married or civil partnership status, pregnancy, race, religion or belief, sex, and sexual orientation. Amendments 66 and 67 removed gender reassignment and having maternal responsibility for a child from the list of relevant characteristics.

Amendment 88 added a proviso that the duty to record would not apply where there is "negligible" use of force. Steve Reed argued that negligible would have to be tightly defined in regulations to avoid becoming a loophole:

> Amendment 88, which the Government were keen to include and I was happy to table, means that the duty to record information will not apply in cases where the use of force is negligible. Statutory guidance will set out the meaning of "negligible", so it is important that that definition, provided by the Secretary of State, is right and defines the term very tightly. In some cases, the minor use of force, such as guiding a patient by the elbow, should clearly not need to be recorded, as that would create an unnecessary burden on professionals working in mental health units. However, I know that the Minister is aware of the need to avoid that becoming a loophole.
>
> The guidance will be subject to consultation, and I know that advocacy groups, which have been providing so much support to us all as the Bill has progressed, have concerns that they want to raise. The consultation will allow them to do so formally, and I welcome that, because the Bill has so far proceeded on the basis of consensus. Indeed, that is the only way that it will succeed.[30]

Amendments 62 and 64 reduced the required time that units would have to hold records from 10 years to 3 years, and removed the requirement for records to be kept at the mental health unit itself. Amendment 95 also clarified that all record keeping must be in line with provisions in the *Data Protection Act 1998* and the common law duties of care and confidence.

Clause 7, as amended, was ordered to stand part of the Bill.

Clause 8: statistics prepared by mental health units

Clause 8 requires responsible persons for mental health units to prepare statistics on a number of points including the number of times force was used at the mental health unit during the previous year, and the

30 PBC Deb 25 April 2018, cc34-5

effect of each use of force on the patient (for example, whether the patient died or sustained a serious injury).

Steve Reed moved amendment 69, which redrafted the clause to add a requirement on the Secretary of State to publish the statistics, which must include data on:

- Place, date and duration of use of force;
- What type of force was used;
- The patient's relevant characteristics;
- Whether the patient has a learning disability or autistic spectrum disorders;
- Whether the patient died or suffered any serious injury.

The amendment was supported by the Government and agreed to.

At the first Committee sitting on 28 March, where clause 9 was debated, amendments were agreed removing the requirement on the Secretary of State to include these statistics in their annual report to Parliament. At the second Committee sitting on 25 April, Luciana Berger moved amendment 69A, which would have reintroduced this requirement. The Minister, Jackie Doyle-Price, explained why the Government opposed this amendment:

> I completely agree with the sentiments behind the amendment in the name of the hon. Member for Liverpool, Wavertree. It will often be appropriate for the Secretary of State to lay before Parliament a financial statement, an important report or a draft piece of guidance to facilitate parliamentary scrutiny. For example, the Mental Health Act 1983 requires the Secretary of State to lay a copy of any changes to permanent practice before Parliament. As the hon. Lady said earlier, in our discussions in a previous sitting we said we very much anticipate that the Secretary of State will lay an annual report on the use of force before Parliament. To make the report specifically about the statistics collected would introduce an aberration into how we treat NHS Digital statistics. We produce a wide range of health statistics each year, and to single out that subset would not be welcome. However, I expect that, in the course of making the annual report on the use of force, the publication of the statistics will provide a basis on which the Secretary of State will report.[31]

Amendment 69A was withdrawn.

Clause 8, as amended, was ordered to stand part of the Bill.

Clause 9: annual report by the Secretary of State

Clause 9 of the Bill as introduced placed a duty on the Secretary of State to prepare an annual report to be laid before Parliament. The report would have to include the Secretary of State's response to any findings made by a court, the CQC, or a coroner in relation to the death of a patient during, or as a result of, the use of force.

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[31] PBC Deb 25 April 2018, c40

Amendment 70, moved by Steve Reed, kept the substantial intention of clause 9 as introduced, but introduced a few minor changes:

- Clarifying that coroners reports that must be included in the report would be ones made under paragraph 7 of schedule 5 to the *Coroners and Justice Act 2009* (known as 'regulation 28 reports');
- Removing the requirement that a response to findings made by a court or the CQC *must* be included in the report, but said that findings from a CQC or relevant health authority's investigation into the death of a patient *may* be included in the report;
- Removing the requirement for statistics collected under clause 8 to be included in the report;
- Allowing the Secretary of State to delegate their responsibilities to conduct a review of coroners reports and to publish the annual report.

The Mental Health Minister, Jackie Doyle-Price, argued that the amendment would help the healthcare system to learn lessons from the death of any patient as a result of the use of force, and confirmed the Government's support for it:

> Drawing together the lessons learnt from a variety of sources into one report will allow greater transparency and shine a light on the issues that need to be tackled by organisations, and it will ensure that the learning from these tragic events is not lost. For that reason, the Government support the amendment.[32]

Clause 9, as amended, was ordered to stand part of the Bill.

Clauses 10 & 11

Clause 10 would have allowed the Secretary of State to require a responsible person to provide information (of a type to be set out in regulations) necessary to prepare the report to Parliament.

Steve Reed argued that these provisions duplicated those in the amended clause 7, and therefore asked the Committee to vote against clause 10.

Clause 11 would have introduced a duty for a responsible person to notify the Secretary of State, within seven days, of a death that occurred during, or as a result of, the person being subject to the use of force while a patient in a mental health unit.

Steve Reed argued that these provisions duplicated existing duties in regulations 16 and 17 of the Care Quality Commission (Registration) Regulations 2009 (SI 2009/3112), and therefore asked the Committee to vote against clause 11.

Clauses 10 and 11 were accordingly disagreed to.

32 PBC Deb 28 March 2018, c23

Clause 12: investigation of deaths and serious injuries

Clause 12 in the Bill as introduced would have placed a duty on the Secretary of State to appoint an independent person to investigate the circumstances of a death, as notified under clause 11, and for that person to report within three months.

Having received a report, the Secretary of State would then have been required to publish the report within 14 days, or publish a statement that a report had been received.

Currently, section 1 of the C*oroners and Justice Act 2009* states that coroners must investigate all deaths in state detention, including people subject to the *Mental Health Act* in hospital. However, many patients in mental health units are voluntary patients not subject to detention under the *Mental Health Act*, so would not be automatically covered by the current requirement. However, the 2009 Act also provides that a coroner must investigate where there is reason to suspect that the deceased died a violent or unnatural death.

In Committee, clause 12 proved the point of strongest disagreement between the Bill's sponsor, Steve Reed, and the Minister, Jackie Doyle-Price.

Steve Reed moved amendment 1, which clarified that the investigator had to be a person independent of the NHS or private mental health providers. However, rather than support this, Jackie Doyle-Price moved amendment 73 to leave out clause 12 and replace it with New Clause 6 (NC6).

NC6 would remove the Secretary of State's duty to appoint someone independent to carry out an investigation, and instead simply require the mental health unit's responsible person to have regard to any guidance on deaths and serious injuries by the CQC, NHS England or NHS Improvement. This would have the effect of putting NHS England's Serious Incident Framework on a statutory footing, as well as other guidance.

Level 3 investigations under the framework – the most serious level – must be carried out by an independent investigator and a report produced within 6 months. Level 1 and 2 investigations are however internal investigations.

Steve Reed argued that given the experiences of Seni Lewis's parents following their son's death, independence in an investigation was crucial:

> My concern is that under the (Serious Incident) framework as it is drawn up, it is still possible for the NHS to avoid such an investigation because it regards it, perhaps wrongly, as an unnecessary burden. As a result, lessons will not be learned, the system will not be held to account and more patients will suffer injury or even death.

> I respectfully invite the Minister, therefore, to comment on who takes the decision to commission a level 3 investigation under the new framework and whether it is possible for the NHS to avoid commissioning the right level of investigation so that the appropriate lessons are not learned and the system not held to account. Moreover, does the framework guarantee that a level 3 investigation will take place following the death of a patient from the use of force?
>
> That is key, because it is the loophole through which the Lewis family fell following the death of their son. That failing led to them being denied justice and to the trauma of not only losing their child in such horrific circumstances but having to fight the state for seven years just to secure justice and to find out what had gone wrong to leave an otherwise healthy 23-year-old losing his life. [33]

The Minister argued that level 3 investigations guaranteed independence from the institution, but that those with the skill and expertise to carry out thorough investigations would likely be those who work or had worked in the NHS. Therefore, explicitly requiring their independence from the NHS itself could affect the quality of any investigations.

Steve Reed withdrew amendment 1, and clause 12 was accordingly disagreed to.

New Clause 6 was agreed to and ordered to stand part of the Bill.

In the Bill introduced at Report Stage, NC6 stands as clause 10.

New Clause 1: legal aid

NC1, moved by Steve Reed, was debated alongside clause 12. The New Clause would have provided legal aid for families of patients who had died following the use of force in a mental health unit.

Steve Reed pointed to Dame Elish Angiolini's 2017 report on Deaths and serious incidents in police custody, which recommended legal aid for families of those who died in police custody. The Government agreed to look at this recommendation as part of the ongoing Lord Chancellor's review into legal aid. Mr Reed argued that NC1 would stop deaths in mental health units falling into a loophole that meant families were not supported, whilst families with cases related to deaths in police custody could become eligible for legal aid.

Jackie Doyle-Price argued that the Bill was not the appropriate mechanism to implement legal aid changes, but said that the Government would look at this issue:

> The hon. Gentleman (Steve Reed) will be aware that the Ministry of Justice is committed to the ministerial board on deaths in custody, and I am one of the rotating co-chairs of that board. We are looking at an urgent review of the provision of legal aid for

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33 PBC Deb 25 April 2018, c42

> inquests, and the position is due to be published later this year as part of the Government's response to Dame Elish Angiolini's review of deaths and serious incidents in police custody. We will take up this matter as part of that. As the hon. Gentleman says, it is important that we consider deaths in mental health detention on the same basis as those in other methods of detention, such as prisons. That review will ensure consistency of support for families.[34]

Steve Reed reiterated his belief that families must have access to legal aid, but would see whether this reform could be introduced through the Government's preferred route first. He withdrew NC1, but stated that he was "reserving the right to reintroduce amendments into the Bill at a later stage if necessary."[35]

5.2 Body worn video: clauses 13-16

Clause 13: police body cameras

Clause 13 in the Bill as introduced would have required on-duty police officers called to a mental health unit for any reason to wear a body camera that is recording from "as soon as reasonably practicable" after the time they receive the request to attend, until they leave the unit.

Steve Reed moved amendments 75, 93 and 96. These amendments redrafted clause 13 to remove specifications on when precisely a camera should be turned on and off, and also only required these to be worn "when reasonably practical." This followed debates at Second Reading as to whether requiring cameras for all police interventions could prevent timely attendance in an emergency, in situations where cameras were not readily available.[36]

Amendment 93 clarified that not wearing a body camera would not automatically make a police officer liable to criminal or civil proceedings, but would be taken into account when determining liability. In moving the amendments, Steve Reed stated that:

> There was agreement on Second Reading about the need to get the provision right; we want maximum transparency without inadvertently preventing officers from attending an emergency if they are not equipped with a working body camera. Therefore, this clause, as amended, would ensure that officers are not in breach of the law if they are unable to access a working camera in an emergency. That means that police officers will use body-worn video cameras in a mental health unit unless there is a strong operational reason not to do so.

34 PBC Deb 25 April 2018, cc45-6
35 PBC Deb 25 April 2018, c47
36 HC Deb 3 November 2017, c1115-8

> Amendment 93 brings the effect of failing to wear or use a body camera into line with the contraventions in the police and criminal evidence codes.[37]

The amendments also included special constables in the definition of police officers, but excluded police community support officers (PCSOs), as PCSOs would not be called to assist in the management of a patient.

Clause 13, as amended, was ordered to stand part of the Bill.

In the Bill introduced at Report Stage, this clause stands as clause 12.

Clauses 14–16

Clauses 14-16 covered retention and destruction of video recordings, right of access to recordings and an independent investigator's right of access to recordings. Steve Reed argued that these provisions covered matters already addressed in other legislation and guidance, in particular the *Data Protection Act* and guidance issued by the Information Commissioner's Office. He therefore asked the Committee to vote against the clauses.

Clauses 14, 15 and 16 were accordingly disagreed to.

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[37] PBC Deb 25 April 2018, cc49-50

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BRIEFING PAPER
Number 08088
2 July 2018