Written Evidence for the House of Commons Public Bill Committee regarding the Mental Health Bill.

1. I am Inspector Jon Owen QPM, the Mental Health Coordinator for Avon and Somerset Constabulary, a position I have held for seven years. My work in this field began over a decade ago and has developed into a specialist role with operational, strategic, local, regional and national responsibilities. During my tenure, I have led police involvement in the design and implementation of award-winning, multi-agency mental health initiatives, including the Integrated Access Partnership—recipient of the NHS Parliamentary Award for Excellence in Mental Health Care (South West Region, 2023), and Highly Commended in the inaugural HSJ Seni Lewis Award for Patient Safety (2024).

2. I have written and implemented force-wide and multi-agency policies and procedural guidance, created bespoke mental health training for officers and staff, and acted as advisor to NHS England during the national rollout of 'Right Care, Right Person' (RCRP). In 2023, I was invited by the Police Service of Northern Ireland to review police decision making prior to a double homicide case and produced a comprehensive expert witness report for the Coroner. I am currently the only serving officer in the UK to be recognised as an expert in this domain by a Coronial Court. I was, graciously, awarded the Queen's Police Medal (QPM) for services to policing and mental health in the 2023 New Year Honours.

3. This submission is offered in both a professional and personal capacity. Any personal opinion will be clearly indicated

4. This submission is intended to assist the Committee in their considerations around the Bill. I hope to highlight a number of detailed issues and complications which may otherwise not be considered. By way of executive summary, I intend to cover five specific areas:

    - The need to extend powers under Sections 136 and 135 to trained authorised persons beyond police officers.
    - The implications of removing police stations as Places of Safety without developing safe alternatives.
    - The risks of raising the admission threshold for Sections 2 and 3 without corresponding community provision.
    - The potential of Mental Health Emergency Departments (MH EDs), and the risk of them becoming police-dependent without legislative reform.
    - Risks regarding legal changes and police interpretation under 'Right Care Right Person' (RCRP)

5. Member of the Committee will no doubt be aware that this Bill has been in consultation and held 'on ice' within the Parliamentary system for years. This consultation and the recommendations from Sir Simon Wessley's review which appear within the Bill pre-date the formal adoption of RCRP as national policy. Without amendment, it risks freezing police involvement into statute for another generation, despite broader public policy aiming to reduce it.

Provision of S135 / S135 / holding powers to 'authorised persons' other than police officers

6. At present, the only agency with powers to detain someone under the Mental Health Act in a public place is the police using S136. Where a warrant is sought by an Approved Mental Health Professional in order to detain someone from their home – once granted – that warrant gives sole authority to the police to enter and detain the person (S135.) This has been the case since the Mental Health Act 1959 and remains so now.

7. The stark reality of this is that you can have a situation where someone in severe mental health crisis is at a doctor's surgery, an ED department or in the street, they can be surrounded by doctors, mental health nurses, paramedics and even Approved Mental Health Professionals (AMHP's) but if they are not willing to act voluntarily (which occurs very frequently) then the police **MUST** become involved because they are the only agency with a power to detain.

8. In practice, it means that where an AMHP has obtained a S135 warrant from a magistrate the police **MUST** be involved in its execution as the warrant can only provide powers of entry and detention to the police.

9. In other words – the police are currently 'baked in' to the response despite national policy now attempting to steer away from that. Unless the legislation is amended this situation will persist.

10. It is my understanding that Baroness May inserted an amendment to extend the power to other 'authorised persons.' I fully support this amendment. I believe that it should also be extended to S135 to ensure that warrants can be executed without the need for automatic police involvement.

11. You may hear evidence from others which suggests it is unsafe or impractical. That there are insufficient staff and that they may be in danger. I do not underestimate the level of change, nor the logistics or resources that would be required. I would respond simply by saying that not every S136 detention involves violence or danger and that such an amendment would be the start of a process. Extending those powers to others once they had been sufficiently trained and with realistic deadlines by which this should be achieved.

12. I believe that there has been a need for this for many years and it has been avoided by arguments such as this and the fact that involvement of the police has effectively prevented the need for change. This is no longer a sustainable argument given that RCRP is now national policy and one of its aims is to reduce police involvement.

13. When set within the context of RCRP – leaving the current Act unamended ensures that the police have to be involved in any detention in a public place – including within very many health settings or where a person is already being attended to by numerous health professionals. By not including this amendment then it is impossible to say that the police are not the "right person" because – by law – they are. They are, in fact, the ONLY people.

14. The police could always be called upon to assist those other agencies if the situation was or developed into something which triggers the RCRP Threshold (immediate risk to life or of serious harm – which would include toward other agencies.) This would require VERY careful protocol writing so that the police still recognised and accepted their role but I believe that the provision

of powers to others is now essential. Partly to match the overall aims and objectives of RCRP but to correct something which has become increasingly out of balance over time.

Observations on removal of police stations as a Place of Safety

15. This amendment has been long requested by many and on the face of it, it appears to be a sensible and welcome provision. However, it is not without complication and I am already in direct consultation with NHS England about what those complications are.

16. The use of police cells as a Place of Safety (PoS) can be broadly put into three circumstances:

    a) Situations where local health facilities are full or do not exist and there is no alternative.
    b) Situations where someone has been arrested on suspicion of a criminal offence but it becomes apparent that there are mental health concerns whereby the person requires formal assessment or, having been assessed, recommendations are made for their detention under the Act but there is no bed (or disagreement about the safety of where they can go.)
    c) Situations which fall within the existing Regulations to the Act whereby a person cannot be safely managed at any other location (due to their behaviour / risk.) Although the wording of the Regulation is far more prescriptive – these have generally become known as "exceptional circumstances" in common parlance.

17. By law (a) and (b) should not be happening and yet, in some forces, the situation occurs regularly. The Regulations in the 2018 amendment to the Act were supposed to make it clear that a police station could only be used in circumstance (c). National figures from the Home Office Annual Data Requirement still show that use of police cells (for a combination of the above three) is still in the thousands.

18. It remains the case that the provision of dedicated Places of Safety in some areas of the country is inadequate and in some places they do not exist at all. Meaning that everyone detained under S136 has to go to ED.

19. My primary concern around the complete removal of police cells as a PoS is around circumstance (c). My concern is not necessarily about the removal of police cells but with regards what alternatives will be in place.

20. Looking at the wording of the existing Regulations we are talking here about people who are so volatile, violent, risky or otherwise dangerous (to themselves or others) that they cannot currently be safely managed anywhere OTHER than a police station. This being the case – no place other than a police station currently exists where they can be taken. If police stations are simply removed completely from the options WITHOUT a new suitable provision being created – then the very places currently being determined as unsuitable will be the only places they can be taken. In short – if you are going to remove police cells completely then there will need to be some kind of alternative that can cope with someone behaving in a manner as per the existing Regulations but without recourse to the police.

21. This is something that could potentially be missed as a consideration due to the infrequency with which it occurs in any particular force. In my force it has happened twice in five years. But – when

you consider the number of forces across the country – it would be my educated guesstimate that this would be a weekly occurrence for "the police" nationally – somewhere.

22. Whilst it is infrequent at individual force level (but a regular occurrence when viewed nationally) it is extremely high impact when it does. It is also fraught with risk. These are the kinds of situations which easily result in the use of prolonged restraint with or without police. If a mental health unit loses control of a patient (which does happen relatively often) then they currently have no option other than to call the police for assistance. This is partly due to the constraints within which they work. They are not allowed to use mechanical restraint, they have little to no PPE; their restraint training is vastly different from that taught to police; their range of tactical options is more limited and can be inefficient in dealing with the most volatile of patients – the very kind who would meet the existing criteria of the Regulations around use of police cells.

23. An Emergency Department is absolutely the very last place a person meeting the current criteria should be taken. It is entirely unsuitable. It would be unsafe for other patients and staff and would require many police officers to safely contain the situation. There is no purpose-built provision within an ED department for a situation like this. ED staff are not trained or equipped to deal with it and would be forced to divert their attention to this situation rather than dealing with other patients.

24. However, currently, many purpose-built dedicated PoS are also not equipped or resourced for such circumstances either. Some may have a purpose-built seclusion room – but if that is already occupied then it is not available. Someone in this behavioural state is unlikely to be safe to leave in a seclusion room. We are talking here about levels of behaviour that would normally be managed in a PICU but for which most PoS staff have no training or experience.

25. Of all the people that agencies encounter in crisis – these are the most vulnerable. The most high risk. The most likely to be restrained. These are the situations which are most likely to result in an adverse outcome. Either for the patient or for the staff trying to manage them. There is already a litany of high-profile cases where attempts to manage extremely volatile patients has resulted in their death – with and without police involvement. An outcome which would be unintended but one which is reasonably foreseeable without suitable provision and alternatives being put in place.

26. It would also be the case, currently, that notwithstanding the objectives of RCRP with regards patient handovers , that where a person who meets the criteria for (c) is taken to a health based PoS – it is likely that the staff there will insist upon police remaining to ensure their safety. This is entirely consistent with precedent and common law (*R v Webley*) where the receiving agency must be capable, willing and informed in order for responsibility to be handed over. Nothing in RCRP or the proposed Bill alters this. As things stand, if the legislation were altered to remove police cells then a health-based PoS could (quite legitimately state) that they are neither capable nor willing to accept sole responsibility and the police would be required to remain.

27. This again – is not what the aims and objectives of RCRP would envisage. This is something that could take years to design, develop and implement. It would need to be made very clear within the legislation or any accompanying Code of Practice that it is not something that has changed overnight – even when the law is passed. That it is something that can only happen area by area once provision exists. RCRP implementation has seen the police setting arbitrary deadlines by

which they will stop doing something. It is my personal opinion that that could not be allowed for this. A deadline a few years down the line could be set but great caution would need to be exercised in how police interpret this.

Observations around increasing the admission threshold for S2 and S3 of the Mental Health Act

28. My observations here centre around repeating the situation which emerged following the introduction of the Community Care Act in 1998.

29. This was a well-intentioned piece of legislation. It was intended to accelerate the closure of the old-fashioned asylums which had become viewed as ineffective, inappropriate and expensive. The problem was that it was not sufficiently funded.

30. Consequently, people who had previously (and inappropriately) been placed into asylums suddenly found themselves thrust into the world without sufficient support and into an environment where they were not yet equipped to cope.

31. There were a number of high-profile incidents, including homicides, following the introduction of this Act which forced the incumbent Government to add additional measures to the legislation in the interests of public safety.

32. What can also be demonstrated is that the police use of Section 136 also started to rise significantly following the introduction of the 1998 Act. It has continued to rise and only in the last couple of years has there been any hint of a decrease. It remains many thousands times more a year than it was in 1997. There is not sufficient space to explore the potential reasons for that here but the correlation between the 1998 and the subsequent huge increase in use of S136 is unmistakable. It is likely that this change will lead to an increase in Community Treatment Orders.

33. It is also the case that in this same period the number of available mental health beds has decreased significantly.

34. The argument would no doubt be that if the threshold were increased then there would be more beds available for those deemed to be at most risk to themselves or others. The problem with this argument is that it creates a new tier of people who are just sub-threshold who will now be being managed in the community. Those who would have been in hospital but who are now not.

35. Unless there is sufficient provision for Community Care (which may well be very intensive in many cases) then it is highly likely that more incidents will take place in public and which will involve recourse to the police. It is likely that police use of S136 will start to increase again. Especially if police remain the only agency with the power.

36. My appeal to the Committee is to consider that whilst this is a very well-intentioned amendment there is a history from which we can learn and there is a danger of it being repeated.

The new Mental Health ED's in light of the proposed Bill and RCRP

37. We have been running a pilot project in Avon and Somerset area with BNSSG ICB and the Avon and Wiltshire MH Partnership called the Urgent Access Centre which operates within the

Southmead hospital estate. Its range has been limited but it was always seen as a precursor to something like an MH ED. I, therefore, fully support the initiative for MH ED's.

38. At present there are only two gateways to get support from secondary care providers – either through a referral from a GP (which can take a very long time) or through emergency detention by the police (or S135 warrant.) It is currently not possible to walk in to somewhere at 3am and get the help needed. ED's are doing their best and many provide on-site liaison teams but the rest of the system does not adequately support them (e.g. there is no real AMHP coverage at night, there is a national shortage of S12 doctors to assist with assessments.)

39. If the new MH ED's are well resourced and supported by 24/7 system changes then there is every chance that they could succeed and make a huge difference. However, just building the infrastructure will not be sufficient and, unless some of the changes I have outlined within my evidence so far are introduced, there is a possibility that they will become a magnet to the police.

40. I believe that these MH ED's will need to be fully legally self-sufficient to ensure that this does not happen. Taking my earlier example as case in point – the moment someone decides they want to leave the establishment (whether they have self-presented or been taken by ambulance / police or relative) unless the legislation is changed to provide health staff with S136 or some other holding power then the police will, necessarily, have to be called to the ED to prevent that happening.

41. Given that there will now be a 24-hour focal point where people can go it is likely that more people will attend – making this even more likely than it is now. The frequency with which this already happens cannot be over-estimated. It already occurs multiple times a day in my own force area from within existing ED's.

42. The risks also cannot be over-stated. I invite members of the Committee to review the Coroner's report or press coverage of the inquest in Northern Ireland which touched upon the deaths of Michael and Marjory Cawdery at the hands of Thomas McEntee. Their deaths occurred in 2017. The inquest was only held in 2023 after a number of erroneous internal reviews and reports. This was the case for which I was an expert witness and whilst there was multiple failures and misunderstandings across a number of days – amongst all agencies involved – it laid bare the dangers of treating someone as voluntary and hospital staff having no power to stop someone who wanted to leave. (For reference – on the final day of events Mr McEntee was taken to a hospital in Portadown voluntarily - when he should have been detained under A130 (S136 equivalent) – police did not remain. Within half an hour his demeanour changed again and he stormed out. Hospital staff could not legally stop him. Shortly after that he entered the home of Mr and Mrs Cawdery (an octogenarian couple who had just returned from shopping) and killed them both in a frenzied knife attack.

43. With RCRP now being national policy – the intention is to try and remove the police from as much as possible in this arena. By creating a new facility but without extending powers – there is a risk that it will actually lead to more police involvement.

44. There is nothing at all within the Bill which touches upon any proposed changes to responsibility at the point of proposed handover from police to NHS. Whilst the National Partnership Agreement on RCRP speaks of an aspiration to achieve this within an hour – that NPA is not legally binding

and does not include all the agencies involved in the processes (e.g local authorities are not signatories.) Therefore, we must continue to rely on existing precedent I outlined above (*R v Webley*) which effectively means that the proposed receiving agency must be capable, willing and informed – if they feel that they are not – they do not have to accept responsibility and the responsibility remains with the agency who have control of the person. In this case, the police. Who must then remain to fulfil their legal duty of care. The law has not been amended to take into consideration the aspirations of the NPA. A MH ED, unless it is well resourced and entirely self-sufficient, will just mean that instead of waiting in an existing ED – police will now be waiting in one of the new ones.

Risks regarding legal changes and police interpretation under RCRP

45. With all of my observations, on all topics, and the proposed changes under consideration (extension of police powers to others, removal of police cells) it is my personal opinion that accompanying guidance to the legislation needs to be very clear that, even when the Bill is passed, the changes may well not come into force until there is sufficient and appropriate provision within the NHS. It would help all concerned if realistic future timelines and deadlines were specified but there is a danger of police interpretating any legal changes as being instant and leaning on RCRP as a means to somehow enforce other agencies to do something they may well not be equipped or ready to do. *"You have powers now, it is now your responsibility."* I believe we should be aiming for that transfer or sharing of responsibility as soon as possible but it cannot happen the day the law receives Royal Assent. Some of these changes will take a few years to implement safely and are not without financial and resourcing obstacles.

Conclusion

46. This concludes my observations and submission to the Committee. I respectfully submit it for your attention and consideration. I would like to thank you for taking the time to read and consider its contents. I apologise that it is over 3000 words but it was very hard to convey the detail in fewer words than I have written here.

47. I can be contacted via email Jon.Owen@Avonandsomerset.police.uk should any member wish to discuss my submission further. I understand that the Committee is not currently proposing to have in-person sessions but I would be willing to attend and be questioned further if that changes. I wish the Committee well in their deliberations around this very important Bill. It is a once in a generation opportunity. It is unlikely to be reviewed again for many years. I believe that the legislation needs to be in sync with things like RCRP which have been introduced since the Bill was first drafted, which are now national policy and which have aims and objectives that could be supported more by suitable amendments or inclusions within the Bill.

Jon Owen QPM
Inspector 667
Mental Health Coordinator
Avon and Somerset Police
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