Health Services Safety Investigations Body

Investigation 1: report 1 of 2

Mental health crisis care: legislative challenges in emergency departments

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Before reading this report

This report considers the care of people experiencing mental health crisis and includes discussion about self-harm, suicide and death. Some readers may find the contents of this report distressing. Information about how to access mental health support can be found on the NHS website.

It is important to note that the emergency department is the right place for many mental health emergencies, however prolonged stays may worsen patients' conditions and create challenges in maintaining a safe environment for everyone.

A note of acknowledgment

We would like to thank the many people who contributed to this interim investigation report, including patients, family members and staff in emergency departments and mental health professionals working in acute settings. We would also like to thank the families and carers who spoke to us who have experienced the death of family members who were described as being in mental health crisis.

About this report

This report is intended for healthcare organisations, policymakers and the public to help improve patient safety in relation to safety issues identified for people experiencing a mental health crisis who come into contact with urgent and emergency care services.

This report focuses on the significant legal, policy and safety gap in the care of people in emergency departments (EDs) in mental health crisis. During consultation on this report, concerns were shared with HSSIB about the current challenges in relation to the resourcing and configuration of mental health services that exacerbate challenges faced in the ED. A second report in mental health crisis care in ED will report further on:

- the knowledge, skills, and resources available to emergency departments to care for patients in mental health crisis, including access to information held by other services;
- how the physical environment in emergency departments impacts on the care provided to patients in mental health crisis;
- staff decision making about when to admit or discharge patients who have presented in mental health crisis.

For readers less familiar with this area of healthcare, medical and legal terms are explained in section 1 and appendix 2.

Executive summary

Purpose of this report

In October 2025 HSSIB launched two investigations that explore the safety issues for people experiencing a mental health crisis who come into contact with urgent and emergency care services. This interim report was produced due to the early identification of a significant legal, policy and safety gap in the care of people in emergency departments (EDs) in mental health crisis.

It is reported that around 3% of all ED attendances are mental health related. However, people experiencing mental health problems are twice as likely as other patients to remain in the ED for more than 12 hours.

People in mental health crisis may need to be assessed for admission to a mental health hospital in line with the Mental Health Act 1983. Delays in these assessments being undertaken, and/or the lack of availability of mental health inpatient beds once a person has been recommended for admission, can lead to patients remaining in EDs for prolonged periods.

The investigation findings

- There is an absence of clear legal powers to lawfully prevent vulnerable individuals from leaving the ED while awaiting assessment or admission.
- This legal ambiguity exposes patients to increased risk of harm and/or being unlawfully deprived of their liberty, and places staff in a position of uncertainty when attempting to manage safety.
- For those requiring formal admission to a mental health hospital, an application under the Mental Health Act 1983 cannot be completed until a bed has been identified, which can take days.
- Staff and organisations reported they are often faced with choosing “the least harmful way to break the law” in order to try and keep patients safe.
- EDs are not designed to provide therapeutic mental health care and prolonged stays may worsen patients’ conditions and create challenges in maintaining a safe environment for everyone.

HSSIB makes the following safety recommendations

Safety recommendation R/2026/082:

HSSIB recommends that the Department of Health and Social Care urgently reviews the current legal framework and addresses the current legislative gaps in emergency care for people in mental health crisis and clarify the extension of legal powers for health professionals to hold someone in the emergency department. This will safeguard people who are currently arriving at the emergency department in a mental health crisis and the staff who care for them to support safe, consistent and legally compliant care.

Safety recommendation R/2026/083:

HSSIB recommends that the Care Quality Commission works with stakeholders to produce a position statement on existing legal powers, and the expectations for support for staff, for the care of people experiencing a mental health crisis in emergency departments (including mental health emergency departments and mental health crisis assessment services), who are not detained under a formal legal framework. This should include a review of current guidance and existing powers to help support safe, consistent, and legally compliant care in the absence of comprehensive legislation, while minimising harm and addressing the unique challenges of prolonged stays in the emergency department.

Introduction

In October 2024 HSSIB launched two investigations to explore the safety issues for people experiencing a mental health crisis who come into contact with urgent and emergency care services. This interim report highlights patient safety concerns linked to a legal, policy and safety gap which affects patients in mental health crisis who remain in emergency departments for extended periods.

1. Background and context

1.1 Mental health crisis

1.1.1 Mental health crisis describes when a person feels at breaking point and where they need urgent help. Someone might have a known mental health condition and experience a mental health crisis, or it can be something they have never experienced before. It is usually very frightening for the person experiencing the crisis and those around them. When people are in mental health crisis, they need timely access to support that is compassionate and meets their needs.

1.1.2 Most people experiencing a mental health crisis who go to an emergency department (ED) will be discharged and/or signposted to other services in the community. For some people however, admission to hospital on a voluntary or compulsory basis is needed.

1.1.3 Patients in mental health crisis who attend an ED can have a recommendation for an admission to a mental health hospital under the Mental Health Act 1983. Section 135 of the Mental Health Act 1983 provides a legal framework for the police to intervene when there is

concern for an individual's mental health. It allows police and mental health professionals to enter a person's home to assess their mental health and, if necessary, remove them to a place of safety. This Section is invoked in specific circumstances where (in broad terms) the person is believed to be suffering from a 'mental disorder' and may be at risk of harm or neglect. In addition, Section 136 of the Mental Health Act 1983 allows a police officer to remove someone (adult or child) from a public place to a place of safety if they appear to be suffering from a 'mental disorder' and are in immediate need of care or control.

1.1.4 The ED is a 'place of safety' as defined by the Mental Health Act 1983. In real terms, however, it is only a place of safety if the patient can be kept safe if, and/or when, the police leave.

1.2 Mental health crisis: an overview of the current legal and policy framework

The Mental Health Act 1983, the Mental Health Act 2025, and associated Code of Practice

1.2.1 The Mental Health Act 1983 and the Mental Capacity Act 2005 are the frameworks that allow appropriate healthcare professionals to fulfil their obligations to make sure that people get the right care and support if they are having a mental health crisis. Many people who go to an ED for help with their mental health crisis may need to be kept there to keep them and/or other people safe.

1.2.2 The Mental Health Act 1983 is the primary statutory framework governing the detention and treatment of people experiencing serious mental health crises. The Mental Health Act 2025 reforms and replaces key provisions of the Mental Health Act 1983. The governing legislation however remains the Mental Heath Act 1983 and is referred to as the Mental Heath Act throughout this report. When referring to any recent reforms, the term 'the 2025 Act' will be used to avoid confusion.

1.2.3 The 2025 Act introduces several important reforms that will influence how mental health care decisions are made. Despite these reforms, there remains a lack of clarity about whether health professionals can legally hold someone in an ED until they can be assessed. The Mental Health Act did not grant authority to detain individuals who are not admitted as inpatients, and this position will not be changed by the reforms introduced by the 2025 Act.

1.2.4 The 'Code of Practice: Mental Health Act 1983' sets out how the Mental Health Act should be implemented in practice (Department of Health, 2015). The Code of Practice provides statutory guidance to health and social care authorities and staff on how they should proceed when undertaking duties under the Mental Health Act. While the 2025 Act has now been enacted and makes changes to the way the Code of Practice is prepared and who it guides, there has not yet been a new renamed Code published under the 2025 Act.

The Mental Capacity Act 2005 and Deprivation of Liberty Safeguards Code of Practice

1.2.5 The Mental Capacity Act 2005 protects and empowers people who may lack the ability to make certain decisions for themselves, ensuring decisions are made in their best interests. It provides a legal framework that can be used by healthcare professionals when supporting people where they have a reasonable belief they lack capacity during a mental health crisis.

1.2.6 There are two Codes of Practice associated with the Mental Capacity Act 2005: one for the main body of the Mental Capacity Act (Department for Constitutional Affairs, 2007), and one for the Deprivation of Liberty Safeguards (DoLS) (Ministry of Justice, 2008). They are statutory Codes approved by Parliament.

1.2.7 Deprivation of Liberty Safeguards provides a legal framework to protect people who lack the mental capacity to make decisions about their care and treatment. They aim to make sure that any care that limits a person's liberty is done in the least restrictive way and is in the person's best interests.

1.2.8 A person can only lawfully be deprived of their liberty where there is formal authority to do so. A deprivation of liberty is very likely to occur when someone is not free to leave and is under continuous supervision and control (Care Quality Commission, 2022; Mind, 2023). If the person lacks capacity to agree to be in the ED for example, and they are being prevented from leaving, it is very likely that they will be 'deprived of their liberty', and the Mental Capacity Act 2005 will generally not provide the authority for this. If the person has capacity to agree to be there, and refuses, then neither at present, nor under the 2025 Act, will there be authority to keep the person there. Amendments to the Mental Capacity Act 2005 set out in the Mental Capacity (Amendment) Act 2019 were made; they were not a full overhaul, but rather targeted changes aimed at improving safeguards, clarity and protections (Mental Capacity Act, 2019).

1.2.9 The Mental Capacity (Amendment) Act 2019 introduced the Liberty Protection Safeguards (LPS), which are intended to replace the current Deprivation of Liberty Safeguards (DoLS). The LPS framework is intended to protect individuals aged 16 and over who lack the mental capacity to consent to care or treatment that may amount to a deprivation of liberty. It aims to ensure that a person's rights, wishes and best interests remain central to all decision-making. Once implemented, the LPS (Department of Health and Social Care, 2021) are expected to resolve some of the deficiencies described above. However, the timeline for their implementation remains uncertain, and they may not fully address all existing gaps.

Wider legal obligations and professional guidance

1.2.10 The European Convention on Human Rights (n.d.) imposes statutory obligations upon healthcare professionals. Staff have a legal duty to respect, protect and actively promote human rights, ensuring decisions are lawful, proportionate, and justified, especially where they interfere with a person's rights or freedoms.

1.2.11 The Royal College of Emergency Medicine has published an advisory statement which does not directly address or resolve specific legal gaps in ED mental health care, but sets out best practice principles for the care of patients in the ED awaiting a mental health bed (Royal College of Emergency Medicine, 2025a).

Detention under the Mental Health Act

1.2.12 For detention under the Mental Health Act to be lawful, patients will usually be assessed by two to three people although not necessarily at the same time:

- an approved mental health professional (AMHP)
- a doctor approved by the Secretary of State under section 12 of the Mental Health Act and
- a doctor who knows the person or, if this is not possible, another doctor with experience of mental health conditions.

1.2.13 The purpose of the assessment is to decide whether a patient needs to be compulsorily admitted to hospital. If two medical recommendations for detention are completed and the AMHP considers it appropriate that the patient should be detained, the patient would be compulsorily admitted to a mental health inpatient facility. A person can only be detained under Section 2 (to assess) or 3 (to treat) if strict criteria are satisfied, looking in particular at the risks they pose to themselves or others. The 2025 Act will tighten these criteria when it comes into force.

1.2.14 The Care Quality Commission has a duty under the Mental Health Act to monitor how services exercise their powers and discharge their duties when patients are detained in hospital or are subject to community treatment orders or guardianship. The latest 'Monitoring the Mental Health Act in 2024/25' report was published in January 2026 (Care Quality Commission, 2026). While a key focus of the report is on care of patients detained on mental health inpatient wards, it acknowledges the impact of pressures on the health and care system, including the ongoing pressure on inpatient mental health services and delays in accessing care resulting in some people reaching mental health crisis and needing urgent and emergency care.

1.3 Responding to mental health crisis: the Right Care, Right Person approach

1.3.1 When people are in mental health crisis, they need timely access to support that is compassionate and meets their needs. Right Care, Right Person (RCRP) is a national agreement between heath and police partners designed to ensure people with health and/or social care needs get help from the right professional with the right skills. It outlines a set of expectations as to when the police should – and should not – be involved when a person is in mental health crisis (Department of Health and Social Care, 2024a; Independent Office for Police Conduct, 2024; Royal College of Emergency Medicine, 2024; 2025b). The RCRP approach, and threshold for police response to a mental health-related incident, does not change the police's role under the Mental Health Act.

1.3.2 As highlighted in section 1.1.3, people detained under Section 136 of the Mental Health Act may be taken to the ED as a place of safety. In addition, a person may go to the ED themselves and the manifestation of their mental health crisis may result in the police invoking Section 136 in the ED.

1.3.3 Under Section 136, police may detain a person in a place of safety for up to 24 hours. The period of 24 hours beginning with:

'(i) in a case where the person is removed to a place of safety, the time when the person arrives at that place;

(ii) in a case where the person is kept at a place of safety, the time when the constable decides to keep the person at that place'.

A doctor who is responsible for the examination of a person detained under section 135 or 136, may extend this by up to 12 hours, to a maximum of 36 hours, but only for a valid reason, such as the person not being medically fit for assessment. Once the Section 136 time limit expires, police no longer have lawful authority to detain the individual.

1.4 Extent of mental health crisis in the emergency department

1.4.1 When patients have had recommendations made for admission to a mental health inpatient bed, mental health bed shortages have resulted in growing numbers of patients being subject to long waits in the ED. This is despite Section 140 of the Mental Health Act which requires that every integrated care board and every local health authority board has responsibility to identify hospitals that can provide urgent admission for people detained under the Act. However, the reality is that there are not beds available for patients in cases of 'special urgency' or for patients under 18, when needed, to prevent people waiting for long periods in emergency departments.

1.4.2 Getting It Right First Time (2021) highlighted a significant increase in the number of people being admitted to mental health hospitals as inpatients via the ED route because of a possible lack of access to other services and identified a lack of systematic data regarding which patients go to the ED or access liaison services.

1.4.3 NHS England data presented at a National Learning Forum ‘Mental Health Emergency Departments’ (NHS England, 2025a) reported that around 3% of all ED attendances are related to mental health issues. This figure results in approximately 9,000 mental health related attendances per week. Many mental health emergencies require treatment for an injury or physical health related illness too. Additionally, people who have a diagnosed mental health illness may be attending the ED for an unrelated physical health issue. However, people experiencing mental health problems are twice as likely as other patients to remain in the ED for more than 12 hours. Moreover, among those waiting over 72 hours in the ED, almost a quarter (24%) are mental health related and include people with dementia, people with serious mental illness and those in mental health crisis. Other national reports have identified a rise in the number of patients attending EDs in mental health crisis (NHS Confederation, 2024; Royal College of Nursing, 2025).

1.4.4 For the period January 2024 to December 2025, the Courts and Tribunals Judiciary published a number of prevention of future deaths (PFD) reports highlighting coroners’ concerns about the care and treatment of people experiencing a mental health crisis who had presented to the ED including:

- five PFD reports relating to deaths by suicide among people who attended and then left the ED (Courts and Tribunals Judiciary, 2024a; 2025a; 2025b; 2025c; 2025d)
- two PFD reports relating to the death of a person within the ED (Courts and Tribunals Judiciary, 2024b; 2024c).

2. Findings

2.1 Legal limitations/gaps relating to detaining patients in the emergency department

2.1.1 The investigation identified prevention of future deaths reports that made specific reference to coroners’ concerns relating to the legal gap and its implications, for example:

‘The legal powers and resources available for mental health patients in the Emergency Department of Hospitals is limited and as such detrimental to those attending Accident and Emergency Departments when suffering from a mental health crisis.’

Prevention of future deaths report (Courts and Tribunals Judiciary, 2025d)

‘Patients cannot be detained under the Mental Health Act 1983 whilst in the emergency department. There is a significant risk that some of them are being detained unlawfully, without recourse to the legal safeguards provided by the Mental Health Act 1983. In addition, they do not have a Responsible Clinician.’

Prevention of future deaths report (Courts and Tribunals Judiciary, 2025e)

2.1.2 Current legal frameworks, including the Mental Health Act and the Mental Capacity Act 2005, do not provide timely or practical solutions for urgent detention outside inpatient settings. They also do not provide for a situation where mental health staff, local authority staff, and mental health trusts are unable to meet their obligations to conduct a MHA assessment and admit to hospital in a timely manner. While Section 136 of the Mental Health Act offers limited authority, its strict time constraints and reliance on police intervention create significant operational challenges. Once these time limits expire, neither common law nor existing statutory provisions can justify continued detention, exposing both patients and staff to risk. These limitations not only compromise patient safety but also create a risk of providers acting outside the law, unlawfully detaining patients, and breaching the European Convention on Human Rights (see 2.2.5) under Article 5 - the right to liberty and security, and Article 8 - the right to respect for private and family life.

2.1.3 The investigation, with the help of subject matter advisors, considered what the legal grounds are for stopping a patient leaving the ED. These are considered below:

Section 2 or 3 Mental Health Act

- patients attending an ED are not considered inpatients, leaving professionals without statutory powers, so this cannot be relied upon.

- whereby the patient is detained to the hospital in which the ED is located, or where part of an ED is designated for these purposes an inpatient ward. This may be technically lawful but it would require the (relevant part of the) ED to be able to fulfil the functions and obligations of a mental health hospital inpatient ward, such that it may be unachievable for staff to keep people safe.

Section 5 Mental Health Act – this emergency holding power can only be used for patients already admitted to hospital (including an acute trust), but not in an ED, so this cannot be used.

Section 136 Mental Health Act – police could be called to use their powers and this is certainly lawful in an ED. However, the police might decline to attend; whether such a refusal would be lawful would give rise to complex debates based upon the level of risk that the person posed to themselves or others. In addition, it is not good practice and a very negative and potentially a traumatising experience for patients to have police called to restrain them in a healthcare setting. Unless extended, a Section 136 only lasts for 24 hours which will not cover those patients waiting for a bed for longer than this time.

Extension of Section 136 – if the patient is under Section 136, this can only be extended by 12 hours for clinical reasons and not because of a delay in finding a bed, so this cannot be relied upon for patients waiting longer than 24 hours.

Section 6 Mental Capacity Act 2005

- only provides authority to restrict a person's liberty, and healthcare professionals and subject matter advisors were concerned that many of the scenarios described went beyond restriction of liberty.

- cannot be used to cover time spent waiting for the Mental Health Act powers to be in place. In 2011, R (Sessay) v South London and Maudsley NHS Foundation Trust highlighted a significant gap in current procedures, exposing a system wide issue regarding the legal framework and operational practices for the care of patients in a place of safety.

Deprivation of Liberty Safeguards (DoLS) – a legal subject matter advisor told the investigation that in practical terms, a hospital would be very unlikely to be able to grant itself an urgent authorisation quickly enough to avoid an unlawful detention. It is also

questionable whether a hospital could lawfully issue itself an authorisation to cover a person who is in the ED, and not yet admitted as an inpatient. The DoLS cannot be used to a detain a person for purposes of assessment or treatment of mental disorder where they are objecting to admission or treatment. It is therefore highly questionable whether it would be appropriate for a hospital to grant a self-authorisation where the intention is to bring about such an admission, and the only reason that it has not happened is because of a shortage of beds.

The Liberty Protection Safeguards (LPS) – the timeline for implementation of LPS remains uncertain, and they may not fully address all existing gaps. The LPS cannot cover those who have capacity, they cannot cover those under 16 years of age, and it appears that there is doubt about whether they will provide immediate authority in the ED setting where the intention is to bring about detention under the Mental Health Act but this cannot be achieved because of bed shortages.

Court order – it would in principle be possible for a court order to be sought to authorise deprivation of liberty pending a patient's admission. In practical terms, however, this is very unlikely to be achievable within a short period of time. Difficult questions of law also arise as to whether a court can authorise deprivation of liberty where a statutory framework (the Mental Health Act or Mental Capacity Act) already provides an administrative framework.

2.1.4 In addition, while the police have the authority to invoke Section 136 within the ED, during site visits the investigation heard from stakeholders and healthcare staff that this rarely happens promptly and is always time limited, as detailed above. The investigation repeatedly heard concerns from healthcare professionals that the police will not attend the ED.

Limitations of alternative legal mechanisms

2.1.5 Under the Mental Capacity Act 2005, options such as requesting urgent authorisation under the DoLS or applying to the Court of Protection exist in theory, but in practice neither is achievable within the required timeframe.

2.1.6 Where a person lacks capacity to agree to remain in the ED, the Mental Capacity Act 2005 allows brief restraint under Section 6 but not a deprivation of liberty (that is, for a 'non-negligible period of time'). There is no statutory definition of deprivation of liberty; however, a legal subject matter advisor told the investigation it is likely to be in the region of minutes to hours, rather than days, especially where the person is making clear that they wish to leave. In addition, DoLS cannot be used for the reasons cited above. The Mental Capacity Act 2005 can also only apply to people aged 16 and over.

2.1.7 A legal subject matter advisor told the investigation that any claim for unlawful deprivation of liberty or false imprisonment could result in substantial damages.

Regulatory oversight on use of legal powers applied in the emergency department

2.1.8 The investigation identified gaps in how the use of legal powers is monitored in the ED. The investigation highlights that the only use of the Mental Health Act permitted in the ED would be Section 136. The Home Office collects data from police forces which includes a breakdown in relation to people taken to an ED versus people taken to health-based places of safety (Home Office, 2025). NHS England collects data on the use of Mental Health Act powers from mental health and acute trusts (NHS England, 2024). The data collected includes short-term holding powers used by acute trusts if people are admitted to another department in the hospital.

2.1.9 The Care Quality Commission (CQC) undertook an assessment of Mental Health Services in Acute Trusts. Its assessment looked at services across acute trusts, including EDs. The report highlighted that:

'… staff in acute hospitals were often not clear about the legal process for detaining someone in hospital. When they were detaining a person under the Mental Health Act, staff were often unclear about roles and responsibilities between acute and mental health trusts. More generally, staff in acute hospitals lacked knowledge about the Mental Health Act and how it worked.' (Care Quality Commission, 2020)

The CQC also reported that 'there was confusion around the Mental Health Act and Mental Capacity Act 2005 and when to use which piece of legislation and associated guidance'. It was reported that while:

'…the acute trust is responsible for the oversight, management and support of staff in adhering to the Mental Health Act, they found that staff understanding and application of the Mental Health Act was poor. This could put patients at risk and in some cases was breaching their human rights.' (Care Quality Commission, 2020)

2.1.10 The investigation was told by healthcare staff and CQC staff that there are challenges in how the CQC implements its regulatory framework in this area. The investigation was told that these challenges include balancing the need to uphold patients' human rights while also monitoring patients' safety while they are in detention before an inpatient bed becomes available. The absence of regulatory oversight in monitoring the application of legal powers in EDs poses risks, including the risk of inconsistent practices across hospitals, and an increase in the risk of unlawful detentions and inadequate documentation. It also minimises oversight of how patients' rights are considered and leaves staff vulnerable to challenge and any subsequent legal proceedings.

2.1.11 The investigation was told by healthcare professionals and national stakeholders that the CQC cannot give the advice that frontline professionals require. The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 prohibit providing services without consent unless the person lacks capacity, or are detained under the Mental Health Act and they also prohibit depriving someone of liberty without lawful authority. If the CQC was to advise otherwise, it would itself be acting unlawfully.

2.1.12 The CQC's 'State of care' report (Care Quality Commission, 2025) highlights significant concerns regarding the current DoLS framework, describing it as unsatisfactory and in need of urgent reform. The report identifies a rise in DoLS applications, placing significant pressure on local authorities that are struggling to meet statutory deadlines. As a result, many individuals face prolonged waits without proper legal authorisation, leaving them unlawfully deprived of their liberty.

2.1.13 The CQC also found considerable variation in staff understanding of when and how to apply safeguards. In some cases, restrictive measures, such as locked doors or physical redirection, were not recognised as requiring authorisation, increasing the risk that unlawful practices have become embedded in hospital culture.

2.1.14 Further ongoing delays in publishing the updated Code of Practice and the continued postponement of Liberty Protection Safeguards have compounded these issues, and are reported to be leaving the healthcare system under severe strain.

Government position

2.1.15 Written and oral submissions of evidence from a wide range of stakeholders were submitted to the House of Commons Select Committee following scrutiny on the draft Mental Health Bill and criminal justice system in November 2022 (Department of Health and Social Care, 2022; 2024b; UK Parliament, 2022). The evidence included recommendations requesting greater powers for ED healthcare professionals; however, the recommendation to give these powers has not been implemented with the situation described as "stuck". The reasons for this are described as multifactorial and include workforce shortages and capacity constraints, lack of inpatient mental health hospital beds and inadequate community services, financial uncertainties, and uncertainty about, and the complexity of, training, guidance and Code of Practice updates. All of these factors are repeatedly cited across parliamentary documents, Department of Health and Social Care papers, and clinical research (Department of Health and Social Care, n.d.; Mason et al, 2025; UK Parliament, 2025).

2.1.16 In a research briefing published in August 2025, a government minister acknowledged that there is a lack of clarity about whether health professionals can legally hold someone in an ED until they can be assessed under the Mental Health Act, but said there was no current consensus on the right way to address it. They said the government has committed to exploring the issue further:

> ‘We will engage with stakeholders to understand how the current legal framework is applied and identify solutions to the problems raised. We will also provide further guidance on the existing legal framework, including the handover process from police to health, in the next revision of the code of practice.’
>
> **(House of Commons Library, 2025)**

2.1.17 The investigation is aware that formal consultation on the extension of powers available to professionals in different situations and settings under the MHA is planned, which will include those working in urgent and emergency care services. The consultation will include, but not be limited to consulting on the operation of sections 135 and 136 powers.

2.1.18 The investigation was told by the Department of Health and Social Care that it ‘has committed to extensive engagement in developing the revised Code, including with people with lived experience and their families and carers, staff and professional groups, commissioners, providers and others to do this. In addition, a draft of the revised Code of Practice is planned to go to public consultation’.

2.2 Operational challenges arising from the legal uncertainties in the emergency department

Application of legal powers in the emergency department

2.2.1 The investigation found variations in how legal powers were applied within the ED, indicating inconsistent practices aimed at covering gaps in the current legal framework. Some staff reported relying on the Mental Capacity Act 2005 to bridge these gaps. Most healthcare professionals described use of physical and chemical restraint to try and stop people leaving, despite knowing it is an unlawful deprivation of liberty, because it was considered the ‘least worst’ scenario.

“These patients are unwell and vulnerable and we would feel negligent in most cases allowing them to leave when the only reason they are not detained is because of a desperate national lack of resources.”

Staff member insight

“We have a cavalier attitude to people’s human rights as there is no legal framework – there is no data no numbers. All we have is hidden deprivation of liberty.”

Consultant psychiatrist insight

2.2.2 The investigation was told that people with legal backgrounds are having to train healthcare professionals in “the least harmful way to break the law” and described this as “an appalling situation to be in”. The investigation was told by an ED consultant that “It is normal that capacity is used in this situation, but you can have capacity and still need an admission under the Act”.

2.2.3 The investigation heard and observed that delays in finding mental health inpatient beds is a problem. In a scenario where an informal admission is agreed, then a formal admission under the Mental Health Act is not implemented in line with least restrictive practice. However, because locating an available mental health bed can take days, the agreement to admit informally may change during this delay. As a result, patients may leave before a bed is found, despite ongoing and identified risks.

2.2.4 During a site visit, the investigation was told a patient had been locked in a single room with a toilet for 110 hours. It was not safe for staff to be in the room with them and it was not safe for the door to be unlocked as the patient kept attempting to leave and was desperate to end their life. Staff described that the patient was not receiving any therapeutic intervention and it felt “cruel” and “inhumane” for them to be waiting so long for a bed when they were so mentally unwell.

2.2.5 In the situations described above, either hospital staff or police must consider the patient's human rights, and the rights of others, under the European Convention on Human Rights (ECHR). A legal subject matter advisor told the investigation that hospital staff and police will need to have an evidence-based assessment of the relative risks of:

- continuing to detain the person with no lawful authority (and thereby contravening their Article 5 ECHR right to liberty and security) pending their admission to hospital under the Mental Health Act; and
- discharging the person and thereby putting either the person or others at risk of a breach of rights under ECHR Article 2 (right to life) and Article 3 (freedom from torture, degrading or inhuman treatment).

The situation was described by staff as leaving patients and staff vulnerable, and the fear of adverse consequences related to deaths and inquests is profound.

> "… to have no means to be able to make the right moral and ethical judgement, to save the life of a patient who you know probably had come to ED for a reason is just an absolute travesty."
>
> **Focus group staff member insight**

2.2.6 In mental health crisis situations, healthcare professionals have expressed particular concerns relating to Article 2 (right to life), Article 5 (right to liberty and security) and Article 8 (right to respect for private and family life).

> "The dilemma is stark: do you hold the person unlawfully, breaching their Article 5 rights, or do you let them go, knowing they may kill themselves or others, or cause serious harm? If you release the patients, you may be in breach of your positive obligations as a state agent under Article 2 or Article 3 of the European Convention on Human Rights."
>
> **Consultant psychiatrist insight**

2.2.7 The investigation was told by a legal subject matter advisor that in theory, it would always be possible to go to court to get lawful authority to hold a person in hospital or another setting pending the completion of relevant statutory processes to admit and/or authorise deprivation of

liberty. In reality, however, this was described as ‘a non-starter in most cases given the realities of resources; and there will still be gaps which are not covered time-wise, as well as complex jurisdictional questions as to the extent of the court’s powers’.

2.2.8 In these circumstances, patients are unlawfully deprived of their liberty and healthcare professionals are forced to breach their Article 5 rights. The law assumes there will never be a service failure or an inability to admit someone to hospital, but that assumption does not reflect reality. Healthcare professionals and organisations describe a “lose lose” situation, as without breaching Article 5, they could subsequently be held responsible for a patient dying, for example if a patient leaves the department, under Article 2.

2.2.9 The investigation was told by healthcare professionals in the ED that they do not fully understand the law and that when a person attempts to leave, that they want to keep the person safe and prevent them leaving. The investigation was told of one example where a nurse was told by the police to keep a patient that had absconded “in sight”. The nurse described following the patient in dangerous traffic and then being told by their manager they should not have followed the person beyond the hospital boundary.

2.2.10 The investigation heard that both police and ambulance services often declined to carry out welfare checks when a patient leaves the ED, even if the individual was considered high-risk of harming themselves or others, unless a specific address was provided. Healthcare staff frequently are not able to provide the necessary information, making them feel a significant pressure of responsibility for people’s safety even when they have left the ED. This gap created a fragmented response between the ambulance and police services, with each directing healthcare staff to contact the other. Healthcare staff reported feeling “completely helpless”, “unsupported”, and left responsible to “manage the risk” alone.

2.2.11 Stakeholder feedback has indicated that Right Care Right Person has added further ambiguity in relation to responsibility for carrying out welfare checks with some onus being placed on ED staff to do this. However, there is limited capacity among staff in acute hospital services to support this.

Challenges in undertaking timely Mental Health Act assessments and availability of inpatient beds

2.2.12 The investigation was told by many staff of examples of patients coming to hospital EDs who were suffering from an acute mental illness or in a mental health crisis. In an ideal scenario and in line with national guidance, they would be assessed by the liaison psychiatry team within 1 hour (National Institute for Health and Care Excellence 2016; Royal College of Psychiatrists, 2020).

2.2.13 The investigation was told of examples where patients were not seen within an hour and there were various reasons for this. One common reason shared was patients arriving at the ED in a state of acute alcohol and/or substance intoxication. In these situations, staff said it was difficult to carry out a safe and accurate mental health assessment because the patient may be confused, unable to communicate clearly, and lacking capacity to understand information and decisions about their care. As a result, staff often had to wait until the effects of alcohol and/or substances subsided before starting the assessment, which caused delays.

2.2.14 Other reasons for delays included a lack of suitable rooms for staff to carry out assessments and an influx of referrals that exceeded the available staff capacity to complete them.

2.2.15 The investigation has identified long waits for Mental Health Act assessments. The investigation was told that obtaining a Mental Health Act assessment in a timely way was nearly always impossible due to problems with workforce shortages, specifically of AMHP's and section 12 approved doctors. Of those people who were available, they often had to travel long distances to undertake the assessment. These delays were described as "a nightmare" by staff and will be explored further in the main investigation report due to be published in summer 2026.

2.2.16 During site visits, patients who had been triaged as needing assessment by liaison psychiatry services had left the ED without being seen. One nurse described feeling they were "letting patients with mental health illness down every single day […] the department is so busy and I can't see that they have left. All I can do is ring the police and ask them to do a welfare check". The nurse explained that "I rarely get feedback as to whether the patient is safe".

2.2.17 In all sites visited and during conversations as part of the investigation, delays in finding an inpatient bed were significant. The investigation was told of examples of patients waiting in the ED for several days, the longest reported wait being 13 days. The consequence of this is that if there is no bed the recommendation for detention remains unsigned and has no power, leaving the patient in legal limbo.

> "It is routine now for EDs at any one time to have 5 to 15 patients in ED waiting for beds and at times these patients can be waiting for days/weeks."
>
> **Emergency department consultant**

2.2.18 On the occasions when patients have had their Mental Health Act assessment completed in a timely way and have two medical recommendations for detention, they are not formally detained until a hospital bed is identified for their admission. In this scenario, there are

no practicable or feasible legal grounds to stop a patient leaving before a bed is identified. However, the fact that they are considered unwell enough to require urgent admission under the Mental Health Act suggests that staff may be considered negligent or to have acted unlawfully in allowing them to leave and potentially come to harm.

2.2.19 The investigation heard and observed that it is now very common for patients in the ED to be waiting for mental health hospital inpatient beds for days rather than hours. The investigation was told that the ongoing national bed crisis and unprecedented pressure on mental health services suggests no change to this situation in the foreseeable future.

2.2.20 The Faculty of Liaison Psychiatry within the Royal College of Psychiatrists told the investigation ‘our position is that there is no “legislative gap” leading to unlawful deprivations of liberty in emergency departments. Rather, there is a “service provision gap”: no unlawful deprivation of liberty would occur if NHS and local authority services were configured and resourced to ensure that initial assessment, care, support, and treatment were conducted and admission arranged within 12 hours of arrival’.

2.2.21 The investigation was told by a subject matter advisor that “the law exists in a fictional zone where there are never any resource complications and everybody is always able to do their job”. The investigation was told that it is common that “currently after a Mental Health Act assessment [when] a recommendation for detention has been made, patients wait in an ED without any further mental health input as they are waiting for a bed and are not reviewed again to ensure admission is still the least restrictive action”. The investigation was told by other sites that the liaison psychiatry service will do daily reviews of all patients although it is rare for any appropriate treatment or therapeutic interventions to start.

2.2.22 One senior nurse explained: “When patients with mental health problems are waiting, they’re not receiving any psychological interventions or treatment.” Another senior nurse highlighted the gap between assessment and actual therapeutic intervention: “We only have two permanent registered mental health nurses, and the rest are agency staff. There’s no therapy – just a psychiatry liaison assessment that prescribes next steps, but that’s not therapeutic care.” This was described as leaving patients without meaningful therapeutic support or treatment during critical waiting periods.

2.2.23 The Faculty of Liaison Psychiatry told the investigation that addressing ‘the service gap would involve the development and introduction of consistent practice standards for emergency medicine staff, mental health staff, and AMHP’s, along with resourcing psychiatry and AMHP on call rotas to meet these standards. Alongside this, measures would be needed to improve emergency access to psychiatry inpatient beds and would include optimising bed management

processes, freeing up access to beds by optimising community support to facilitate early discharge, and in some areas ensuring that the number of inpatient beds is increased to an appropriate number for the population'.

2.2.24 The investigation was told "the state of children's mental health is even more confusing". A child may have an assessment under the Mental Health Act and a recommendation for an admission may be made. However, despite the recommendation (and outside the strict terms of the Mental Health Act) a Tier 4 CAMHS case manager can override this and refuse the admission. This leaves the child in legal limbo with no powers available to healthcare professionals to keep the child in the ED and despite the risk to the child/others and safeguarding concerns.

The safety of the emergency department

2.2.25 The ED is not designed for the care of patients with severe mental illness in crisis. In his independent investigation of the NHS in England, Lord Darzi (2024) stated that, "bright busy and noisy A&E Departments are completely inappropriate places for someone in mental health distress". The investigation identified six prevention of future deaths reports, published in 2024 and 2025, which have raised concerns about the unsuitability of the environment for people experiencing a mental health crisis (Courts and Tribunals Judiciary, 2024a; 2024b; 2024c; 2025d; 2025e; 2025f). The impact of the environment will be explored further in the main investigation report due to be published in summer 2026.

2.2.26 The investigation has witnessed scenarios where a Section 136 has expired before a formal Mental Health Act assessment has taken place. In addition, the investigation has observed examples of people being brought into the ED under a Section 136 and the police insisting the ED staff take over the person's care, even if the Section 136 had not expired. Initially police are responsible for the safety of a patient on a Section 136. If an ED allows the police to leave, they take on this responsibility. A discussion should take place between an ED senior healthcare professional and the police officers about if or when the police may leave. This is to ensure the ED have staff and resources to deal with the risk of the patient absconding. This did not happen in all cases and the investigation observed adversarial approaches between the police and ED staff when the police's decision to leave was challenged.

2.2.27 The investigation was told that disagreements should be resolved through discussion between the ED consultant in charge and the duty police inspector; however, this was not always possible. ED staff shared challenges, especially when more junior staff are on duty and there is a power imbalance between police and healthcare staff. The investigation was told by all sites that they do have local policies which guide further escalation if required.

2.2.28 One site visit highlighted significant safety concerns associated with police leaving within a specified timeframe and additional security staff taking over the responsibility for keeping people safe. The ED environment was incredibly busy with 13 patients requiring mental health care. A patient was very agitated and shouting, but staff were reluctant to restrain them in line with the requirement for least restrictive practice and they were concerned if the patient was under heavier sedation, this would further delay their Mental Health Act assessment. One physical health patient left the ED and described feeling “scared”.

2.2.29 All sites visited described similar challenges involving police arriving at the ED with patients placed in spit hoods, foot cuffs, and handcuffs while describing the attendance as “voluntary”. Staff across locations noted consistent explanations from police that these restraints were used “for their [the police officers’] safety”. The police were however suggesting the person was a “voluntary” admission and then leaving the patient.

2.2.30 The investigation spoke with a senior police force representative from an area the investigation visited, who shared the challenges they face with healthcare staff not understanding legal frameworks. The police representative described a “significant lack of understanding of the powers police do, and more importantly do not, have – sometimes we are asked to hold patients when we have no powers to do so, for example to administer a sedative”. They advised that ED healthcare professionals would benefit from conflict resolution training and access to equipment to protect themselves (referring to restraint devices like hand and foot cuffs and spit hoods). However, this is not possible in ED as the National Institute for Health and Care Excellence (2015) recommends that mechanical restraint is not used outside high secure forensic hospitals, and the Mental Health Act Code of Practice (Department of Health, 2015) requires extensive safeguards to limit its use.

2.2.31 The investigation asked for clarification on circumstances when the police request to leave even if the Section 136 has not expired and the ED staff are not able to safely take on responsibility for the patient. The police representative said: “I am not aware of this, and if this were my patch, I would be very concerned.” They further clarified that: “… not a single officer would walk away if a patient or staff member were in danger in the ED, even if the 24-hour limit had been exceeded.”

2.2.32 The police representative shared concerns that decisions to refer patients for Mental Health Act assessments are delayed when a patient is under a Section 136 as it “gives healthcare staff more time and [the patient] is not their problem until that runs out”.

2.2.33 The investigation was told by the police representative and healthcare organisations that they do have regular meetings with police liaison officers to manage safety concerns. These meetings were described as “very helpful”. The police talked about the importance of building relationships between health and police staff. The investigation was told however and observed that there is significant variation in this provision.

Requirement for practical solutions to address the current safety concerns

2.2.34 Healthcare professionals and national stakeholders told the investigation there is a growing frustration with the delay in implementing practical legal solutions that could address the current crisis. One such example shared was consideration of the revised Section 4B of the Mental Capacity Act 2019 and that the government should not wait for the full implementation of the Liberty Protection Safeguards before enacting this provision. This was described by a subject matter advisor as ‘a practical, immediate step that could help address the legal vacuum’.

2.2.35 The revised Section 4B of the Mental Capacity Act 2019 would allow deprivation of liberty in an emergency of a person aged 16 or over who lacks capacity to consent to the relevant act where it is necessary to provide life-sustaining treatment or carry out a vital act. This is not setting specific, so could apply in EDs or in scenarios where paramedics need to bring someone into hospital on an emergency basis. A consultant psychiatrist told the investigation:

> “A simple amendment to allow authorisation under DoLS, rather than Liberty Protection Safeguards, would immediately provide a lawful basis to detain individuals lacking capacity in emergency situations […] Implementing this change would not resolve all the legal gaps however it would significantly reduce them – particularly for the majority of individuals in crisis in emergency departments who lack capacity.”
>
> **Consultant psychiatrist insight**

2.2.36 It was reported that the Department of Health and Social Care has previously had a view that the revised section 4B (when implemented) cannot be used when the process of assessment under the Mental Health Act has started (UK Parliament, 2022). However, a legal subject matter advisor told the investigation this position was legally unclear. Stakeholders also commented that section 4B was designed to hold people until they can have a mental health assessment, but the ‘major problem is actually holding onto people after this’ where no mental health bed may be available.

Conclusion

2.2.37 The investigation highlights the absence of clear legal powers to lawfully prevent vulnerable individuals from leaving the ED while awaiting assessment or admission to hospital. This is exacerbated by prolonged delays in Mental Health Act assessments and/or unavailability of mental health inpatient beds. EDs are not designed to provide therapeutic mental health care and prolonged stays may worsen patients' conditions and create challenges in maintaining a safe environment for everyone.

2.2.38 This legal ambiguity exposes patients to increased risk and places staff in a position of uncertainty when attempting to manage safety. These concerns have been raised previously with NHS England, the Department of Health and Social Care, and during parliamentary scrutiny of the Draft Mental Health Bill (UK Parliament, 2022) and there is a growing frustration with the delay in implementing practical legal solutions that could address the current crisis.

2.2.39 The findings demonstrate a requirement to address this legal ambiguity and provide nationally consistent guidance to support safe, lawful decision making for people experiencing mental health crises in ED settings.

HSSIB makes the following safety recommendations

Safety recommendation R/2026/082:

HSSIB recommends that the Department of Health and Social Care urgently reviews the current legal framework and addresses the current legislative gaps in emergency care for people in mental health crisis and clarify the extension of legal powers for health professionals to hold someone in the emergency department. This will safeguard people who are currently arriving at the emergency department in a mental health crisis and the staff who care for them to support safe, consistent and legally compliant care.

Safety recommendation R/2026/083:

HSSIB recommends that the Care Quality Commission works with stakeholders to produce a position statement on existing legal powers, and the expectations for support for staff, for the care of people experiencing a mental health crisis in emergency departments (including mental health emergency departments and mental health crisis assessment services), who are not detained under a formal legal framework. This should include a review of current guidance and existing powers to help support safe, consistent, and legally compliant care in the absence of comprehensive legislation, while minimising harm and addressing the unique challenges of prolonged stays in the emergency department.

Next steps

The HSSIB investigation will continue to explore the care of patients in crisis who attend emergency departments. Additional findings and safety learning will be presented in the final investigation report. If you would like to share any experience or have further information that may be relevant, please contact Investigations@hssib.org.uk.

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4. Appendix 1

Investigation approach

During our series of investigations into mental health inpatient settings, we heard concerns about the care of people in mental health crisis which may benefit from a HSSIB investigation. We carried out a range of work to help further understand these concerns, including conversations with stakeholders, reviewing available data, and analysing existing literature, including coroners' reports to prevent future deaths.

Feedback from stakeholder engagement was supportive of HSSIB work to explore mental health crisis care and suggested that it would add value in terms of a system-focused lens on the safety issues.

As a result of this work we launched two investigations that explore the patient safety issues associated with care pathways for people experiencing a mental health crisis who come into contact with urgent and emergency care services.

- **Investigation 1** – Mental health crisis: care of patients in emergency departments. The investigation launched in October 2025 with a final report anticipated to be available in summer 2026.
- **Investigation 2** – Mental health crisis: ambulance service response via NHS 111 and 999. This investigation will launch in spring 2026, following completion of substantive work on the first investigation, and is anticipated to be available in spring 2027.

This interim report is linked to evidence collected to date in response to a significant legal, policy and safety gap in the care of people who are in mental health crisis in emergency departments (EDs).

Evidence gathering

The investigation engaged with multiple sites, including a range of hospital types such as district general hospitals, foundation trusts, and university and teaching hospitals. The sites represented a geographical spread covering metropolitan and rural areas. The initial selection below was made on the basis of the trusts that ranked in the top 10 for 2 or more of the 12-hour breach measures (where patients have waited more than 12 hours from arrival in the ED to being seen and discharged or transferred/admitted) from the NHS Futures urgent and emergency mental health dashboard (NHS England, 2025b) and is based on data from the Emergency Care Data Set.

The three measures prioritised to inform selection were:

- Average length of delay over 12 hours – the highest ranking trusts being those where patients with mental health issues waited the longest.
- Total excess time that all patients with mental health issues impacted by delays over 12 hours had waited (results presented in minutes and calculated by the volume of people impacted by delays multiplied by the average length of delay over 12 hours) – the highest ranking trusts being those where either the numbers of people experiencing delays over 12 hours and/or the excess waiting times are higher.
- Highest volume of 12-hour breaches – the highest ranking trusts being those where the numbers of people impacted by 12-hour breaches was greatest.

The investigation then profiled the areas served by trusts in terms of the population profile, including ethnic and demographic diversity, levels of deprivation and geography (urban/rural), to inform the final selection.

Stakeholder engagement and consultation

During visits the investigation spoke with a range of staff who were working in EDs, psychiatric liaison services, crisis services, mental health crisis assessment centres, psychiatric clinical decision units, and environments where people in mental health crisis were being cared for. Speaking to staff was key, as well as seeing the adaptations made and observing ‘work as done’.

The investigation engaged with:

- healthcare professionals including medical doctors, registered nurses, registered mental health nurses, occupational therapists, psychiatrists, psychologists, social workers, drug and alcohol teams, on-site police, security staff, legal teams in trusts and trust management and executives
- security staff working in EDs
- a senior police force representative
- legal teams working in hospitals
- a legal Subject Matter Advisor
- integrated care boards
- national organisations including the Department of Health and Social Care, NHS England, Care Quality Commission, Nursing and Midwifery Council, Royal College of Emergency Medicine, Royal College of Psychiatrists, Getting It Right First Time (GIRFT), Office of the Chief Allied Health Professions Officer for England, Cygnet, NHS Resolution, Association of Ambulance Chief Executives, Royal College of Paramedics, National Mental Health Forum Council
- charitable organisations including the Centre for Mental Health, Action Against Medical Accidents (AVMA), Black Thrive Global, Suicide Crisis, Making Families Count, Rethink
- many patients, families and carers face-to-face at their home, and patients and/or their family members in the ED or mental health urgent assessment centres.

The investigation engaged with stakeholders to gather evidence and check for factual accuracy, and for overall sense-checking. The stakeholders contributed to the development of the safety recommendations based on the evidence gathered.

This is one of two reports under Investigation 1 – Mental health crisis: care of patients in emergency departments. The final report is anticipated to be available in summer 2026.

5. Appendix 2

Glossary

Approved Mental Health Professionals (AMHPs)	AMHPs represent a fundamental legal safeguard under the Mental Health Act 1983 for people at risk of compulsory hospital admission or controls in the community that impact their human rights. AMHPs have the ultimate power to decide whether a person is taken to hospital or alternative care.
Common law	Common law is law that is created by judges through their decisions in court cases, rather than by Acts of Parliament (legislation). It is also known as ‘case law’ or ‘judge-made law’.
Liaison psychiatry services	Liaison psychiatry services in acute physical health hospitals ‘address the mental health needs of people being treated primarily for physical health problems and symptoms’ (Royal College of Psychiatrists, 2013). In England, liaison psychiatry services are typically commissioned, managed and delivered as part of mental health services rather than acute physical hospital services. This means these staff are employed by the mental health provider but are based in the acute hospital, where they work collaboratively with the physical healthcare staff.
Responsible Clinician	A Responsible Clinician is the Approved Clinician with overall responsibility for the care of a patient detained under the Mental Health Act 1983.
Section 136 suite	A Section 136 suite is a facility for people who are detained under Section 136 of the Mental Health Act 1983. It provides a place of safety while potential mental health needs are assessed and necessary arrangements are made for ongoing care. Patients can be taken there directly by the police, ambulance or community mental health teams or home treatment teams. Patients may also be transferred there directly from a hospital emergency department. Section 136 suites are normally located at NHS trusts.
Tier 4 CAMHS case manager	A Tier 4 CAMHS case manager is responsible for overseeing the care of young people with the most severe mental health issues (NHS England, 2018).

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