IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2017 1099

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 60(1)
*Section 67 of the **Coroners Act 2008***

Inquest into the Death of LUKE JOHN DE PIAZZA

Delivered On:	26 JUNE 2018
Delivered At:	THE CORONERS COURT OF VICTORIA 65 KAVANAGH STREET, SOUTHBANK
Hearing Date:	19 JUNE 2018
Findings of:	PHILLIP BYRNE, CORONER
Representation:	MR MARK O'SULLIVAN, MINTER ELLISON, ON BEHALF OF ALBURY WODONGA HEALTH
Counsel Assisting the Coroner	MR DARREN MCGEE

I, PHILLIP BYRNE, Coroner, having investigated the death of Luke John De Piazza
AND having held an inquest in relation to this death on 19 June 2018
at The Coroners Court of Victoria
find that the identity of the deceased was Luke John De Piazza
born on 30 March 1982
and the death occurred 3 March 2017
at Albury Base Hospital, Borella Road, Albury, NSW, 2640

from:

1(a) HANGING

in the following circumstances:

1. In this finding I do not propose to focus upon what I will call historical issues, save to say Mr De Piazza, a much troubled man, had a long-standing history of mental health issues. My focus is upon issues proximate to his untimely death.

2. On 25 February 2017, six days prior to his death, Mr De-Piazza, a voluntary patient at Nolan House, a Psychiatric Inpatient Unit at Albury Base Hospital, requested discharge. Hospital staff reported that Mr De-Piazza was asked to reconsider his request for discharge, however he declined. Staff further reported that Mr De-Piazza appeared calm and settled and did not express any suicidal ideation, or thoughts of harm to himself or others. He did not, at that time, meet the quite strict criteria for compulsory treatment.

3. On 2 March 2017 at approximately 4.24pm, Mr De Piazza presented himself to the Albury Base Hospital Emergency Department, where it is claimed he told nurses he left Nolan House without his medication, was hearing voices, and wanted to jump in front of a car. He was described as cooperative and calm. Mr De Piazza was triaged as a priority code two which indicates he would need to be seen within 10 minutes, however he left the emergency department prior to being assessed.

4. Hospital staff reported that throughout that day, Mr De Piazza had called Nolan House on many occasions requesting to speak with a female inpatient on the ward, who it appears he had befriended during his earlier stay at the facility. I am satisfied a wish to see this woman was the real basis for his attendance this day.

5. At approximately 5.30pm, Mr De Piazza reattended Nolan House and began banging his head on a glass window at the counter Patients claimed Mr De Piazza told them earlier he had a firearm. Hospital staff, concerned at the behavior of Mr De Piazza, and in fear for their safety, asked him to leave however he refused and staff called a code black "lock down" and contacted police.

6. A short time later police arrived, wrestled Mr De Piazza to the ground, handcuffed and searched him. No firearm was located. Mr De Piazza was placed in the rear of a police vehicle and asked why he was claiming to have a gun. Mr De Piazza told police he knew they (police) would come and he just wanted to be shot by them. He then said "your gun is right there, can you not just shoot me, just end it".

7. Given his erratic behavior, Mr De Piazza was apprehended by a NSW police member under section 22 of the NSW Mental Health Act 2007, the equivalent of section 351 of the Victoria Mental Health Act 2014, and he was, as required, conveyed to the emergency department of the Albury Base Hospital at approximately 6.00pm where, after a medical assessment it was anticipated he would undergo a mental health review/assessment.

8. However, at approximately 6.30pm, prior to mental health assessment, Mr De Piazza absconded. From the outset that was a matter of concern to me as I was required to consider who was responsible for his security prior to the mental health assessment being undertaken.

9. Police were called out and initiated a search of the immediate area, however were unable to locate Mr De Piazza.

10. At approximately 7.35pm, Mr De Piazza was found hanging in an amenities block at the caravan park at Wodonga back in Victoria where he resided. He was taken to Albury Base Hospital where he later died. Police reported identifying no suspicious circumstances associated with Mr De Piazza's death.

11. The matter was appropriately reported to the Coroner. In the circumstances I did not direct a formal brief of evidence be prepared however requested additional information from Albury Wodonga Health, and statements from members of the NSW police involved in the incidents involving Mr De Piazza.

12. In a statement provided under the hand of Dr Alan England, Albury Wodonga Health advised that the attending police were requested to stay to ensure that Mr De Piazza remained at the facility until assessed, but declined the request.

13. Through the NSW State Coroner, I sought statements from NSW police members who conveyed Mr De Piazza to the hospital. Subsequently I received formal statements from Senior Constable Amaru Medina and Constable Kayla Zwan. I was also provided with a copy of a contemporaneous note in relation to their involvement signed by both police members.

14. In broad terms in their statements, attending police members advised that the security officer, Mr Matthew Fletcher, employed by a private security firm, not the hospital, indicated to the triage nurse that he was somewhat concerned as Mr De Piazza would be the third person awaiting assessment and requested further security be provided.

15. In Dr England's statement it was claimed that nursing staff requested the police members stay, but they declined.

16. In their statements the attending police members maintain that after discussions between them and Dr Laurence Veness, Dr Veness and Mr De Piazza, they were advised they were no longer required and could go. Interestingly, in the contemporaneous note referred to earlier, the police members accept that nursing staff asked them to remain until Mr De Piazza was mentally assessed, but were subsequently advised by the doctor they could leave.

17. In light of the apparent contention I sought a further statement from Albury Wodonga Health.

18. A second comprehensive statement and attachments under the hand of Dr Ken Cheng, Acting Director of Medical Services/Deputy Director of Medical Services, was provided through their solicitors, Minter Ellison.

19. I have found this material most helpful particularly as it demonstrates some of the potential difficulties that can arise primarily due to what I will call "cross border issues".

20. Rather than me seeking to encapsulate some of the issues involved, lest I lose or misconstrue something in the translation, I include in this finding important excerpts from Dr Cheng's statement; he wrote:

> "*Coroner Byrne has enquired as to who has responsibility for an individual that has presented to a mental health facility under the Mental Health Act 2007 (NSW) by police for assessment. I agree with the Chief Psychiatrist that once such an individual is released from the custody of the apprehending police officer, that person enters into the care of the hospital. However, I note the following:*
>
> *a) the Mental Health Act 2007 (NSW) is silent as to at what point in time a person attending a mental health facility pursuant to Section 22 is released from the custody of the apprehending police officer;*
>
> *b) in Victoria, the Department of Health has issued the* ***enclosed*** *'Mental Health Act 2014 Quick Guide – Victoria Police', which states that:*
>
> > *'By agreement between police and hospital staff, police may release the person from custody into the care of hospital staff before the assessment is complete subject to the following considerations:*
> >
> > - *if there are* ***no significant safety concerns****, police can transfer care to hospital staff and the person is released from police custody. If care is transferred, hospital staff will be responsible to arrange for the person to be assessed by a registered medical practitioner or mental health practitioner;*
> > - *if there* ***are significant safety concerns****, police, by agreement with hospital staff should remain until the assessment by a registered medical practitioner or mental health practitioner is complete';*
>
> *c) the Department of Health and Human Services has issued the* ***enclosed*** *'Victoria Police Protocol for Mental Health: A Guide for Clinicians and Police', which states that:*

'Before handover, police should provide clear and comprehensive verbal information to the accepting hospital clinical staff.

Before custody transfer to the hospital, police should complete the Mental Disorder Transfer (VP Form L 42), including the name of the attending registered medical practitioner or mental health practitioner, date and time of release and provide a copy to the mental health clinician who has accepted responsibility for the person.

Handover of a person can only occur when police and hospital clinical staff agree it is safe and in line with the practice principles.

Police may be asked by clinical staff to remain until the person can be examined if the person is acting aggressively or is otherwise considered to be a risk. Police are then responsible for monitoring the person's safety until the hospital's clinical staff accept custody.

Police cannot delegate custody of the person to a hospital security guard, receptionist or administration staff. Nor can they leave a person who is still in police custody in a secure room within a hospital if the hospital has not formally accepted care of that person.

A person examined at a hospital emergency department will no longer be in police custody when responsibility for that person is transferred to the care of a mental health clinician at the hospital. After transfer the mental health clinician/hospital is responsible for the treatment and security of the person'.

21. Because of their significance in relation to determining who has the onerous responsibility of ensuring a patient detained under section 351 (and hopefully section 22 in NSW) is secured until formal mental health assessment, I annex to my finding the documents titled Mental Health Act 2014 – Quick Guide Victoria Police, (Appendix 1) and Department of Health and Human Services – Victoria Police Protocol for Mental Health (appendix 2) referred to in Dr Cheng's statement.

22. As can be seen there are some important differences between NSW and Victoria in the processes involved in transferring custody/care/control, (use what term you may), of a patient brought in by police for a mental health assessment. Basically speaking the NSW "handover" is, in my view, less formalised.

23. In an endeavor to address the difficulties observed in this case, the hospital undertook a comprehensive Root Cause Analysis which made a number of recommendations, some of which were accepted and implemented in a timely fashion.

24. I note with added interest that the relevant "cross border" issues involved here were discussed at the Across Border Emergency Liaison Committee. Again, rather than me seeking to paraphrase the outcome of those discussions as described by Dr Cheng, I include in my finding a further excerpt from Dr Cheng's statement; he wrote:

> "*the patient's case has been discussed at the Across Border Emergency Liaison Committee. The hospital has proposed developing a formal protocol document whereby the respective police officer and senior ED doctor countersign a document to the effect that the care of the patient has been transferred from the apprehending police officer to the hospital. In this regard, I* ***enclose*** *a copy of the draft 'Mental Health Presentation with Police: AWH Acceptance of sole responsibility for care' document that the hospital has prepared. However, the local police advised that such a protocol would need to be approved by management at New South Wales Police;*"

25. Due to its significance in matters such as this, I also annex to my finding the draft document titled Mental Health Presentation with Police: AWH Acceptance of Sole Responsibility for Care (Appendix 3).

26. I do not propose to be critical of either the NSW police members, or indeed, Dr Veness. Although Dr Veness has no recall, I am satisfied he did indeed authorise the NSW police members to leave. I note that in advising police members they could leave, Dr Veness maintains that although no formal section 27 review had occurred, Mr De Piazza had demonstrated a "willingness to co-operate", was "calm", had agreed to wait for assessment and had also agreed to take Olanzepine 10mgs. Dr Vanees did not consider Mr De Piazza to be, at that time, at significant risk of self-harm. Consequently, in spite of what occurred thereafter, I do not believe that assessment, which I accept was open to him, was unreasonable.

27. I see no point in pursuing the issue of Mr Fletcher permitting Mr De Piazza to leave. Once the proposed protocol is formalised a hospital will be required to ensure the security of a patient until review/assessment.

28. I add that I can only speculate as to whether Mr De Piazza would have been admitted as a compulsory patient had he been assessed.

29. Many years ago my colleague, Deputy State Coroner West, made a pertinent comment with which I concur; he wrote:

> *"This tragedy highlights the dilemma facing health professionals who manage and treat individuals with mental illness and their difficulty in predicting when a patient is at risk of crossing the suicide threshold. The patients' actions are frequently impulsive. Prior attempts and risk factors may be well documented, however, such material can rapidly go out of date and thus be less helpful as an indication of future behavior. While the difficulties associated with fluctuating risk behavior are well recognised; it is imperative that health professionals remains vigilant in their attempts to identify indicators of anxiety, depressed mood and self harm".*[1]

FINDING

30. I formally find Luke John De Piazza died on 3 March 2017 at Albury Base Hospital, due to hanging in circumstances where he intended to intentionally take his own life.

COMMENT

31. Pursuant to section 67(3) of the *Coroners Act 2008*, I make the following comments connected with the death.

32. For my purposes, whether Mr De Piazza was in the custody of the apprehending NSW police member, or the hospital at the time he absconded is somewhat academic, as whatever the situation, I did investigate the circumstances of his absconding to an extent to satisfy public expectation.

33. Noting that in Dr Cheng's statement the proposed formal protocol has not been "approved" by management of the NSW Police. On 20 June 2018, my Legal Officer inquired of Mr O'Sullivan as to whether the proposed protocol had been approved.

34. Mr O'Sullivan advised that the Memorandum of Understanding (MOU) included the following proposals at pages 24 and 26 respectively:

    a) *"Where the person is to be released from police custody, attending police will clearly communicate with clinical staff their intention to release the person from NSWPF custody. Attending police will complete a handover of the patient and communicate to clinical staff any identified risks in order to determine appropriate ongoing security requirements. Police will not withdraw before this process is completed."*

and:

[1] Case COR 2001 3310

b) *'Presenting agency staff will not withdraw prior to the completion of the handover process. ..... Once the formal handover of the person has been completed, hospital staff are responsible for the care and management of behavioral issues. .... Where the level of risk is unable to be safely managed, police may be called upon to assist'.*

35. It is unclear to me whether the relevant issues referred to in the MOU have been approved and adopted. In any event, I do not propose to delay finalisation of my Finding, but merely provide a copy of my finding to NSW Police Command for their information. I only add that in my view the proposals are consistent with the Victorian position and eminently appropriate.

36. I direct that a copy of this finding be provided to the following:

Ms Sarah De Piazza, Senior Next of Kin;

Mr Mark O'Sullivan, Minter Ellison on behalf of Albury Wodonga Health;

Dr Neil Coventry, Office of Chief Psychiatrist;

NSW Police Commissioner; and

Leading Senior Constable, Kelly Ramsay, Coroner's Investigator, Victoria Police.

Signature:

PHILLIP BYRNE
CORONER
Date: 26 June 2018

Coroners Court of Victoria

APPENDIX 1

health

Mental Health Act 2014

Quick guide – Victoria Police

Police protocol

The *Department of Health and Victoria Police Protocol for Mental Health* is currently being updated. More detailed information about the changes outlined below will be included in the protocol.

Apprehension of person with mental illness by police

Section 351 of the *Mental Health Act 2014* (the Act) replaces the existing section 10 in the *Mental Health Act 1986*.It enables a police member to apprehend a person if they are satisfied that the person appears to have mental illness and because of the apparent mental illness, needs to be apprehended to prevent serious and imminent harm to the person or to another person. Police are not required to exercise any clinical judgment about whether the person has mental illness.

As soon as practicable following the apprehension of the person, police must arrange for the person to be taken to a registered medical practitioner or mental health practitioner. For this purpose, police may arrange for the person to be taken to the emergency department of a public hospital to enable a registered medical practitioner or mental health practitioner at the hospital to examine the person.

Emergency department staff will generally arrange for a registered medical practitioner or mental health practitioner from the hospital's mental health team to examine the person to decide whether to make an Assessment Order.

By agreement between police and the hospital staff, police may release the person from custody into the care of hospital staff before the assessment is complete subject to the following considerations:

- if there are **no significant safety concerns**, police can transfer care to hospital staff and the person is released from police custody. If care is transferred, hospital staff will be responsible to arrange for the person to be assessed by a registered medical practitioner or mental health practitioner.
- if there **are significant safety concerns**, police, by agreement with hospital staff should remain until the assessment by a registered medical practitioner or mental health practitioner is complete.

The Act does not limit any other power of police in relation to a person apprehended under section 351.

Authorised person

'Authorised persons' are police officers, ambulance paramedics and medical practitioners or mental health practitioners employed by a designated mental health service.

The Act permits authorised persons to enter premises, apprehend people, use force and bodily restraint and provide transport to take people to a designated mental health service in prescribed circumstances, for example when a person subject to an Inpatient Assessment Order needs to be taken to hospital.

Bodily restraint

'Bodily restraint' is any form of physical or mechanical restraint that prevents a person having free movement of their limbs.

An authorised person may use bodily restraint to enable a person to be safely taken to or from a designated mental health service or any other place. The bodily restraint may only be used where it is necessary to prevent

serious and imminent harm to the person or to another person. It may only be used if all reasonable and less restrictive options have been tried or considered and have been found to be unsuitable.

Search and seizure

Search

Authorised persons may search a person who is being transported under the Act if they suspect that the person is carrying something that could help the person to escape or that presents a danger to health and safety. The authorised person must explain the purpose of the search to the person being searched to the extent that is reasonable in the circumstances.

The power to search includes:

- quickly running the hands over the person's outer clothing (a 'pat-down' search) or passing an electronic metal detection device over or close to the person's outer clothing
- requiring the person to remove his or her overcoat, coat or jacket and any gloves, shoes or hat and examining those items of clothing
- requiring the person to empty their pockets or allowing their pockets to be searched.

A search must be the least invasive possible, conducted in a way that provides reasonable privacy and done as quickly as possible.

If the person being searched is 16 or younger, a search must be in the presence of a parent or if a parent is not reasonably available another adult.

A search that involves running the hands over a person's outer clothing must be conducted by an authorised person of the same sex as the person searched or a person of the same sex as the person searched under the direction of the authorised person.

Seizure

If an authorised person finds something during a search that could be used to help the person escape or is a danger to health and safety, the authorised person may seize and detain the item.

The authorised person must then make a written record specifying the date, the item and the name of the person from whom it was taken. Some items, such as weapons, firearms and drugs of dependence must be retained by police after they are seized and dealt with in accordance with police procedures. Other items may be handed over to the receiving mental health service for safe-keeping so that the item can be returned to the person when it is safe to do so.

Transport

Transport should be provided by the least restrictive means possible. In many cases people can be safely transported via private means or in a mental health service vehicle. However, where this is not safe, Ambulance Victoria continues to have lead responsibility for providing transport. Police will continue to have a role in transport, either in conjunction with other transport providers or to provide transport where a person cannot be safely transported by other means.

Information disclosure

The Act permits disclosure of information where it is necessary to lessen or prevent a serious and imminent threat to an individual's life, health, safety or welfare or to prevent a serious threat to public health, public safety or public welfare. Police and Area Mental Health Services should develop local protocols to guide information disclosure via the local emergency services liaison committees.

Please refer to www.health.vic.gov.au/mentalhealth/mhactreform for other information about the Act.

To receive this publication in an accessible format phone 1300 656 692 or emailmhactreform@health.vic.gov.au.

Authorised and published by the Victorian Government, Melbourne, June 2014.

APPENDIX 2

Department of Health and Human Services–Victoria Police protocol for mental health

A guide for clinicians and police

VICTORIA POLICE

VICTORIA State Government | Health and Human Services

To receive this publication in an accessible format email
mentalhealthreform@dhhs.vic.gov.au

Authorised and published by the Victorian Government, 1 Treasury Place, Melbourne.

Where the term 'Aboriginal' is used it refers to both Aboriginal and Torres Strait Islander people. Indigenous is retained when it is part of the title of a report, program or quotation.

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Contents

1. Introduction

This protocol sets out the agreed arrangements for interactions between Victoria Police and mental health clinicians when supporting people with mental illness.

Throughout this protocol 'mental health clinician' is used to describe all clinicians who support people with mental illness. This includes psychiatrists, registered medical practitioners, nurses and mental health practitioners. Where the protocol refers specifically to registered medical practitioners and mental health practitioners, only the specifically named practitioner has the legislative power to act.

For queries relating to the application of this protocol, contact:

Assistant Director, Programs and Performance
Mental Health Branch
Department of Health and Human Services
Email: mentalhealthreform@dhhs.vic.gov.au

or

Portfolio Manager, Mental Health, Priority Communities Division
Victoria Police
Telephone: 9247 6666

1.1. Objectives

The objectives of the protocol are to:

- clarify the respective roles, responsibilities and procedures for interactions between police and mental health clinicians;
- give people with mental illness, their families and carers certainty and confidence in the responses of police and mental health clinicians; and
- provide a framework for developing local agreements.

1.2. Legislation and policy framework

Collaboration between mental health clinicians and police requires effective working arrangements within existing legislative and policy guidelines.

The protocol does not alter existing internal agency legislative and policy guidelines. The protocol only applies to situations where either the police or a mental health clinician has requested assistance from the other.

The primary governance legislation for Victoria Police is the *Victoria Police Act 2013.*

The primary legislation underpinning this protocol is the *Mental Health Act 2014* (the Act).

All section references are to the Act, unless otherwise stated.

The Act (section 11) contains a number of principles to guide the provision of mental health services. Any person performing a duty or function or exercising any power under the Act must have regard to the mental health principles. The principles state that persons with mental illness should:

- Be provided assessment and treatment in the least restrictive way possible, with voluntary assessment and treatment preferred.
- Be provided services with the aim of bringing about the best possible therapeutic outcomes and promoting recovery and full participation in community life.
- Be involved in all assessment decisions, treatment and recovery and be supported to make or participate in those decisions, with their views and preferences respected.
- Be allowed to make decisions about their assessment, treatment and recovery that involve a degree of risk.
- Have their rights, dignity and autonomy respected and promoted.
- Have their medical and other health needs, including any alcohol and other drug problems, recognised and responded to.
- Have their individual needs (whether as to culture, language, communication, age, disability, religion, gender, sexuality or other matters) recognised and responded to.

The principles also acknowledge:

- Aboriginal people receiving mental health services should have their distinct culture and identity recognised and responded to.
- Children and young people receiving mental health services should have their best interests recognised and promoted as a primary consideration, including receiving services separately from adults, whenever this is possible.
- Children, young people and other dependents of people receiving mental health services should have their needs, wellbeing and safety recognised and protected.

- Carers (including children) for people receiving mental health services should:
  - be involved in decisions about assessment, treatment and recovery, whenever this is possible; and
  - have their role recognised, respected and supported.

These statutory principles recognise the special vulnerability of children and young people both as service users and carers for people receiving mental health services.

1.3. Practice principles

The following principles underpin this protocol and should inform day-to-day decision-making:

Collaboration: collaboration between police and mental health clinicians is critical to help people with mental illness receive treatment, support recovery and participate safely in the community. Collaboration means respecting professional judgment, independence and applying a problem-solving approach to requests for assistance. Where differences occur, an attempt will be made to resolve them at the earliest convenience.

Person focused:. The safety and welfare of a person with mental illness and of any others present will be a primary consideration in decision-making. This means using the necessary professional judgement for the situation and upholding the human rights of the individual, while having regard to duty of care considerations. It is acknowledged that many people with mental illness have experienced a range of trauma (including physical and sexual abuse).

Least restrictive practices: police and mental health clinicians will respond to the needs of people with mental illness in the least restrictive means practical to minimise any interference with that person's human rights, including their liberty, privacy and dignity. .

Timely response: police and mental health clinicians will attend situations as soon as practicable and without undue delay. This also means recognising the importance of releasing staff from the other service as soon as they have performed their function and are no longer required.

Confidentiality and exchange of information: police and mental health clinicians will share information only with the consent of the person (where that person has capacity to consent) or where authorised by legislation.

1.4. Review

The protocol will be reviewed within two years of its commencement; or following relevant legislative changes (such as the implementation of the recommendations of the Royal Commission into Family Violence (2016)); whichever occurs first.

2. Police requests for assistance from mental health clinicians

2.1. Apprehension by police under section 351

Section 351 of the Act permits police to apprehend a person to determine if an Assessment Order should be made for that person.

Protective Services Officers (PSOs) working at a designated place have limited power to apprehend under section 351. As soon as practicable after apprehension, a PSO will transfer custody of the person to the police.

The use of section 351 does not limit any other custody powers, obligations or legislative requirements that police or PSOs may have in relation to an apprehended person.

2.1.1. Criteria for apprehension

Police and PSOs may only apprehend a person under section 351 if they are satisfied:

- the person appears to have mental illness; and
- because of the person's apparent mental illness they need to be apprehended to prevent serious and imminent harm to themselves or to another person.

Being 'satisfied' the person appears to have mental illness is based on the person's behaviour and appearance and any other relevant information including information from the family and carer if appropriate.

Police and PSOs are not required to exercise any clinical judgment on whether a person has mental illness.

'Serious' and 'imminent' are to be given their ordinary meanings. In the case of imminent, this means about to happen or impending.

If the criteria for apprehension under section 351 do not apply but welfare concerns exist see part 2.4: 'People presenting to police with welfare concerns'.

2.1.2. Other factors influencing the person's presentation

A person apprehended under section 351 may be drug or alcohol-affected, have a cognitive impairment or a medical condition that mirrors mental illness.

A person who is intoxicated or has cognitive impairment can still be examined under section 351 where the criteria for apprehension is satisfied. The registered medical practitioner or mental health practitioner who examines the person will prioritise the person's needs. For example, they may make a referral to an appropriate disability service.

2.1.3. Planning the apprehension

A decision by police to apprehend a person under section 351 should be informed by:

- a person check on LEAP;
- general mental health information about how to approach and apprehend the person (contact the local mental health triage or Mental Health and Police (MHaP) response for support with this); and
- specific mental health information about the person to be apprehended when that information can be disclosed (see part 5.2 'Disclosure by mental health service providers').

2.1.4. Entering premises to apprehend

Under section 353, police may use reasonable force to enter any premises to apprehend someone under the provisions of the Act.

The decision whether reasonable grounds exist to force entry is a police decision, although it is preferable for a mental health clinician to contribute to the risk assessment.

Before using reasonable force to enter premises under section 353 police must:

- be satisfied that the criteria for apprehension under section 351 apply to the person;
- have reasonable grounds for being satisfied the person may be at the premises;
- undertake a risk assessment and (unless urgent entry is required) obtain authority from a sub-officer before using force; and
- announce to any person at the premises that they are authorised to enter under sections 351 and 353 and give the person the opportunity to let the police enter.

If entry is not permitted, reasonable force may then be used to enter the premises.

On entering, police must identify themselves to the person to be apprehended, explain why they are to be apprehended and inform them where they will be taken.

Police procedures apply for securing the premises and reporting any property damage. The police policy on reimbursement of costs applies to forced entry under section 353.

2.1.5. The apprehension

Police will document the circumstances of the person's apprehension under section 351 in the *Mental Disorder Transfer* (VP Form L 42) and provide a copy to the registered medical or mental health practitioner to help them conduct an examination.

2.1.6. Power to search the apprehended person

Police have power under section 354 to search an apprehended person before taking the person to be examined. The search power under the Act can only be used in prescribed circumstances (see part 4.3 'Powers associated with transport').

A common law search power may be applicable when a person is detained by a PSO.

2.1.7. Arranging a mental health examination for an apprehended person

As soon as practicable after apprehending a person under section 351, police must arrange for them to be taken to a registered medical practitioner or mental health practitioner in the community, or an emergency department, hospital or designated mental health service for an examination. The examination must be conducted in person.

Where practical, examination in the community (including the person's home) is preferred because it is least restrictive of the individual's rights. It also avoids unnecessary transport.

2.1.7.1. Examination in the community

To arrange for a practitioner to examine a person in the community contact either:

- the MHaP response; or
- the nearest mental health triage.

If a practitioner is not available the person should be taken to an emergency department, hospital or designated mental health service for an examination.

Police should provide relevant information to the examining practitioner. This may include incident details, safety and risks (like threats, family violence and firearms), drug and alcohol history, intervention orders, family court proceedings and family circumstances. Critical information not recorded on the *Mental Disorder Transfer* (VP Form L 42) should be recorded in the clinical notes. The disclosure of personal information must be with the person's consent (where that person has capacity to consent) or be authorised by legislation (see part 5.4: 'Disclosure by police').

If there is no operational need, police will not take a person to a cell or interview room at a police station for assessment. Examination in a police cell should only occur when it is necessary for the safe examination of the person after all reasonable less restrictive options have been tried or considered unsuitable.

Police are required to remain until the registered medical practitioner or mental health practitioner completes the examination. After examination, the practitioner will either make the person subject to an Assessment Order (Inpatient or Community) or advise police to release the person. At this point, the person will no longer be in police custody, unless arrested for criminal offences (permitted by section 464A(2) and (4)(i) *Crimes Act 1958*).

Where the person is made subject to an Inpatient Assessment Order, they are in the custody of the practitioner and the order is sufficient authority for them to be taken to a designated mental health service and detained for assessment. The practitioner responsible for making the order will determine which authorised person(s) will be responsible for transport.

A person who is released may still need help (see part 2.4: 'People presenting to police with welfare concerns').

2.1.7.2. Examination at a hospital

Where an examination is to occur at a hospital, the apprehended person should be taken to the hospital emergency department that covers the location where the apprehension occurred. This should happen whether the person is an existing client or they live outside the catchment area. Where possible, police should alert the relevant mental health triage of the apprehension and provide an estimated time of arrival (ETA).

Before handover, police should provide clear and comprehensive verbal information to the accepting hospital clinical staff. This includes details of the incident, safety and risk factors (such as threats, family violence and firearms), drug and alcohol history, intervention orders, family court proceedings and family circumstances. The disclosure of information by police must be with the person's consent (where that person has capacity to consent) or be authorised by legislation (see part 5.4: 'Disclosure by police').

Before custody transfer to the hospital, police should complete the *Mental Disorder Transfer* (VP Form L 42), including the name of the attending registered medical practitioner or mental health practitioner, date and time of release and provide a copy to the mental health clinician who has accepted responsibility for the person. Critical information not recorded on the VP Form L 42 should be recorded in the clinical notes.

Handover of a person can only occur when police and hospital clinical staff agree it is safe and in line with the practice principles (see part 1.3: 'Practice principles'). For example, a person can be released from police custody if there are no significant safety risks or concerns for themselves or others. Consistent with the practice principle of timely response, the release of a person from police custody is to be initiated as soon as police are no longer required.

Police may be asked by clinical staff to remain until the person can be examined if the person is acting aggressively or is otherwise considered to be a risk. Police are then responsible for monitoring the person's safety until the hospital's clinical staff accept custody.

Police cannot delegate custody of the person to a hospital security guard, receptionist or administration staff. Nor can they leave a person who is still in police custody in a secure room within a hospital if the hospital has not formally accepted care of that person.

A person examined at a hospital emergency department will no longer be in police custody when responsibility for that person is transferred to the care of a mental health clinician at the hospital. After transfer, the mental health clinician/hospital is responsible for the treatment and security of the person.

2.1.8. Threats

If an apprehended person threatens to hurt anyone it is expected a risk assessment will be carried out at the time to determine the appropriate safety measures to be taken and to assess whether to notify the person who has been threatened. Depending on the circumstances, the risk assessment will be conducted by police and/or mental health clinicians.

Apparent mental illness does not prevent the person being charged in relation to a threat.

Police and mental health clinicians should be aware of increased risk where family violence is evident or intervention orders exist. After a threat, the conditions of any existing intervention should be reviewed. If no intervention order exists consideration should be given to obtaining an order.

If police need advance notice of a patient's discharge from hospital due to safety concerns, a written request can be made to the hospital emergency department or mental health service provider (see part 5.3: 'Advance notice to police of patient discharge').

If a threat is made after custody of the person is transferred to a mental health clinician, they may advise the threatened person to seek police assistance. If the identity of the person threatened or their contact details are not known, the threat should be reported directly to police.

The disclosure of personal and health information must comply with the relevant legislation (see part 5: 'Disclosure of information').

2.1.9. Licence review

Risk mitigation may include a review of whether a person should hold a driver's, firearm or other licence. To suspend or cancel firearms licences, send a report to the Manager, Regulation Support Unit (03 9247 3217) at the Licensing and Regulation Division.

Police who suspend or cancel a licence should notify the patient's mental health clinician so their record can be updated.

2.1.10. Where an apprehended person escapes from police custody or absconds from hospital

If an apprehended person escapes or absconds before being formally released or before an Assessment Order is made for them, the police may apprehend that person again if section 351 criteria apply to them at the time.

If an apprehended person escapes or absconds after an Assessment Order is made for them, an authorised psychiatrist or their delegate may request the police apprehend the person under section 352 if they are 'absent without leave' (AWOL) from the service. This can only occur if the person is subject to an Inpatient Assessment Order.

2.2. People engaged in siege or high risk situations

Police are responsible for incident control and the safety of everyone at high-risk incidents such as a siege or hostage situation in the community.

Where section 351 is not engaged and it becomes apparent that a person has mental health issues, police should contact their local mental health triage for general clinical advice on communication and response strategies. Mental health clinicians may provide police with contact details for family and carers able to provide additional background information where permitted by legislation.

Police should keep the relevant mental health triage informed of the situation so they can monitor the need for onsite attendance, plan for the deployment of clinical staff or advise on changes in the person's behaviour. Police will only request a mental health clinician to attend if it is safe.

Mental health clinicians cannot act as negotiators.

If police seek mental health information about a person, in the absence of that person's consent a mental health service provider may only disclose mental health information to the police in compliance with the Act (see part 5: 'Disclosure of information').

For example, section 346(2) (e) may permit the disclosure of health information to police to reduce or prevent:

- a serious and imminent threat to the person's life, health, safety or welfare; or
- a serious threat to public health, safety or welfare.

Only health information necessary to achieve this purpose may be disclosed.

2.3. Offenders and suspects in police custody

Police are responsible for the health and safety of those in their custody. If a suspect or offender appears to have mental illness, reveals suicidal thoughts or tries to self-harm while in custody, police have a duty of care to ensure that person's safety and arrange appropriate care.

If appropriate assistance is provided and risk mitigation occurs, apparent mental illness or suicidal thoughts do not prevent police continuing the investigation.

A person is considered to be in police custody while they are:

- under arrest or apprehended;
- in the company of a police officer awaiting interview or being interviewed;
- being transported by Victoria Police or its delegate; or
- detained or remanded in a police gaol.

2.3.1. Police interviews

2.3.1.1. Fitness for interview

If a person to be interviewed seems to be experiencing mental illness, has a physical condition that mirrors mental illness and/or is suicidal or self-harming, police should get clinical advice from a forensic medical officer (FMO) to determine that person's fitness for interview.

A FMO may attend to examine the person or provide telephone advice. The FMO will not undertake an assessment for treatment, advise police on the person's criminal responsibility or assess fitness for bail or remand hearings.

Police should not request a mental health clinician (including the person's treating clinician) to determine their fitness for interview.

If the person is a patient of a designated mental health service, with the person's consent the FMO may consult with their treating mental health clinician to form a view regarding the person's fitness for interview. In the absence of consent, a mental health service provider may only disclose health information to the FMO in compliance with the Act (see part 5: 'Disclosure of information').

If an FMO says the person is unfit for interview, the investigation and disposition of an offender may still continue without an interview.

If a person is to be remanded, their ongoing safety, assessment and treatment are the responsibility of the Custodial Health Service (see part 2.3.2: 'Detainees and prisoners in police gaols').

If there are still mental health concerns after the person's release from custody, police may apprehend them using section 351, if the criteria apply (see part 2.1: 'Apprehension by police under section 351').

2.3.1.2. Independent third person

If police suspect a person to be interviewed has some kind of cognitive impairment that affects their ability to communicate and understand information, an independent third person (ITP) must be arranged to be present during the interview; likewise when a statement is being made by victims and witnesses. Police should not ask mental health clinicians (including the person's treating clinician) to perform this role. For more information, see the Victoria Police and Office of the Public Advocate ready reckoner titled *Responding to a person who may have a cognitive impairment.*

2.3.2. Detainees and prisoners in police gaols

Police must call the Custodial Health Advice Line (CHAL) for help to manage a person in custody who appears to be presenting with mental illness (including feeling suicidal) and where other medical assistance is required. CHAL can be contacted 24/7 on 1300 681 926.

CHAL is provided by the Victoria Police Custodial Health Service, a state-wide service for the health and risk management of persons in police custody and prisoners remanded in police gaols. The service supports frontline policing through the provision of medical, nursing and pharmaceutical services. They provide mental health and general medical assessments, advice on drug and alcohol issues, fitness for custody, medication queries and first aid (including emergencies). They do not undertake fitness for interview assessments.

2.4. People presenting to police with welfare concerns

Police routinely interact with people who need help with various health and welfare issues.

Where someone appears to have mental illness, police may get advice and assistance from MHaP or their local mental health triage if not in an area covered by MHaP. Where other welfare issues arise, police may use the Victoria Police e-Referral system (VPeR) to refer the person to specialist support services.

VPeR is not appropriate for people with apparent mental illness who are in crisis.

3. Mental health clinician requests for assistance from police

3.1. Welfare checks and missing persons

Where a mental health clinician has serious concerns about the welfare of a patient being treated in the community, and where the conduct of a welfare check on that person is a risk to the clinician or to others, the clinician may ask police to assist with a welfare check.

The purpose of engaging police is to locate the person and ensure that they are safe.

Before getting police to do a welfare check, there is an expectation that a mental health clinician has attempted to contact the person's family or carer.

It is expected that a clinician will be available to accompany police on a welfare check so they can assess the mental health needs of the person and make arrangements for them to receive appropriate services. Police are not clinicians and cannot undertake a mental health assessment. If a welfare check does not locate the person, the relevant mental health clinician remains responsible for determining what further action should be taken. This may include making further inquiries to try to locate the person or making a missing person report.

3.1.1. Urgent welfare requests

Clinicians may request urgent police assistance with a welfare check (see part 3.2 'Urgent requests for police attendance' for the urgent request criteria). Clinicians should call Police Communications directly on '000' (not the local police station) and provide relevant information about the urgency of the request.

3.1.2. Non-urgent welfare requests

Clinicians should contact the station nearest to where police attendance is required. Arrangements may be made for attendance through a Mental Health Liaison Officer, duty sergeant or senior member in charge at the time, as police often require notice to respond to these requests.

It is not appropriate for a clinician to fax a request directly to a police station without any preliminary discussion of the need for police involvement.

Police require the following information for a welfare check:

- the name, date of birth and address(es) of the patient;
- the type of premises;
- name and contact phone numbers of clinicians who will meet police at the address;
- the nature and urgency of the welfare concerns, giving as much notice as possible;
- details of the compulsory treatment orders applicable to the patient including expiry date;
- the circumstances when the patient was last seen;
- attempts made to contact the patient, family or carer;
- the known current risks/triggers for the patient;
- typical behaviours and communication strategies; and
- any known medical conditions.

3.1.3. Apprehension options

If a person located by a welfare check requires assessment or treatment, it may be necessary for police to apprehend them under section 351 or section 352 if they are subject to a compulsory treatment order and are absent without leave (see part 2.1: 'Apprehension by police under section 351' and part 3.4: 'Compulsory patients absent without leave').

If there are welfare concerns but the criteria for apprehension under section 351 or 352 do not apply, police may use their common law powers to enter premises if they believe it is necessary to help the person. In circumstances when police and/or mental health clinicians cannot make direct contact with the person, reasonable forced entry may be used to enter premises.

3.1.4. Community treatment orders

If a person subject to a Temporary Treatment Order or a Treatment Order in the community doesn't comply with treatment under their order, a police station should not be used as a venue for a mental health clinician to administer medication. If the person's treatment cannot take place in the community, the mental health clinician should consider varying the order to an inpatient order.

3.1.5. Missing person report

Police will accept a missing person report in relation to any patient (whether compulsory or not) if:

- their whereabouts are unknown; and
- genuine fears are held for their safety or welfare.

To make a report, mental health clinicians must complete a printed copy of the *Victoria Police Missing Persons' Report* (VP Form L18A), phone a local police station to initiate the report and then fax the form to the attending or nominated police officer for recording on LEAP.

The mental health service must notify police if they locate a missing patient. This will enable police to update their missing person records, end the active investigation and minimise the risk of a future unauthorised apprehension.

The mental health service must also update police on any change to the status of the patient. If the patient is no longer a compulsory patient, the police have no apprehension power under section 352 and will treat the patient as any other missing person.

If the missing person is a voluntary patient and there are no welfare concerns when they are located, police cannot compel them to return to the mental health service. Police can only notify the service that the patient has been located. Police cannot divulge the patient's whereabouts without their consent. Section 351 remains an option for missing persons located by police where section 351 criteria are satisfied.

3.1.6. Long term missing person

If a compulsory patient is not located within a reasonable time, the mental health clinician should again involve the patient's family/carer in discussions about further action to try to locate the person. For example, requesting consent to disclose relevant medical records to police or asking the family/carer to provide to police with DNA samples, such as a hair or toothbrush (see part 5: 'Disclosure of information').

3.2. Urgent requests for police attendance

In most circumstances, mental health clinicians will manage any challenging behaviours by persons requiring assessment or treatment. However, clinicians may request urgent police attendance where:

- there is a genuine and immediate risk of self-harm or injury to anyone;
- a person is causing significant damage to property;
- a person is committing or has just committed a criminal offence;
- a person is armed with a weapon;
- the clinician knows about or has experienced a person's recent history of violence and a police presence is considered necessary for the safety of those present; or
- the clinician believes that due to the location, time or nature of the situation, a police presence is necessary for safety.

Police will prioritise attendance as they do any other emergency call.

Clinicians should call Police Communications directly on '000' (not the local police station) and give relevant information, including details to assist police to identify the person (name, date of birth, address) and any other information to help police manage the incident and determine an appropriate response.

Police Communications will allocate the request to the relevant police unit or supervisor; give an estimated response time and advise on risk management strategies until police arrive.

3.2.1. Police attendance

Police should be briefed about the incident when they arrive. If the person is a compulsory patient, police must verify their patient status under the Act and the authority of the relevant clinical staff.

Police are responsible for decisions about managing and investigating the incident, according to their operational procedures.

Mental health clinicians are responsible for:

- ensuring compliance with the requirements of the Act;
- assisting police to return to other duties as soon as is reasonable;
- notifying the family and/or carers and keeping them informed of the patient's current health status (subject to liaison with police and the patient's consent); and
- arranging support and debriefing patients affected by the incident.

Once the incident is resolved, police should consider reviewing whether the person should hold a driver's, firearm or other licence (see part 2.1.9: 'Licence review').

When required, the most senior police member present and mental health clinician should arrange for staff directly involved in the incident to participate in a joint debriefing and forward a report to the relevant Emergency Services Liaison Committee.

3.2.2. Police involvement in bodily restraint of a patient

Only specified clinicians under Part 6 of the Act can authorise the bodily restraint of a person at a designated mental health service. The relevant clinician is also responsible for ensuring any bodily restraint is carried out in accordance with the Act.

Police assistance with bodily restraint (including restraint to administer treatment such as an injection) may only be requested in circumstances where there is a genuine and immediate risk of self-harm or injury to anyone.

When police assist with bodily restraint, the intervention remains the responsibility of the relevant clinician. Police should consider the directions of the clinician responsible for the restraint. However these directions must be balanced with operational safety principles to ensure the safety of police and those around them, including the patient. Ultimately, police are responsible for their operational decisions.

The use of handcuffs is a police decision and must be only for operational purposes. Police must submit a *Use of Force* form when using handcuffs.

3.2.3. Carriage of police operational equipment

Carrying police operational equipment is a police decision based on an operational risk assessment. However, health and mental health services prefer that police do not carry operational equipment (such as firearms, capsicum spray or foam) when attending hospitals, inpatient services and community mental health services. This is because of the perceived risk of injury associated with such equipment. Where police assess that there is no operational need to carry their equipment, they should store these appropriately in the police equipment safe available in most hospitals and inpatient facilities. If no safe loading unloading device facility is available, police must follow Operational Safety Tactics Training procedures for unloading firearms in an open area.

3.3. Reporting of criminal offences

Police encourage reporting of all crime, including threats. A victim may be a patient, mental health clinician or other staff members of a mental health service, emergency department or hospital.

When deciding to report an incident to police, consider:

- the nature and seriousness of the incident; and
- whether the victim or another person on their behalf intends to report the matter to police.

To get advice, clinicians should call their local police station and speak to the Mental Health Liaison Officer, duty sergeant or senior member in charge at the time. Police may offer options, such as making a formal report, referral (which may include counselling) and civil pathways. However, once a crime is reported the police will be responsible for the investigation and decision to prosecute.

Police will support victims of crime throughout the reporting process. Specialist police units can help clinicians and patients with more complex matters, such as family violence, sexual assault and child abuse.

3.4. Compulsory patients absent without leave

Police assistance can only be sought to apprehend a compulsory inpatient who is absent without leave (AWOL) from a designated mental health service under section 352 where a current risk assessment and knowledge of the patient indicates safety issues.

Police assistance can only be requested after reasonable steps have been taken to notify the nominated person, guardian, carer (if satisfied that the person's absence will directly affect the carer and the carer's relationship) or parent (if the patient is under the age of 16 years) to try to locate the person.

3.4.1. Requesting police to apprehend

A mental health clinician should directly notify local police by telephone and then fax a completed form MHA 124 *Apprehension of patient absent without leave* to police. When police receive the MHA 124, they will arrange for the patient's details to be entered into LEAP. Dependant on the local arrangements, mental health clinicians may also be required to fax a completed *Missing Person Report* (VP Form L 18A).

The completed MHA 124 must include the expiry date of the patient's order so police can verify that the patient is AWOL at the time of apprehension.

Police must be notified immediately if the patient's status changes under the Act. If the person is no longer a compulsory patient, police have no power of apprehension under section 352 and will treat them as any other missing person.

It is essential that the mental health service notify police if they locate the patient. This will enable police to update the LEAP records, end the active investigation and minimise the risk of a future unauthorised apprehension.

3.4.2. Planning the apprehension of an AWOL patient

A decision by police to apprehend a patient under section 352 should be informed by:

- a person check on LEAP;
- the MHA 124; and
- any other relevant factors.

The Act requires an apprehended person to be returned to a designated mental health service. Not all hospitals are designated mental health services. The preferred location for the return of the patient should be discussed with the mental health clinician requesting the apprehension.

3.4.3. Apprehending an AWOL patient under section 352

If the apprehension is planned, it is expected that a mental health clinician will be present to assess the patient's current mental health needs and make arrangements for the person to receive appropriate services. The police are responsible for the apprehension as well as the safety of everyone present.

If the apprehension under section 352 is not planned and a mental health clinician is not present, police will advise the relevant mental health triage when they have custody of the patient and their estimated time of arrival at the designated mental health service.

Whether the apprehension under section 352 is planned or not, police will document the circumstances of the person's apprehension in the *Mental Disorder Transfer* (VP Form L 42) and provide a copy to the clinician at the receiving designated mental health service.

Mental health clinicians and police should collaborate wherever possible to facilitate the least restrictive means of apprehension to minimise the risk of force being used. In certain circumstances police may use reasonable force to enter premises to return the patient to the designated mental health service. This may involve using bodily restraint and search powers to enable the patient's apprehension and safe transport (see part 2.1.4: 'Entering premises to apprehend' and part 4.3: 'Powers associated with transport').

3.4.4. After apprehension

Where possible, police will return the patient to their treating designated mental health service, provided it does not prolong the time the patient is in police custody (for example if the police locate the patient a considerable distance from their home). Otherwise, police should take the patient to the nearest designated mental health service. It is the responsibility of the patient's service of origin to locate an inpatient bed.

At handover, police should provide the *Mental Disorder Transfer* (VP Form L 42) and all other relevant information to the accepting clinical staff, including incident details, safety and risks (such as threats, family violence, firearms), drug and alcohol history, intervention orders, family court proceedings and family circumstances. Critical information not recorded on the VP Form L 42 should be recorded in the clinical notes. The disclosure of personal information by police must be with the consent of the person or be authorised by legislation (see part 5: 'Disclosure of information').

3.5. Apprehending interstate patients and others

3.5.1. Interstate patients

A compulsory patient who is AWOL from an interstate mental health facility may be apprehended in Victoria under section 326.

An interstate compulsory patient can be apprehended in Victoria if the patient:

- is AWOL from a state or territory with a cross-border agreement with Victoria under section 315; and
- could be apprehended under the law of the 'home' state or a warrant or other document has been issued in that state that authorises the person's apprehension – such as an interstate apprehension order.

Victoria currently has cross-border agreements with New South Wales, South Australia and the Australian Capital Territory. More information about Victoria's cross-border ministerial agreements is available on the department's website <http://www.health.vic.gov.au/mental-health/practice-and-service-quality/service-quality/working-across-service-boundaries>.

The home state will complete an Interstate Apprehension Order and nominate who will apprehend the person in Victoria. Only authorised persons in Victoria and those authorised by the law of the 'home state' may apprehend the person. The list of authorised persons includes police and ambulance paramedics (see part 7: 'Definitions').

In most cases, the interstate mental health facility will negotiate directly with a Victorian designated mental health service regarding the return of the interstate person, without the involvement of Victoria Police.

3.5.2. Process

Where the interstate mental health facility's risk assessment indicates a need for police involvement, the interstate facility will deal directly with Victoria Police. They should contact the Victoria Police Records Services Division on (03) 9247 5928 or (03) 9247 5957 and then fax the completed interstate apprehension order to (03) 9247 5968. Records Services Division operates 24/7. There is no requirement for police to lodge the documents at court.

Records Services Division will create and record a *Person Whereabouts Desired* (VP Form L12) and *Person Physical Description* (VP Form L10) report on LEAP.

Before apprehending the individual, police will:

- confirm with the interstate mental health facility or Records Services Division that there is current legal authority for the apprehension;
- confirm the person's identity; and
- tell the person why they are being apprehended.

After apprehension police will:

- notify the local mental health triage of the Victorian designated mental health service where the person is being taken and the ETA;
- arrange for the documents to be faxed to the receiving designated mental health service if it is impracticable to have a copy of the documents in their possession on arrival at the designated mental health service; and
- complete the *Execution Details* form and provide copies to both Records Services Division to update LEAP and the receiving designated mental health service.

Police will take the person to the Victorian designated mental health service closest to the place where they were apprehended. On arrival, police will transfer responsibility for the patient to a mental health clinician as soon as practicable. There is no requirement for police to retain custody of the patient pending an assessment or examination by the service.

An authorised psychiatrist of the receiving designated mental health service will ensure that:

- the interstate mental health facility and any other persons nominated to apprehend the patient are notified of the apprehension; and
- arrange timely return of the patient to their home state.

For information on responsibility for costs associated with the return of the patient to their home state (see part 4.4: 'Transport costs').

3.5.3. Persons on Non-Custodial Supervision Orders

Designated mental health services supervise people on Non-Custodial Supervision Orders (NCSO). NCSOs allow a person found not guilty of an offence due to mental impairment to reside in the community subject to reporting and treatment conditions (see section 26, *Crimes (Mental Impairment and Unfitness to the Tried) Act 1997*).

The designated mental health service supervising a person on a NCSO may request that the person be apprehended by police if they fail to comply with their order and their safety or that of the public will be seriously endangered unless they are apprehended.

The power to apprehend under the *Crimes (Mental Impairment and Unfitness to the Tried) Act 1997* cannot be used to apprehend a person subject to a Community Temporary Treatment Order or a Community Treatment Order under the Act. The power to apprehend under the Act cannot be used to apprehend a person subject to a NCSO.

Where a person is subject to both a NCSO and a compulsory treatment order under the Act, the treating clinician must decide which order to use to apprehend the person.

4. Transport

4.1. General principles

The following principles apply to the transport of people under the Act.

4.1.1. Least restrictive

Consistent with the objectives of the Act, transport to or from any location under the Act should be by the least restrictive means practical and in a way that provides for the care of the person with a mental illness and minimises interference with that person's human rights including their liberty, privacy and dignity.

'Least restrictive' means consideration by the mental health clinician of whether a person can be safely transported by family, friends, mental health staff using an agency vehicle or a non-emergency patient transport (NEPT) vehicle or ambulance.

4.1.2. Use of an ambulance

Part 4 of this protocol should be read in conjunction with the *Protocol for the transport of people with mental illness* (2014), which details arrangements for the ambulance transport of people with mental illness.

Ambulance Victoria is responsible for providing emergency transport for people with mental illness under the Act. An ambulance must be used to transport a person who has concurrent serious physical health needs.

An ambulance must also be used if the person requires sedation or restraint for safe transport unless an NEPT vehicle is available with an authorised person on board to monitor sedation or restraint under the Act. NEPT staff are not authorised persons under the Act.

4.2. Requesting police involvement in transport

Mental health clinicians can ask police to assist with the transport of people with apparent mental illness, when they pose a serious and imminent risk of harm to anyone. The clinician's decision to request police assistance should be based on a clinical risk assessment of the person's current and past behaviour. It should also be informed by awareness that involving police in transport may aggravate past trauma.

Clinicians may request police involvement in transport by calling Police Communications ('000').

If police and ambulance are both required, the mental health clinician should contact police and ambulance concurrently and arrange to meet at a common location. This might be at a different location to the person requiring transport. The arrival of police at the meeting point before ambulance should not result in a downgrade in the urgency of the ambulance response.

Police decide the extent of their involvement in transport, but cannot delegate responsibility for a person in their custody (for example responsibility for a person apprehended under section 351 cannot be given to ambulance paramedics).

Police involvement in transport may include:

- accompanying the person in another vehicle (for example an ambulance or NEPT vehicle);
- escorting another vehicle (for example an ambulance or NEPT vehicle); and
- as a last resort, transporting the person in a police vehicle.

Following the transfer of custody of the person to a mental health clinician at the destination, police are not responsible for providing transport to second mental health service if there is no bed available at the first destination. In those circumstances, the receiving mental health service is responsible for the person until an ambulance, NEPT or agency vehicle arrives to transport to the second destination.

However police involvement in the second transport may be requested due to the risk of harm as set out above.

4.2.1. Using a police vehicle

If based on clinical advice, police determine that transport in a police vehicle is necessary, they will:

- ensure at least two police are involved;
- ensure the person is under constant observation throughout the journey;
- avoid prone restraint (face down) to support the person's ability to breathe;
- use handcuffs only when necessary;
- never transport a person sedated under the Act or who has serious physical health needs;
- wherever possible, comply with local protocols and notify the nearest mental health triage or its equivalent of their ETA via Police Communications; and
- transport the person to the nearest hospital emergency department or designated mental health service.

Prone restraint should not be used. All restraints are high risk and prone restraint has been identified as a significant risk factor in deaths arising from positional asphyxia.

4.3. Powers associated with transport

4.3.1. Sedation and bodily restraint for safe transport

Section 350 authorises the use of sedation and bodily restraint for the purpose of safe transport. Sedation and bodily restraint may only be used for transport if:

- all reasonable and less restrictive options have been tried or considered and found to be unsuitable; and
- it is necessary to prevent serious and imminent harm to the person or others.

Sedation may only be administered by a registered medical practitioner or a registered nurse /ambulance paramedic directed by a registered medical practitioner. Ambulance paramedics and registered nurses may also administer sedation within the scope of their ordinary practice. The person administering the sedation must document its use and provide a handover to responsible clinical staff at the destination.

Police and other authorised persons are empowered to use bodily restraint for safe transport. If bodily restraint is necessary, it is preferable that police hand-cuffs are not used. The use of police issue handcuffs should therefore be a last resort and a police decision based on operational purposes. An authorised person who uses bodily restraint must document its use.

4.3.2. Searching persons

Section 354 empowers police and other authorised persons to search someone before they take them to or from a designated mental health service (or other location) if they reasonably suspect that person to be carrying something that:

- presents a danger to the health and safety of the person or others; or
- could be used to help that person escape.

Search means:

- quickly running hands over outer clothing;
- passing an electronic metal detection device over outer clothing,
- requiring the person to remove only their overcoat, coat, jacket or similar clothing and any gloves, shoes and hat and examining those items of clothing; or
- requiring the person to empty their pockets or allow their pockets to be searched.

Where the person is 16 years or under the search must be conducted in the presence of a parent or another adult (if it is not reasonably practicable for a parent to be present).

As far as practical, searches must be conducted by an authorised person of the same gender or someone of the same gender under the direction of an authorised person.

Trans and gender diverse or intersex people should be searched by a person of the gender with which the person to be searched identifies.

Whenever necessary, reasonable efforts should be made to locate a person of the appropriate gender to conduct the search.

The person conducting the search must:

- explain the purpose of the search;
- ask for the person's cooperation and provide reasonable privacy;
- inform them whether they will be required to remove clothing and why it is necessary;
- conduct the search as quickly as possible; and
- conduct the least invasive kind of search possible.

Where a young person is admitted to hospital on the basis of the consent of their parent(s) or guardian, the cooperation of a parent or guardian and the young person should be sought before a search.

4.3.3. Seizing and detaining property

Section 356 allows police and other authorised persons to seize and detain property found as a result of a search, if they are satisfied the item:

- presents a danger to the health and safety of the person or others; or
- could be used to help the person escape.

If police are given illegal items (such as drugs or firearms) seized by other authorised persons during a search, they are to be handled according to Victoria Police policy and guidelines. Refer to section 356 for more information.

4.4. Transport costs

4.4.1. Transport within Victoria

4.4.1.1. Using an ambulance

Where an ambulance is used to take a person to a designated mental health service under the Act, Ambulance Victoria bears the cost of the journey and there is no charge to Victoria Police or mental health services. However, where an ambulance is used for transport between hospitals, the sending hospital may be liable for the cost of the ambulance.

Information on responsibility for the payment of fees for inter-hospital and other journeys provided by ambulance or licenced NEPT providers, is available on the department's website <www.health.vic.gov.au/hospitals-and-health-services/patient-care/ambulance-and-nept/ambulance-payment/payment-responsibilities>.

4.4.1.2. Using a police vehicle or escorts

There is no charge to mental health services for the use of a police vehicle or police escorts for transport under the Act.

4.4.2. Transport outside Victoria

If an interstate person is apprehended in Victoria under an Interstate Apprehension Order, the interstate mental health facility requesting the person's return is responsible for the cost of the person's transport home, unless otherwise agreed between the Victorian mental health service and the interstate mental health facility. Costs may include airfares and escort fees.

5. Disclosure of information

The consent of the person should be sought before any disclosure of their personal or health information.

If the person consents, then the disclosure is permitted to the extent agreed by the person. Mental health clinical staff and police should document the disclosure of information and the consent in the appropriate record.

Where a person cannot consent or refuses to consent, in specified circumstances legislation may allow information to be disclosed.

5.1. General principles

The decision to disclose information requires the following consideration:

- What is the purpose for disclosing the information?
  - Can the purpose be served by providing de-identified information?
  - What is the minimum information necessary to serve the purpose?
- Does the person consent to disclose their information?
- Without consent, is the disclosure authorised by law? If not, the information must not be disclosed.

A decision to disclose information that takes into account these factors and is made in good faith will be consistent with the Victorian *Charter of Human Rights and Responsibilities Act 2006*.

Personal information means information or opinion (including information or an opinion forming part of a database) about an individual whose identity is apparent or can reasonably be ascertained from the information or opinion, but does not include information to which the *Health Records Act 2001* applies.

Examples include the information police collect to perform their law enforcement or community functions, such as names, dates of birth, addresses, contact details, intervention orders and criminal histories.

Health information means personal information or opinion about:

- the physical, mental or psychological health (at any time) of an individual;
- a disability (at any time) of an individual;
- an individual's expressed wishes about the future provision of health services; or
- a health service that is provided to an individual.

Health information also includes other personal information collected when providing health services. For example information about a person's compulsory treatment order or the date they are due to be discharged from hospital.

5.2. Disclosure by mental health service providers

Section 346 of the Act is the principal law regulating the disclosure of health (including mental health) information to police. The *Health Records Act 2001* is the principal law governing the collection and use of health (including mental health) information by mental health service providers.

A mental health service provider who discloses information to police must document the disclosure on the client's clinical record, including the reasons for disclosure. When clinically appropriate, a clinician should communicate the disclosure to the person.

5.2.1. Disclosure with consent

Section 346(2) (a) permits the disclosure of health information with the consent of the person receiving services.

5.2.2. Disclosure without consent

Section 346 (2) allows mental health service providers (including staff, contractors, volunteers and board members) to disclose health information without the consent of the person in certain circumstances. The following subsections are most relevant to the disclosure of health information to police.

5.2.2.1. Reduce or prevent a serious and imminent threat

Section 346(2) (e) of the Act allows a mental health service provider to disclose health information to police to reduce or prevent:

- a serious and imminent threat to a person's life, health, safety or welfare; or
- a serious threat to public health, safety or welfare.

The information must only be disclosed to someone who can act to prevent or lessen the threat, such as the police or Vic Roads. For example, where dangerous driving is threatened or has occurred. Only information necessary to achieve that purpose can be disclosed.

5.2.2.2. Person is deceased, missing or suspected to be deceased or missing

Section 346(2) (e) of the Act allows a mental health service provider to disclose health information to police if the person:

- is suspected to be or is deceased;
- is suspected to be missing or is missing; or
- has been involved in an accident or other misadventure and is incapable of consenting to the disclosure.

The disclosure of information in these circumstances should only be to help identify the individual or locate family members for compassionate reasons.

If the individual is missing or has been involved in an accident or misadventure, the disclosure should not be against the expressed wishes of the individual before they disappeared or became incapable of consenting. However, if police know or suspect the individual is deceased, the wishes of the individual expressed before their disappearance should not prevent clinicians from disclosing health information.

5.2.2.3. Required to carry out functions or exercise powers under an Act

Section 346(2) (c) of the Act allows a mental health service provider to disclose health information to police if the information is needed for the mental health service provider to carry out functions or exercise powers under the *Mental Health Act 2014* or any other Act.

For example, providing health information to police to enable them to return an AWOL patient.

5.2.2.4. Permitted by other legislation

Section 346(2) (d) allows a mental health service provider to disclose health information to police if the disclosure of information is permitted by an Act other than the *Health Records Act 2001*.

For example, section 183 of the *Firearms Act 1996* states that a health professional, as defined, is immune from civil and criminal liability if they notify police that they believe a client who has a firearms licence or intends to apply for a licence is not a fit and proper person to possess, carry or use a firearm.

5.3. Advance notice to police of patient discharge

Police may request advance notice of the imminent release of a patient.

Discharge information is health information within the meaning of the Act, so advance notice to police requires the patient's consent. It is the responsibility of police to seek consent.

In the absence of consent, advance notice may only be given if the disclosure is allowed under section 346(2). For example:

- to reduce or prevent a serious and imminent threat to a person's life, health, safety or welfare;
- to question the person to determine their involvement in a criminal offence directly related to the person's current assessment or admission (permitted by section 464A(2) &(4)(i) *Crimes Act 1958*); or
- to execute a warrant of apprehension for a criminal offence.

The request for advance notice must be in writing to the person nominated by the emergency department or the Director of Clinical Services where the person is being assessed or receiving treatment. To avoid the person being surprised on discharge, police must ensure the person is informed of the request.

The request should include:

- the full name and date of birth of the person;
- whether the person has consented to the request;
- sufficient information about the basis for the request for example, the alleged serious and imminent threat, the alleged crime or the existence of an apprehension warrant, to enable the mental health clinician to determine if advance notice can be given; and
- the investigation officer's contact details and alternate contact details for a station supervisor or officer in charge.

The emergency department nominee or Director of Clinical Services must notify police of their decision. Both the request and decision must be added to the patient's hospital admission record as a priority.

The investigating police member or in their absence, the alternate officer must be given reasonable notice of the patient's discharge time. If police cannot be contacted at least six hours before discharge, as a last resort, the clinician should give notice to police by calling '000'. Details of the notification must be recorded in the clinical notes.

The police officer who made the request must complete a *Person Whereabouts Desired* form (VP Form L 12) and get it approved by a supervisor and recorded on LEAP. This enables other police to follow up if the requesting officer is unavailable.

5.4. Disclosure by police

Police may need to disclose information about a person to mental health clinicians, ambulance paramedics, family, carers and other persons who might be at risk.

Two laws govern the disclosure of information by police; the *Privacy and Data Protection Act 2014*, which covers personal information and the *Health Records Act 2001*, which covers health information.

5.4.1. Disclosure with consent

Both Acts allow police to disclose information with consent.

5.4.2. Disclosure without consent

Both Acts allow police to disclose information without the consent of the person in certain circumstances.

The following is most relevant to the disclosure of personal and health information to mental health clinicians.

5.4.2.1. Reduce or prevent a serious and imminent threat

The privacy principles under both Acts allow police to disclose information to mental health clinicians to reduce or prevent:

- a serious and imminent threat to a person's life, health, safety or welfare; or
- a serious threat to public health, safety or welfare.

The information may only be disclosed to someone who can act to prevent or lessen the threat, for example, a mental health clinician. This is not a blanket exemption, police must base each decision to disclose on the specific circumstances of the situation. Only information necessary to achieve that purpose can be disclosed.

These criteria may permit the disclosure of information about threats, family violence and the existence of intervention orders, firearms, current family law proceedings or a history of violence.

5.5. Reportable deaths

5.5.1. Obligations of mental health service providers

The *Coroners Act 2008* requires mental health service providers to notify of a 'reportable death' and to provide information to police as part of the investigation into the death. Hospitals and designated mental health services must immediately report any death that occurs in care to police via Police Communications ('000').

All deaths of inpatients and persons who are compulsory, security or forensic patients or subject to a Non-Custodial Supervision Order must also be reported to the Chief Psychiatrist. The Chief Psychiatrist's guideline on *Reportable Deaths* is available on the department's website <www.health.vic.gov.au/about/key-staff/chief-psychiatrist/chief-psychiatrist-guidelines/reportable-deaths>.

If a death occurs on the premises of a metal health service, clinicians should not disturb the scene. They should help police with information on the client's history, circumstances before their death and interactions with any potential witnesses. The Director of Clinical Services at the designated mental health service is the key contact for police.

Section 103 of the *Coroners Act 2008* makes it an offence for any person to hinder or obstruct a Coroner or a person acting under a Coroner's authority (for example police) in exercising powers under this Act.

5.5.2. Police obligations

Police will investigate the circumstances surrounding a person's death and compile an inquest brief for the Coroner.

As part of their investigation, police may contact the mental health triage nearest to the deceased person's residence to determine if they were a mental health service client. If the person was a client, triage should refer police to the authorised psychiatrist or their delegate to get the required information. Under sections 39 and 40 of the *Coroners Act 2008*, a Coroner may authorise in writing a member of the police force to enter, inspect, copy and/or take possession of specified documents or items, including medical records, reports or opinions on behalf of the Coroner.

6. Governance and liaison

6.1. Emergency Services Liaison Committees

Emergency Services Liaison Committees (ESLCs) address local issues arising from emergency responses by mental health services, ambulance and police to improve service delivery to shared clients. ESLCs:

- develop, deliver and update local protocols for inter-agency service collaboration and coordination;
- address operational service issues, including the use of force, restraint and transport (ambulance and police);
- agree on joint case plans for shared consumers/patients, particularly those who present frequently and/or who have multiple and complex needs (case planning);
- arrange inter-agency training and information sessions to share knowledge and skills (including induction sessions and 'ride-alongs'); and
- inform the Relationship Governance Committee of ongoing or systemic issues requiring attention, local initiatives/achievements and any recommendations.

There are 21 local ESLCs with additional committees in sub-regional/rural areas.

6.2. Relationship Governance Committee

The Relationship Governance Committee (RGC) is co-chaired by the department and Victoria Police. The RGC identifies policy, systemic and operational issues at a state level for joint attention. It also promotes consistency and capability in delivering joint operational responses.

6.3. Dispute resolution

Disputes between mental health clinicians and police should be resolved as early as possible, in a way that ensures the rights of the person with mental illness are promoted.

When a dispute arises, staff should seek a resolution in accordance with their respective organisational policies and this protocol. The organisations involved should use all reasonable endeavours to resolve the dispute through negotiations and if necessary, mediation.

If the issues require more intervention to reach resolution, then staff should formally engage their ESLC. If the issue has policy implications, the ESLC should refer the matter to the RGC.

The Secretary, Department of Health and Human Services and the Chief Commissioner of Police must be informed about significant issues that may affect collaboration between mental health service providers and police.

7. Definitions

All section references refer to the *Mental Health Act 2014* (the Act), unless otherwise stated.

Area mental health service (AMHS)	A geographic catchment in which triage, inpatient and community mental health services are delivered. Each AMHS includes a designated mental health service able to provide acute inpatient treatment. A list of adult AMHS catchments, including relevant local government areas, is available on the department's website <http://www.health.vic.gov.au/mentalhealthservices/>.
Assessment Order	Enables an authorised psychiatrist to examine a person to determine whether they have mental illness and require compulsory mental health treatment (section 28). Made by a registered medical practitioner or mental health practitioner. Assessment may be conducted in an inpatient setting or in the community. The making of an inpatient Assessment Order authorises the person to be taken to a designated mental health service for examination.
Authorised person	Is defined under the Act (section 3) as: • a police officer; • an ambulance paramedic; • a registered medical practitioner employed or engaged by a designated mental health service; • a mental health practitioner; or • a member of a class of prescribed persons (none have been prescribed to date).
Authorised psychiatrist	A psychiatrist appointed as an 'authorised psychiatrist' for a designated mental health service by the governing body of that service (section 150). The authorised psychiatrist has specific powers, duties, functions and immunities under the Act.
Bodily restraint – physical and mechanical	A form of physical or mechanical restraint that prevents a person having free movement of his or her limbs, but does not include the use of furniture (including beds with cot sides and chairs with tables fitted on their arms) that restricts the person's ability to get off the furniture (section 3). Part 6 prescribes the use, authorisation and monitoring of bodily restraint in a designated mental health service. Section 350 outlines the use of bodily restraint for the safe transport of a person under the Act.
Chief Psychiatrist	A psychiatrist appointed (section 119) by the Secretary, Department of Health and Human Services with responsibilities under the Act to provide clinical leadership and promote continuous improvement in the quality and safety of mental health services.
Compulsory patient	A person subject to an Assessment Order, Court Assessment Order, Temporary Treatment Order or a Treatment Order (section 3).

Custodial Health Service	The Victoria Police Custodial Health Service coordinates the welfare of persons in police custody and prisoners remanded in police gaols. The service does not assess fitness for interview. The service: • provides on-call nursing care and assessment services for persons in custody; • provides on-call medical care and assessment for persons in custody through a network of medical officers; • provides medical opinions on fitness to be detained; • advises on the management of people with mental illness or disability in custody; • delivers prisoner health care training programs for police, at all levels; and • promotes public awareness of prisoner health care.
Department	Department of Health and Human Services.
Designated mental health service	A hospital or public health service prescribed in schedule 1 of the *Mental Health Regulations 2014*. Forensicare is also a designated mental health service. A list of designated mental health services is available on the department's website <www.health.vic.gov.au/mental-health/practice-and-service-quality/mental-health-act-2014-handbook/compulsory-treatment/designated-mental-health-services>.
Emergency Services Liaison Committees	Are local committees that address issues arising from emergency responses. Their membership includes representatives from Victoria Police, hospital emergency departments, designated mental health services and Ambulance Victoria .
Forensicare	The trading name for the Victorian Institute of Forensic Mental Health. Forensicare is a designated mental health service that provides secure inpatient services for forensic patients and security patients at the Thomas Embling Hospital.
Forensic Medical Officer	Is a police officer who is responsible for advice and assessment about whether a person in custody is fit for interview. Forensic Medical Officers are also responsible for the collection of medical evidence from victims and offenders and the presentation of expert evidence in court.
Forensic patient	A person found by a court to be unfit to stand trial or not guilty of an offence by reason of having a mental impairment (section 350). A mental impairment includes mental illness.
Independent third person	Maybe an adult, relative or friend of a person to be interviewed by police provided the person is not associated with the police inquiry. They may also be a volunteer trained by the Office of the Public Advocate. More information about independent third persons is available on the Public Advocate's website <http://www.publicadvocate.vic.gov.au/our-services/volunteer-programs>. When police propose to interview a person they believe has a cognitive impairment, they must arrange for an independent third person to be present. The requirement for an independent third person applies whether the person to be interviewed is a witness, victim or suspect.

LEAP	The Law Enforcement Application Package (LEAP) is the primary Victoria Police computer system used by frontline members. It contains information on people who are witnesses, victims and offenders of crime and other incidents in which police are involved.
Mental Health and Police (MHaP) response (formerly PACER)	MHaP response teams combine a mental health practitioner and a police member who respond to a mental health crisis, rather than it escalating unnecessarily and involving an emergency department. The MHaP response is being progressively rolled out across Victoria. Contact the local mental health triage or police for more information. Unless there are significant safety issues, there is no requirement for the police who first respond to remain at the scene after handing over care of a person with mental illness to MHaP. An individual MHaP member (practitioner or police) may request police remain at the scene if they have safety concerns.
Mental health clinician	Is not a defined term in the Act. For the purposes of the protocol, 'mental health clinician' is used to mean staff with professional qualifications and experience in working with people with mental illness. It includes mental health practitioners, nurses, registered medical practitioners and psychiatrists.
Mental illness	A medical condition that is characterised by a significant disturbance of thought, mood, perception or memory (section 4). Specific symptoms and signs will vary depending on the type of mental illness and the person's age. Police do not have to make a clinical judgement when exercising powers under the *Mental Health Act 2014*.
Mental health liaison officers	Are police members located across the state who: • foster communication and collaboration with local mental health service providers; • are aware of current mental health policy and procedures, local initiatives and protocols and referral agencies; • support local members with mental health-specific advice, information and education; • report issues and suggestions to the local Emergency Services Liaison Committees; • develop and promote prevention, early intervention and other mental health response strategies; • provide a first point of contact for members of the community on mental health-related issues; and • promote mental health work at internal and external forums. Contact the nearest police station to identify the local liaison officer.
Mental health practitioner	A registered nurse, registered psychologist, social worker or registered occupational therapist who is employed or engaged by a designated mental health service (section 3).
Mental health service provider	A designated mental health service or a publicly funded mental health community support service (section 3).

Mental health triage (formerly known as Psychiatric triage service)	A service provided by public mental health services 24 hours a day, seven days a week. Triage is a clinical function. The role of the triage clinician is to conduct a preliminary screening prior to a person being examined to assess the nature and urgency of the response required. Police may contact their nearest mental health triage to request advice on: • communication and response strategies to assist with managing the person's presenting behaviours; and • referral options. Information about mental health triage is available on the department's website <http://www.health.vic.gov.au/mental-health/mental-health-services/support-and-intervention/acute-community-intervention-service>.
Mental Health Tribunal	An independent tribunal established under the Act (section 152). The tribunal makes compulsory treatment orders, hears applications for the revocation of orders, applications against transfers, applications for electroconvulsive treatment and neurosurgery for mental illness. The tribunal also periodically reviews the orders of security patients.
Non-emergency patient transport	Non-emergency patient transport (NEPT) includes high, medium and low acuity road and air transport provided under the *Non-Emergency Patient Transport Act 2003* and the regulations made under that Act. NEPT practice is guided by these clinical protocols published by the Department of Health and Human Services. People receiving mental health services who are assessed as suitable and stable for transport may be transported by NEPT services regardless of their level of acuity. The legal basis for transport, will determine who is required to accompany the person. NEPT staff are not authorised to use restraint or sedation. If restraint or sedation is required, the person being transported must be accompanied by and under the care of a person able to use restraint or administer sedation in accordance with the Act. NEPT may be booked through Ambulance Victoria by calling 1300 366 313 or by contacting a licenced provider.
PACER (Police and Clinician Emergency Response)	Refer to the definition of MHaP in this glossary.
Police stations	A list of police stations and Police Service Areas is available on Victoria police website <http://www.police.vic.gov.au/content.asp?Document_ID=7
Psychiatric triage service	Refer to Mental health triage.
Registered medical practitioner	A doctor registered under the Health Practitioner Regulation National Law to practice in the medical profession other than as a student. A psychiatrist is a registered medical practitioner.
Seclusion	The sole confinement of a person to a room or any other enclosed space from which it is not within the control of the person confined to leave

	(section 3). The use, authorisation and monitoring of seclusion for persons receiving mental health services in a designated mental health service is prescribed by Part 6 of the Act.
Temporary Treatment Order	Enables a person to be compulsorily: • treated in the community; or • taken to, detained and treated in a designated mental health service (section 45). An authorised psychiatrist may make a TTO for a person if they are satisfied that the criteria in section 5 apply to the person. The maximum duration of a TTO is 28 days.
Treatment Order	Enables the person to be compulsorily: • treated in the community; or • taken to, detained and treated in a designated mental health service (section 52). The Mental Health Tribunal may only make a TO for a person if they are satisfied that all of the treatment criteria apply to the person. These are the same as the criteria for making a TTO (section 5). The maximum duration of a TO for a person under 18 years of age is three months. For a person 18 years or older the maximum duration of a Community Treatment Order is 12 months and for an Inpatient Treatment Order is six months.
Triage	Refer to Mental health triage.
Victoria Police e Referral system (VPeR)	Victoria Police IT referral system. It provides referrals for individuals in need of non-crisis, non-family violence assistance to appropriate support services. VPeR mental health referrals require the consent of the person referred. Police provide the person's contact details to the relevant agency through VPeR and the agency will attempt to make contact with the person to provide advice or support.
Voluntary patient	A person who is not subject to a compulsory treatment order under the Act but who voluntarily receives mental health treatment.

APPENDIX 3

Albury Wodonga Health

Emergency Department –

Mental Health Presentation with Police: AWH Acceptance of Sole Responsibility for Care

Date: ..... / ..... / .....

1. **Person's name:** ..... has presented to Albury / Wodonga *(strike through one)* Hospital Emergency Department with: *(strike through two)*

- NSW Police, under a s22 Request by a member of NSW Police Force for assessment of a detained person;
  OR
- NSW Police, under a s33 Forensic provisions order *(Police remain until assessment outcome decision made)*
  OR
- Victoria Police, under a s351 Mental disorder transfer.

2. **Police search conducted:** ☐ Yes ☐ No

3. **a) Following arrival to the Emergency Department:** *(strike through one)*

- It is safe for Police to leave the Emergency Department
  OR
- It is NOT safe for Police to leave the Emergency Department;

AND: *(strike through two)*

4. **a) Emergency Department staff accept sole responsibility for care of the person**

OR

b) Emergency Department staff ask that Police members remain until safety risks / concerns can be solely managed by hospital staff or contractors

OR

c) Emergency Department staff discharge the person back into custody of the Police.

Senior ED MO name:	Senior ED MO signature:	Time:
Police member name: *(Optional section)*	Number:	
Signature:	Police Station:	

Copy handed to Police member / or faxed to Police Station @ ..... hrs on ..... / ..... / ..... .