



Mental Health Units (Use of Force) Act 2018

2018 CHAPTER 27

Reporting

6 Recording of use of force

- (1) The responsible person for each mental health unit must keep a record of any use of force by staff who work in that unit in accordance with this section.
- (2) Subsection (1) does not apply in cases where the use of force is negligible.
- (3) Whether the use of force is “negligible” for the purposes of subsection (1) is to be determined in accordance with guidance published by the Secretary of State.
- (4) Section 11(3) to (6) apply to guidance published under this section as they apply to guidance published under section 11.
- (5) The record must include the following information—
 - (a) the reason for the use of force;
 - (b) the place, date and duration of the use of force;
 - (c) the type or types of force used on the patient;
 - (d) whether the type or types of force used on the patient formed part of the patient’s care plan;
 - (e) name of the patient on whom force was used;
 - (f) a description of how force was used;
 - (g) the patient’s consistent identifier;
 - (h) the name and job title of any member of staff who used force on the patient;
 - (i) the reason any person who was not a member of staff in the mental health unit was involved in the use of force on the patient;
 - (j) the patient’s mental disorder (if known);
 - (k) the relevant characteristics of the patient (if known);
 - (l) whether the patient has a learning disability or autistic spectrum disorders;

Status: This is the original version (as it was originally enacted).

- (m) a description of the outcome of the use of force;
 - (n) whether the patient died or suffered any serious injury as a result of the use of force;
 - (o) any efforts made to avoid the need to use force on the patient;
 - (p) whether a notification regarding the use of force was sent to the person or persons (if any) to be notified under the patient's care plan.
- (6) The responsible person must keep the record for 3 years from the date on which it was made.
- (7) In subsection (5)(g) the "patient's consistent identifier" means the consistent identifier specified under section 251A of the Health and Social Care Act 2012.
- (8) This section does not permit the responsible person to do anything which, but for this section, would be inconsistent with—
- (a) any provision of the data protection legislation, or
 - (b) a common law duty of care or confidence.
- (9) In subsection (8) "the data protection legislation" has the same meaning as in the Data Protection Act 2018 (see section 3 of that Act).
- (10) In subsection (5)(k) the "relevant characteristics" in relation to a patient mean—
- (a) the patient's age;
 - (b) whether the patient has a disability, and if so, the nature of that disability;
 - (c) the patient's status regarding marriage or civil partnership;
 - (d) whether the patient is pregnant;
 - (e) the patient's race;
 - (f) the patient's religion or belief;
 - (g) the patient's sex;
 - (h) the patient's sexual orientation.
- (11) Expressions used in subsection (10) and Chapter 1 of Part 2 of the Equality Act 2010 have the same meaning in that subsection as in that Chapter.