Friday
15 June 2018

Volume 642
No. 154

HOUSE OF COMMONS
OFFICIAL REPORT

PARLIAMENTARY DEBATES

(HANSARD)

Friday 15 June 2018

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The House met at half-past Nine o'clock

PRAYERS

[Mr Speaker *in the Chair*]

9.34 am

Mr Steve Reed (Croydon North) (Lab/Co-op): I beg to move, That the House sit in private.

Question put forthwith (Standing Order No. 163), and negatived.

Mental Health Units (Use of Force) Bill

Consideration of Bill, as amended in the Public Bill Committee

New Clause 1

Independent investigation of deaths

"(1) A registered manager must within seven days of becoming aware of a death to which this section applies notify the Secretary of State in writing of that death.

(2) This section applies to a death if—

(a) the death occurred during, or as a result of, the use of force on the deceased patient, and

(b) the use of force occurred at a mental health unit managed by the registered manager.

(3) On being notified of a death, the Secretary of State must appoint an independent person—

(a) to investigate the circumstances of the death, and

(b) to prepare a report regarding that death.

(4) A person appointed under this section must be independent of the NHS and of private providers of mental health services.

(5) A person appointed under this section must provide a report within three months of that appointment.

(6) The Secretary of State must within 14 days of receiving the report publish—

(a) the report, or

(b) a statement that a report under this section has been received.

(7) The Secretary of State may only publish a statement under subsection (6)(b) if satisfied that the publication of the report would be contrary to the public interest, which includes causing prejudice to—

(a) any potential or ongoing court proceedings,

(b) the conduct of a senior coroner's investigation under Part 1 of the Coroners and Justice Act 2009.

(8) A statement published under subsection (6)(b) must include—

(a) the name and date of birth of the deceased,

(b) the date and place of the death,

(c) the place at which the use of force occurred, if different from the place of the death,

(d) the identity of the registered manager in relation to the mental health unit, and

(e) how the publication of the report would, in the opinion of the Secretary of State, be contrary to the public interest.

(9) The Secretary of State must publish the report as soon as practicable upon the conclusion of the proceedings or investigation."—*(Mr Reed.)*

Brought up, and read the First time.

9.35 am

Mr Steve Reed (Croydon North) (Lab/Co-op): I beg to move, That the clause be read a Second time.

Mr Speaker: With this it will be convenient to discuss the following:

New clause 2—*Independent investigation of deaths: legal aid—*

'(1) Schedule 1 to the Legal Aid, Sentencing and Punishment of Offenders Act 2012 (civil legal services) is amended as follows.

(2) After paragraph 41 (inquests) insert—

"41A Investigation of deaths resulting from use of force in mental health units

(1) Civil legal services provided to an individual in relation to an investigation under section (independent investigations of deaths) of the Mental Health Units (Use of Force) Act 2018 (independent investigation of deaths) into the death of a member of the individual's family.

(2) For the purposes of this paragraph an individual is a member of another individual's family if—

(a) they are relatives (whether of the full blood or half blood or by marriage or civil partnership),

(b) they are cohabitants (as defined in Part 4 of the Family Law Act 1996), or

(c) one has parental responsibility for the other."

Amendment 86, in clause 1, page 1, line 13, leave out sub-paragraph (ii).

Amendment 87, page 1, line 15, leave out subsection (4).

Amendment 44, page 2, line 3, leave out "force" and insert "restraint".

Amendment 40, page 2, line 4, after "use" insert "or threat ".

This amendment, together with Amendments 41 to 43, would extend the definition of the use of force for the provisions in the Bill to cover threats of the use of force and coercion.

Amendment 88, page 2, line 4, leave out "mechanical or chemical" and insert "or mechanical".

Amendment 89, page 2, line 5, leave out paragraph (b).

Amendment 41, page 2, line 5, after "isolation" insert "or threat of isolation".

See explanatory statement for Amendment 40.

Amendment 42, page 2, line 5, at end insert "or

(c) the coercion of a patient."

See explanatory statement for Amendment 40.

Amendment 90, page 2, leave out lines 14 and 15.

Amendment 91, page 2, leave out lines 16 and 17.

Amendment 43, page 2, line 17, at end insert—

""Coercion" means the use or threat of force, with the intention of causing fear, alarm or distress to control a patient's behaviour or elicit compliance with the application of a use of force."

See explanatory statement for Amendment 40.

Amendment 92, in clause 2, page 2, line 20, leave out "a relevant" and insert "any".

Amendment 93, page 2, line 23, leave out "relevant".

Amendment 94, page 2, line 25, leave out "relevant".

Amendment 45, page 2, line 30, clause 3, leave out "force" and insert "restraint".

Amendment 95, page 2, line 32, leave out "relevant".

Amendment 37, page 3, line 2, at end insert—

'(6A) A policy published under this section must set out that the use of force will only be used without the sole intention of inflicting pain, suffering or humiliation, or subjecting patients to tortuous, inhumane or degrading treatment, or without inflicting punishment or intimidation."

This amendment would prevent the use of force with the sole intention of causing suffering or harm to a patient, in line with the Mental Health Act code of practice and the UN Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment.

Amendment 36, page 3, line 3, leave out from "out" to end of line 4 and insert—

"(a) a description of each of the methods of restraint that may be used in the mental health unit;

(b) what steps will be taken to reduce and minimise the use of force in the mental health unit by staff who work in the unit;

(c) a description of the techniques to be used for avoiding or reducing the use of force in the mental health unit by staff who work in the unit; and

(d) a commitment to reducing the overall use of force in the mental health unit."

This amendment would require mental health units to commit to reducing the overall use of force, and increase transparency about how they intend to achieve this and what types of force they permit.

Amendment 46, page 3, line 4, leave out "force" and insert "restraint".

Amendment 47, in clause 4, page 3, line 7, leave out "force" and insert "restraint".

Amendment 38, page 3, line 8, at end insert—

'(1A) Information under subsection (1) must include a patient's right to advocacy and how to access an advocate."

This amendment would ensure that people's legal rights to advocacy, under existing provisions, are communicated to them in relation to the use of force.

Government amendment 1, page 3, line 16, at end insert—

"unless the patient (where paragraph (a) applies) or the other person (where paragraph (b) applies) refuses the information."

This allows for cases where a person refuses the information provided, and supersedes subsections (9)(a) and (10)(a).

Government amendment 2, page 3, line 22, leave out subsection (5) and insert—

'(5) The responsible person must take whatever steps are reasonably practicable to ensure that the patient is aware of the information and understands it."

This expands the duty to provide information accessibly so that it requires the responsible person to take whatever steps are reasonably practicable to ensure the patient understands.

Government amendment 3, page 3, line 33, leave out subsections (9) and (10).

Subsections (9)(a) and (10)(a) are superseded by Amendment 1. Subsections (9)(b) and (10)(b) are unnecessary as the information will not be of a nature that would cause distress.

Amendment 96, page 3, line 36, leave out "the responsible person considers that".

Amendment 97, page 3, line 42, leave out "the responsible person considers that".

Amendment 48, in clause 5, page 4, line 3, leave out "force" and insert "restraint".

Amendment 79, page 4, line 3, at end insert—

'(1A) The Secretary of State must publish quality standards for training provided under subsection (1).

(1B) The Secretary of State may delegate the publication of quality standards for training under subsection (2)."

This amendment would require training on the use of force to comply with quality standards.

Amendment 98, page 4, line 6, after "patients" insert "and their families".

Amendment 9, page 4, line 9, leave out paragraph (c).

Amendment 49, page 4, line 11, leave out "force" and insert "restraint".

Amendment 50, page 4, line 12, leave out "force" and insert "restraint".

Amendment 80, page 4, line 13, at beginning insert "trauma-informed care, including"

This amendment, together with Amendment 81, would ensure that training requirements for staff include training on trauma-informed care.

Amendment 81, page 4, line 14, at end insert

"and the impact of the use of force on a patient who may have experienced violence and abuse."

See explanatory statement for Amendment 80.

Amendment 51, page 4, line 15, leave out "force" and insert "restraint".

Amendment 52, page 4, line 16, leave out "force" and insert "restraint".

Amendment 99, page 4, line 18, leave out "the principal".

Amendment 10, page 4, line 18, leave out "or ethical".

Amendment 53, page 4, line 18, leave out "force" and insert "restraint".

Amendment 11, page 4, line 18, at end insert—

"(l) the roles, responsibilities and procedure in the event of police involvement,"

Amendment 12, page 4, line 18, at end insert—

"(m) awareness of acute behavioural disturbance."

Government amendment 4, page 4, line 30, leave out "meets the standards of" and insert

"is of an equivalent standard to"

This is a small drafting change that clarifies that training does not need to be provided under Clause 5 if training that was recently provided was of an equivalent standard to the training provided under that Clause.

Amendment 13, page 4, line 31, leave out subsections (5) and (6).

Amendment 100, page 5, line 8, clause 6, at end insert—

'(7) Guidance under this Act shall be published no later than six months after this Act is passed."

Government motion to transfer clause 6.

Amendment 101, in clause 7, page 5, line 11, after "any" insert "significant".

Amendment 54, page 5, line 12, leave out "force" and insert "restraint".

Amendment 39, page 5, line 13, leave out subsections (2) and (3).

This amendment would improve transparency and accountability about the use of force by ensuring consistency in the recording of all uses of force, not just those that are above a threshold to be set in statutory guidance.

Amendment 102, page 5, line 13, leave out subsection (2).

Amendment 55, page 5, line 13, leave out "force" and insert "restraint".

Amendment 14, page 5, line 13, at end insert

"or does not involve physical contact".

Amendment 103, page 5, line 14, leave out subsection (3).

Amendment 56, page 5, line 14, leave out "force" and insert "restraint".

Amendment 104, page 5, line 17, leave out subsection (4).

Amendment 57, page 5, line 20, leave out "force" and insert "restraint".

Amendment 58, page 5, line 21, leave out "force" and insert "restraint".

Amendment 59, page 5, line 22, leave out "force" and insert "restraint".

Amendment 60, page 5, line 23, leave out "force" and insert "restraint".

Amendment 61, page 5, line 25, leave out "force" and insert "restraint".

Amendment 62, page 5, line 26, leave out "force" and insert "restraint".

Amendment 63, page 5, line 28, leave out "force" and insert "restraint".

Amendment 64, page 5, line 31, leave out "force" and insert "restraint".

Amendment 15, page 5, line 33, leave out paragraph (k).

Amendment 65, page 5, line 36, leave out "force" and insert "restraint".

Amendment 66, page 5, line 38, leave out "force" and insert "restraint".

Amendment 67, page 5, line 39, leave out "force" and insert "restraint".

Amendment 68, page 5, line 40, leave out "force" and insert "restraint".

Amendment 21, page 5, line 41, at end insert—

"(q) the relevant characteristics of the staff involved (if known)"

Amendment 16, page 5, line 43, at end insert—

'(6A) Records must also be kept in the patient's medical notes."

Government amendment 5, page 6, line 5, leave out

"made by or under the Data Protection Act 1998"

and insert

"of the data protection legislation"

Amendments 5 and 6 are consequential on the Data Protection Act 2018.

Government amendment 6, page 6, line 6, at end insert—

'( ) In subsection (8) "the data protection legislation" has the same meaning as in the Data Protection Act 2018 (see section 3 of that Act)."

Amendments 5 and 6 are consequential on the Data Protection Act 2018.

Amendment 17, page 6, line 7, leave out subsections (9) and (10).

Amendment 22, page 6, line 7, leave out from "(5)(k)" to "mean" and insert

"(5)(k) and (q) the 'relevant characteristics' in relation to a patient and member of staff"

Amendment 23, page 6, line 8, leave out "the patient's" and insert "their".

Amendment 24, page 6, line 9, leave out "the patient has" and insert "they have".

Amendment 32, page 6, line 11, leave out paragraph (c).

Amendment 25, page 6, line 11, leave out "the patient's" and insert "their".

Amendment 26, page 6, line 12, leave out "the patient is" and insert "they are".

Amendment 33, page 6, line 13, leave out paragraph (e).

Amendment 27, page 6, line 13, leave out "the patient's" and insert "their".

Amendment 34, page 6, line 14, leave out paragraph (f).

Amendment 28, page 6, line 14, leave out "the patient's" and insert "their".

Amendment 29, page 6, line 15, leave out "the patient's" and insert "their".

Amendment 35, page 6, line 16, leave out paragraph (h).

Amendment 30, page 6, line 16, leave out "the patient's" and insert "their".

Amendment 69, in clause 8, page 6, line 21, leave out "force" and insert "restraint".

Amendment 70, page 6, line 22, leave out "force" and insert "restraint".

Amendment 31, page 6, line 26, leave out "and (n)" and insert "(n) and (q)".

Amendment 71, in clause 9, page 6, line 33, leave out "force" and insert "restraint".

Amendment 72, page 6, line 35, leave out "force" and insert "restraint".

Amendment 82, page 6, line 39, at end insert—

'(2A) The report published under subsection (2) must make reference to the annual statistics published under section 8."

This amendment, together with Amendments 83 to 85, would improve accountability and transparency in the progress towards reducing the overall use of force.

Amendment 83, page 6, line 39, at end insert—

'(2B) The Secretary of State must make a statement to Parliament, as soon as practicable following the publication of report under subsection (2)."

See explanatory statement for Amendment 82.

Amendment 84, page 6, line 41, leave out "and".

See explanatory statement for Amendment 82.

Amendment 85, page 6, line 41, at end insert

"and the statement under subsection (2B)."

See explanatory statement for Amendment 82.

Amendment 73, page 7, line 2, leave out "force" and insert "restraint".

Amendment 18, in clause 12, page 7, line 38, leave out "must take" and insert "should consider taking".

Amendment 19, page 8, line 2, leave out "must wear it and" and insert

"should wear it and try to"

Amendment 20, page 8, line 6, leave out subsections (4) and (5).

Government amendment 7, in clause 13, page 8, line 32, leave out

"has the meaning given by section 2"

and insert

"means a person appointed under section 2(1)"

This improves the drafting of the definition of "responsible person".

Amendment 74, page 8, line 42, leave out "force" and insert "restraint".

Amendment 75, page 8, line 43, leave out "force" and insert "restraint".

Amendment 76, page 8, line 46, leave out "force" and insert "restraint".

Government motion to transfer clause 15.

Amendment 77, in clause 17, page 9, line 24, leave out "Force" and insert "Restraint".

Amendment 78, in title, line 2, leave out "force" and insert "restraint".

Government amendment 8, line 2, leave out "and similar institutions".

This removes from the long title a reference to "similar institutions" as these are not covered by the Bill.

Mr Reed *rose—*

Philip Davies (Shipley) (Con): On a point of order, Mr Speaker. I am sorry to interrupt the hon. Member for Croydon North (Mr Reed), but I want to raise a matter of some importance. Also, I am sorry that I have not given you advance notice of this.

Mr Speaker, you are well regarded for your reputation of championing the rights of Back Benchers, but it has become apparent over the past few days that the rights of Back Benchers in this House are being massively curtailed. The deadline for tabling amendments for Fridays is Tuesday evening, which gives people the opportunity to consider the amendments that have been tabled. The timescale is the same for every Bill's Report stage.

It has become apparent over the past day or so that the Government have a policy of saying that they will not agree to any amendments tabled unless they have at least eight days in which to consider them and to do a write-round of all Departments. That means that no Back Bencher has an opportunity to have any amendments that they table on Report accepted—the Government will automatically not accept those amendments because they have not had time to consider them. This means that the rights of Back Benchers are being massively curtailed, and also that laws will be passed that are not fit for purpose, because amendments that would otherwise have been accepted by the Government will not have been accepted. Will you look into this matter, Mr Speaker?

It seems to me that if Back Benchers are to have the opportunity to get their amendments accepted, we will need a new regime under which they will have to be tabled at least eight days before a Bill is considered; otherwise, we will have no chance. That would mean that the business of the House would have to be brought forward. Can you also confirm that, for anyone who has taken the time to table amendments to improve this Bill, the only way to have their amendments properly considered would be to ensure that we did not get to the end of our debate on these amendments today, meaning that proceedings would have to be rescheduled for a subsequent day, as that would give the Government time to consider whether to accept the amendments? Is that the only course of action open to a Back Bencher who has spent lots of time trying to improve the legislation?

Mr Speaker: I am grateful to the hon. Gentleman for his point of order, which is a source of some concern to me. Off the top of my head, it seems important to distinguish between two not altogether unrelated but, in important senses, separate matters. One is the question of the selection of amendments; the other is the question of the House's treatment of them and the opportunity for treatment of them.

So far as selection is concerned, that is, as the hon. Gentleman knows, a matter for the Chair, and I will go about my duty in this matter the way that I have always done. I hope that I do this dispassionately but with a regard for Back Benchers. He and other colleagues will have discovered over the years that the views of the Government are not a matter of any particular interest or concern to me. If I think something should be selected, it will be selected.

Secondly, the hon. Gentleman will probably not be entirely surprised to know that I was not aware of any new intended arrangements being drawn up for the administrative convenience—I use that term non-pejoratively—of the Executive branch. That is not something of which a Whip has notified me. The Government might well think it most convenient to have rather longer, for the reasons that the hon. Gentleman has adduced, but it is not something of which I have been made aware. I think it would be useful to have knowledge of such a matter, but I do not think that anything can be done today. However, it would be a pity if Back Benchers were hampered in any way.

I would just add that in my limited experience—like the hon. Gentleman, I have never served in government, which I say as matter of some considerable pride—Governments are perfectly capable of operating quickly when it is convenient for them to do so, and of operating at a more leisurely pace when it is convenient for them to do so. If the hon. Gentleman is asking whether I have managed to discern the mindset of the Treasury Bench, I can say only two things. First, I have been here only 21 years, which is quite a short time in which to try to discern the mindset of those on the Treasury Bench. Secondly, if the hon. Gentleman were to think that I did understand fully the mindset of those on the Treasury Bench, he would be attributing to me an intellectual weight that I do not claim for myself.

If there are no further points of order for now, perhaps we can proceed with the oration of Mr Steve Reed.

Mr Reed: Thank you, Mr Speaker. I have sympathy for what the hon. Member for Shipley (Philip Davies) said, but I hope that during today's debate we will find ways of achieving the objectives of his constructive amendments.

The Bill is known as Seni's law after Seni Lewis, a young man from Thornton Heath in my constituency who died in 2010 after a period of severe and prolonged face-down restraint. Seni is one of too many people who have suffered unnecessary and avoidable deaths in our mental health services, and that comes alongside any number of unnecessary and avoidable injuries.

Following the inquest into Seni's death, the coroner's verdict was clear that, without change, what happened to Seni will happen again, and it has already happened to others. That change is this Bill, and I am grateful for support from Members on both sides of the House, the Minister and every single professional and patient advocacy group working in the sector.

New clause 1 is probing. It arises from the fact that Seni Lewis's parents, having suffered the trauma of the loss of their child in completely avoidable circumstances in 2010, had to fight the state for seven years simply to obtain an inquest to find out how their previously healthy 21-year-old son ended up dead on the floor in hospital. The coroner pointed to severe failings by the mental health trust, the police and the Crown Prosecution Service that led to delays in that inquest opening. The root cause of the problem was the insufficiently independent investigation conducted by the mental health trust into its own failings. The answer is to ensure that any death in such circumstances automatically triggers a fully independent investigation into the circumstances and causes of that death, with legal aid provided to the families of the deceased persons so that there is a level playing field for all parties taking part in the inquest.

Currently there is a huge disparity between how investigations are conducted for deaths in mental health units and those in other forms of state detention. When somebody dies in police custody, an external investigation by an independent national body happens automatically, but the same does not happen in a mental health setting. If a patient dies, the trust or private provider investigates itself or appoints another trust or individual to do so. That lack of accountability means that reports can be delayed or kept quiet, and can lack the necessary independence and rigour.

Jeremy Quin (Horsham) (Con): I congratulate the hon. Gentleman on the progress of the Bill, which I hasten to say that I support, but I have a concern about new clause 1. I appreciate that he has tried to address it in subsection (7), which aims to avoid conflict with the coroners, and he may have dealt with my concern, but I was worried about the interaction between the new independent report, the coroner's work and the work of the police, if that is relevant. The hon. Gentleman referred to the external reports produced in other custodial circumstances, so is he able to reassure the House that, were this proposal to go ahead, there would be no conflict between the different authorities: the coroner, the police and the author of the independent report that goes to the Secretary of State?

9.45 am

Mr Reed: The hon. Gentleman raises an important point, and I look forward to the comments of the Under-Secretary of State for Health and Social Care, the hon. Member for Thurrock (Jackie Doyle-Price). It is important that there is consistency across all forms of state detention so that those who suffer traumatic circumstances, or even death, are treated in the same way.

If lessons are not learned from such incidents, the chance to prevent further deaths is missed, and we end up with a series of what look like isolated tragic incidents, such as Seni's death, that are actually part of a wider institutional problem that has not been recognised and therefore not dealt with. It is unacceptable that institutions responsible for the care of patients suffering from mental ill health are subject to less scrutiny than institutions that detain criminal suspects and prisoners. It is no wonder that the casework of the campaigning charity Inquest, which works with bereaved families, shows that so many people who rely on such services no longer have confidence in them.

Another barrier to justice for families is funding for legal representation. Dame Elish Angiolini's excellent report concluded last year that

"families face an intrusive and complex mechanism for securing funding",

because there

"is no legal aid for inquests other than in exceptional circumstances".

The Angiolini report recommended that legal aid should be awarded to families in the case of deaths in police custody. The Government have accepted that there is a need to look at that in the Lord Chancellor's review and, in the spirit of consensus that has characterised the development of the Bill, I would welcome an update from the Minister on what work is being done on that. It makes little sense not to extend legal aid to situations in a mental health unit, because we need consistency across all forms of state custody. The families of patients should certainly not be disadvantaged compared with other bereaved families, and new clause 2 would ensure that legal aid is available to family members in relation to an investigation of an unnatural death in a mental health unit.

I will briefly address some of the amendments tabled by the Government, the hon. Members for Shipley and for Christchurch (Sir Christopher Chope), and the right hon. Member for North Norfolk (Norman Lamb). I welcome their efforts to strengthen the Bill, which has progressed through the Commons with a real sense of consensus, both from the Minister, and from every professional body and patient advocacy active in the sector. It is important that such work continues during the Bill's remaining stages and beyond.

On the scope of the Bill and which mental health units it applies to, the hon. Member for Christchurch tabled amendments 86, 87 and 92 to 95, which would extend the Bill's scope to cover all independent providers of mental health care. The principle behind the amendments seems sound, because every patient, whether NHS or private, should be protected by the same rights. However, I know that the Minister has some concerns about the practicalities of extending the Bill's scope in that way, not least about how wholly private providers would report data through NHS Digital and the limits of statutory guidance in that respect, so I look forward to her comments.

Norman Lamb (North Norfolk) (LD): Does the hon. Gentleman share my view that whether the measure gets into the Bill or not, we need to reach a point at which data is provided from private providers and from the NHS in exactly the same way so that we can compare how people are treated on both sides of the divide?

Mr Reed: I absolutely agree. The Bill sets up a process and attempts to change the culture of the services, and I hope that the Bill's successful passage will not be the end of that process. The right hon. Gentleman's point needs to be taken into account.

Sir Christopher Chope (Christchurch) (Con): I am grateful to the hon. Gentleman for his indication of support for these amendments. When the Government have explained to him why they cannot deal with them, have they explained how the objections he has raised do not occur where the treatment is provided in part by the NHS but not in toto?

Mr Reed: As the Minister is present, it is probably best to allow her to speak for herself, rather than for me to attempt to interpret this on her behalf.

I wish to turn next to the amendments tabled by the right hon. Member for North Norfolk, many of which I support in principle, having raised a number of them myself at previous stages. I am broadly satisfied that many, if not most, of the points will be dealt with through guidance issued by the Department after the legislation, but I look forward to the Minister's further comments and explanations on those points.

Important additions have been made to what falls under the definition of "use of force" as this Bill has developed. One is the use of "chemical restraint", which amendments 88 to 91, standing in the name of the hon. Member for Christchurch, would remove from the Bill. I am afraid that I cannot support those amendments, because the potential effect is that the Bill could limit the use of physical restraint, only to lead instead to an increase in the use of medication—for example, rapid tranquilisation. It is important therefore that the Bill covers all forms of restraint, both physical and chemical.

Sir Christopher Chope: I tabled these amendments on the basis of a sad, current constituency case involving the parents of a very ill young man of 25. He is in and out of a mental health unit, and normally he is in there because he has failed to take his medication. It is designed to reduce the need for force, because he would be violent without it. Surely, the giving of such medication to a person in the circumstances I have described should not be regarded as "force" under the Bill.

Mr Reed: I hear what the hon. Gentleman is saying, but the point remains: if we take measures to deal with only physical restraint but not chemical restraint, we may simply push the services to use chemical restraint, such as rapid tranquilisation, more frequently and we would not wish to see that as an unintended consequence of amending the Bill further.

On the nature of the use of force, the hon. Member for Shipley has tabled amendments 44 to 78, which would replace the word "force" with the term " restraint" throughout the Bill. I do not wish to pre-empt his reasons for doing that, and I suspect he will explain himself well later this morning, but let me say that we used the term "restraint" rather than "force" during an earlier draft of the Bill, so I agree with the general intention behind these amendments. I was persuaded, however, that the current wording ensures greater consistency with other legislation and therefore that the Bill does not run the risk of adding confusion into how the professionals interpret the language used.

The right hon. Member for North Norfolk has tabled a number of amendments dealing with the information provided to patients. Amendment 38 would include in the information given to patients details of their right to independent advocacy, which would help the patient to make the right decisions about their care and involve, where appropriate, carers and families. I certainly agree on the need to give more power to service users, so I would gently encourage the Minister to set out how those objectives might be achieved.

The Bill, as amended in Committee, says that information does not need to be provided where it would "cause the patient distress". I understand that the hon. Member for Christchurch also has concerns about that, which is why both he and the right hon. Gentleman have tabled amendments to remove that potential loophole. I agree on this, and following discussions with the Minister, I am happy to accept Government amendments 1 to 3, which remove this "distress" loophole.

On staff training, the hon. Member for Shipley has tabled amendments 11 and 12, which seek to strengthen the Bill by adding usefully to the list of training topics. I know that he has discussed the Bill with his local care trust, and I welcome that spirit of engagement and representation. Amendment 11 would require training to be given on "roles, responsibilities and procedure" if the police are called to a mental health unit, as happened in the case of Seni Lewis and in many others. That strikes me as a sensible addition to the Bill, ensuring a more joined-up approach between police officers and staff in mental health units. Amendment 12 would also strengthen the Bill. It would add

"awareness of acute behavioural disturbance"

to the list of training topics. That is clearly a valuable thing for staff to be aware of in terms of how restraint may affect someone displaying behavioural disturbance. I support amendments 11 and 12, but before accepting them, it is important to hear whether the Government intend to deal with them through guidance.

There are, however, amendments that I am not happy to accept. Amendment 9 would remove the need for training on diversity, but that is a crucial part of the improved training and it goes to the heart of the Bill's purpose in ensuring equal treatment for everybody by identifying those areas where treatment is not being delivered equally to everybody, whether because of ethnicity, type of disability or gender. If we do not capture that data, we cannot see the problem, and if we do not recognise the problem, we cannot put in place the measures to deal with it. Therefore, I cannot support that amendment.

Jeremy Quin: I wonder whether the hon. Gentleman has any thoughts on amendment 113, which I do not think will be debated. It was tabled by my hon. Friend the Member for Witney (Robert Courts) and it seeks to define what "regular intervals" are and whether there should be annual training. At the moment, the training is to be given at "regular intervals", so does the hon. Gentleman have any thoughts on how regular those intervals should be and whether there should be an annual stipulation?

Mr Reed: I agree with the sentiment, but I do not think that the Bill should be too prescriptive. It is for the Government, working with professionals in the field, to determine the appropriate period within which refresher training should take place. However, it should definitely take place, because training done several years previously can easily be forgotten or the circumstances can change. There is always a need to keep professional practice absolutely up to date.

Research shows that there are real fears about unconscious bias in our mental health services. The Angiolini review, published by the Government last year, shows how a disproportionate number of people from black, Asian and minority ethnic communities have died after the use of force in custody. Black people are four times more likely to be sectioned than white people. Training must reflect those challenges and consideration must be given to the effects of that kind of unconscious bias.

There are also concerns, as shown in amendment 13, proposed by the hon. Member for Shipley, about the frequency with which staff receive training—indeed that point has just been made in this debate. The principle of refresher training is important and the Bill deliberately does not specify how often it is provided, as that needs to be up to the Government, in consultation with professionals. I welcome and accept Government amendment 4, which ensures that training need not be undertaken by a member of staff if they have recently been trained to an equivalent standard.

Turning to the recording of data, the Bill sets out what should be recorded by mental health units when using force, and this is how trusts will be held accountable for the types and frequency of restraint used, as well as which patients they use it on. A number of amendments have been tabled on this issue, and I will deal with a few of them. I appreciate that there is concern about the provision in clause 7(2), which provides that the use of "negligible" force does not have to be recorded; amendments 102, 103 and 39 seek to remove the subsection. I shared similar concerns at an earlier stage of the Bill because I, too, feared that this might be a loophole. The reason this provision is in the Bill is that we want to avoid unnecessary burdens on staff, who might feel otherwise that they have to record every physical contact, such as guiding a patient through a door by the elbow. Such recording would be unnecessary and it is important that the Bill does not set up such circumstances.

I welcome the Minister's assurance that the definition of "negligible" will be very tightly defined in the guidance, and I hope that gives the proposers of those amendments reassurance on the point that was behind them. The Minister has shown real commitment to building consensus on this Bill as it is has developed and I am sure she will do the same on the guidance. I hope that that encourages those Members not to press those amendments to a vote.

On what data should be recorded and why, I note that the hon. Member for Shipley proposes that the characteristics of staff who carry out restrain should also be recorded. That makes sense to me in principle, and the point has been made to me by people who work in the sector. There are real concerns about pre-existing prejudice against people with mental ill health, which might lead to inappropriate behaviour by some staff if it is not identified and corrected. However, up to this stage in the Bill's development, there has been no engagement with the sector on this point, and the opinions and experience of those who work in the sector must be taken into account before we legislate. I look forward to hearing the Minister's views on that, but my preference is for the issue to be considered through consultation, after legislation, and to be dealt with through guidance, if necessary.

10 am

On guidance and information, the hon. Member for Christchurch has tabled amendment 100, which would require guidance to be published within six months. It will be for the Government to publish that guidance, so I invite the Minister to set out the process that she intends to follow, although it is clear that it will be important for the guidance to be published as quickly as is practicable after the legislation has been passed, so that professionals who work in the sector can ensure that they comply with the legislation in the way that the Government expect.

The hon. Member for Shipley has tabled amendments 18 to 20 to clause 12, which contains the provisions on body-worn cameras to be used by police officers who attend mental health units. I fully agree with the principle of the amendments, but I believe that they are not necessary, as clause 12 already contains safeguards that will ensure that police officers need operate cameras only where reasonably practicable and subject to operational requirements. If there are special circumstances that justify their not wearing cameras, that is already acceptable under the clause. It is important to me and to all the bodies that have expressed views on the Bill that it does not restrict the police, so the safeguards are already in clause 12, to the satisfaction of those bodies, which include the College of Policing.

I wish to accept some minor Government amendments that tidy up the drafting: Government amendments 5, 6, 7 and 8. I also accept the two Government motions to transfer clauses.

In conclusion, I am grateful to right hon. and hon. Members for their engagement with the Bill. I appreciate the constructive spirit in which Members have tabled amendments to strengthen further this important legislation. I look forward to the rest of the debate and, I hope, the successful conclusion of the remaining stages.

Philip Davies: May I start by commending the hon. Member for Croydon North (Mr Reed), who is an excellent Member of this House? We clearly do not agree on a lot of things, but he really is an excellent MP. I commend him for two things. First, he has introduced legislation that is of particular interest to him, not least because of what happened to his constituent. He should be commended for doing that, and it goes to show the kind of local MP that he is. It is absolutely right that the tragic case of Olaseni Lewis has prompted him to introduce this legislation, the thrust of which I absolutely support, as he well knows.

Secondly, unlike many Members who promote private Members' Bills, the hon. Gentleman has engaged in a rather constructive manner with everybody who has tabled amendments. I wish it were always like that—as we know, it often is not—but he has certainly engaged, and I absolutely commend him for that. The way in which he has conducted himself throughout the Bill's passage through the House does him an enormous amount of credit, and I am grateful to him.

Having said that, there are parts of the Bill on which the hon. Gentleman and I disagree, as he alluded to in his speech. I absolutely support the thrust of what he is trying to achieve, and a great many parts of the Bill will make a considerable difference, but, as with most pieces of legislation, it would be naive to think that it could

[Philip Davies]

not be improved. As I said in the point of order that I made earlier, I fear that we are in danger of passing a piece of legislation that everybody in the House knows is not as good as it could and should be, largely because of the paralysis in Government decision making, which means that they do not seem to be able to assess and agree amendments with the speed with which the hon. Gentleman appears to have been able to do so. I suspect that is partly because the civil service appears to have taken the Government hostage in the running of public policy.

The Parliamentary Under-Secretary of State for Health and Social Care (Jackie Doyle-Price): My hon. Friend is perhaps one of the most passionate Members about defending and championing the interests of Back Benchers, but I remind him of what the hon. Member for Croydon North (Mr Reed) has just said. The Government have worked with the hon. Gentleman to get his private Member's Bill into a shape that they can support, while recognising that it is his Bill, and it has been taken forward in consultation with the sector. Rather than blame civil servants and processes, my hon. Friend could acknowledge that we want to take the whole sector with us on this Bill.

Philip Davies: I am sure we do, which is why I have consulted my local trust, Bradford District Care NHS Foundation Trust, about the Bill's merits, and why I have tabled some amendments as a direct consequence of the discussions that I have had with the trust. I find the idea that only the Government are interested in moving forward with consensus rather offensive. I have been trying to move forward with consensus, too, as the hon. Member for Croydon North knows only too well. We have reached the stage at which the Government are saying, "I wish we'd known about some of these amendments earlier, because in that case we may well have been able to accept them." What on earth is the point of having a deadline for the tabling of amendments three days beforehand if the Government cannot organise themselves to decide within that timescale whether those amendments should be agreed to? They should operate like most organisations and business do: if they have a timescale to meet, they should meet it, rather than pretend that the timescale is of only passing interest to them.

Jackie Doyle-Price: This is great fun. I come back to the point that this is a private Member's Bill and the Government have agreed their position on it. We are not getting in the way of Back-Bench MPs tabling amendments, because although I will articulate the Government's view on those proposals, it will be for the House of Commons to decide.

Philip Davies: I am grateful to the Minister for that. I appreciate that we are in a strange situation in which the Government do not have time to decide whether to agree with the amendments, but they certainly have time to write speeches on why they will disagree with them because they are not in a position to accept them. We have got ourselves into a completely farcical situation. The Minister is going to read out the speech that has been prepared to say why she cannot accept the amendments, but we all know that the reason why she cannot accept the amendments is that she does not have the Department organised to get things decided within eight days. As I said, that gives the impression that the Government have been taken hostage by the civil service. The Department of Health and Social Care is probably one of the worst offenders for being taken hostage by its civil servants. I am being charitable in saying that, because I presume that that is why so many socialist, nanny-state proposals come from the Department. I cannot believe that the Ministers actually believe in all that rubbish, so it must be the civil servants who are running the Department if those things are coming forward.

With this Bill, it seems that the civil servants, who never want to accept any amendments tabled by anybody other than themselves, are doing their best to try to stop any improvements to the Bill. It is a shame that we have got ourselves into a farcical situation. The Minister is absolutely right: there is nothing to prevent Members from tabling amendments—we know that because we have tabled them, and we are grateful to you for selecting them, Mr Speaker—but we have got ourselves into a rather farcical situation in which we have done an awful lot of work, and my staff have done an awful lot of work, I might add, to try genuinely to improve the Bill, and then we come across this ridiculous bureaucratic situation, about which I have only just found out with this Bill but which no doubt applies to every Bill. It is important that everyone knows that if Members table amendments at this stage of a Bill, they are wasting their time. It is a completely pointless exercise.

Sir Christopher Chope: I do not think that we are wasting our time when we table amendments. Contrary to what my hon. Friend says, I still have faith in the Minister, as I think she believes she is in charge. I believe she comes to this debate with an open mind, and, if, having heard the merits of a particular amendment, she decides that she will allow it, then she will say so from the Dispatch Box.

Let me mention another issue. We often find that because of the constraints on private Members' business, people say, "We'll amend it in the Lords." If the Bill is amended in the Lords, its progress is jeopardised because it then has to come back here again for us to consider the Lords amendments. So in fact the Government should be more assiduous and quick in dealing with amendments to private Members' Bills than amendments to their own legislation.

Philip Davies: My hon. Friend is absolutely right, but he is being slightly naive in thinking that we will get some rapid decision making. As, I think, Mr Speaker, you were alluding to in your response to my point of order, the only time that the Government appear to be able to act with speed is when they think they are going to lose a vote. At that point, they seem to be able to react with miraculous speed. We do not seem to need any write-arounds at that point, or eight days of write-arounds; they appear to be able to cobble something together within seconds, particularly if my right hon. and learned Friend the Member for Beaconsfield (Mr Grieve) clicks his fingers. They then appear to swoop into action in no time whatsoever. It seems to me that if hon. Members actually want to improve the Bill, they should be busily telling their Whip that if we put

these amendments to a vote, they will vote for them—I hope, Mr Speaker, that you will allow some of them to be put to a vote, particularly where the hon. Member for Croydon North says that he actually agrees with them. Perhaps then we might have some rapid decision making after all. We will see, but it has been yet another depressing morning in the history of Parliament for me. I have been here 13 years, but have found out only today how these things work. I started off cynical and I have become even more cynical as time has gone on.

I shall go through the farce of speaking to my amendments, even though we cannot actually make any headway on them. As the hon. Member for Croydon North alluded to, amendments 44 to 78 apply throughout the Bill and change the wording from "use of force" to "use of restraint". I was encouraged to hear him say that he had originally believed that the term should be the "use of restraint", but had been persuaded to change it to "use of force" by, I think, the Government.

The comments I make here largely come after consultation with my local Bradford District Care NHS Foundation Trust. The amendments that I have tabled would ensure that the terminology used in the Bill was correct and in line with that commonly used by mental health trusts. The term "use of force" is predominantly used by police forces in reference to the use of physical force while carrying out their duties. It is important to note that, although the police do play a part in the restraining of patients, it appears that the Bill's primary focus is on the restraint methods used by staff in a mental health unit. Although we must not forget that the police are on occasion called to assist in the physical restraint of patients, it would be more appropriate to adopt the correct mental health terminology for actions used predominantly by mental health staff in a mental health setting. Not only that, but the use of the word "force" in this regard is somewhat misleading and suggests that the restraint being used on patients is being conducted with a degree of aggression, violence or excessive force, which is simply not the case.

I am told that restraining a patient, particularly in a mental health unit, often involves little to no use of actual force in the sense that most of us would understand it. The term "restraint" has been adopted as common terminology within mental health trusts and covers varying degrees of interaction with a patient. It can be applied, for example, to a person simply holding out a hand to stop someone advancing towards them, or to methods of calming such as simply talking to a patient. They are examples of the use of restraint.

Norman Lamb: I am grateful to the hon. Gentleman for giving way. In my experience both from my time as a Minister and from talking to many people in mental health, restraint covers an enormous range of circumstances, from the very light-touch to very considerable force, including pinning people to the floor with face-down restraint, which was the action that led to the tragic death of Olaseni Lewis. It is not right to say that it cannot involve considerable force; it often does.

Philip Davies: The right hon. Gentleman certainly knows more about this subject than I do, and probably more than anybody in this House, and I commend him for that. Absolutely—I am certainly not saying that the use of restraint never involves the use of excessive force; it absolutely does. My point is that it often does not. To throw all these things in together by using the word "force" is not only not within the terminology generally used in mental health trusts, but slightly misleading given what the norm in this area is.

10.15 am

Kevin Foster (Torbay) (Con): I am listening with some interest to my hon. Friend's speech. The purpose of his amendments, as he has said, is to replace the word "force" with "restraint", and he has just given quite a strong list of things that could be restraint. However, surely the whole purpose of this Bill is to focus on force as we see it defined in other legislation. I know from his doughtiness on issues such as nanny state and cotton wool-style politics that the prospect of talking to people with smiles, which he says could be restraint, is the last thing that we want in this type of Bill.

Philip Davies: I understand the points that my hon. Friend makes, and I will come on to some of them later on, as they probably sit better with other amendments that have been tabled. I certainly accept his point, and as always, he makes it well.

I am also concerned that using the word "force" might worry people who are thinking about seeking treatment for mental health conditions. If they see that, it might scare them into wondering what may happen to them in some mental health settings. My view is that the word "force" in this case is not appropriate, not sensible and not actually what is generally used. Of course an element of force is used at times to carry out some methods of restraint, but common sense would suggest that the terminology used in the Bill should be what the sector uses.

Sir Christopher Chope: When one looks at the drafting of clause 1 (6), references to the use of force are to

"the use of physical, mechanical or chemical restraint".

Force is being limited there to restraint, except that there is also,

"the isolation of a patient."

Is it not the case that the drafting is really confusing? It suggests that the only difference between force and restraint is the addition of the isolation of a patient in the definition of use of force.

Philip Davies: My hon. Friend is absolutely right. He has made the point that I was literally just about to make. The use of force is defined as being physical restraint, mechanical restraint and chemical restraint. I reiterate my earlier point that, quite clearly, the most appropriate term to use is "use of restraint". That is what the definition of the use of force is in the Bill. It sounds more sinister than it actually is, and that is clearly more appropriate terminology. I have tabled more than 60 amendments, but that point deals with more than 30 of them—about 35—in one fell swoop. I hope that other Members will accept that "use of restraint" is the more appropriate terminology.

Let me move on now to my other amendments. Amendment 9 to clause 5, which is about training on the appropriate use of force, would remove paragraph (c), which is about

"showing respect for diversity generally".

[Philip Davies]

The hon. Member for Croydon North mentioned that earlier. Restoring the faith of the public in their services is a key element and purpose of this Bill, and why not? We should all have the confidence and reassurance of knowing that when we go to any public service, we will be treated properly. However, when it suggests that illnesses are not diagnosed in proportion to the demographics of our society, I question whether people will draw the wrong conclusion from that. We could question whether anything in our daily lives mirrors social demographics. Of course it does not; it would be absurd to think that it does. What we need to keep in mind is that any illness, and specifically mental illness, is not selective in whom it touches and the outcomes that it can cause. It does not discriminate by people's ethnicity, sexual orientation, religious belief or gender or in any other way. Mental illness is a very complicated and personal experience, which—as is well documented—can have a harrowing and life-changing effect on those who are directly affected by it, and on the people and families around them.

It has been argued that different ethnic groups have different rates and experiences of mental health problems, with people from black, Asian and minority ethnic groups in the UK more likely to be diagnosed with mental health problems and more likely to experience a poor treatment outcome. It is documented that for every 1,000 people of the black/black British population, approximately 41 are in contact with secondary mental health services. What is not mentioned so much is that for every 1,000 people of the white British population, approximately 37 are in contact with the same level of service. In actual numbers, 1.3 million of the total 1.5 million patients in contact with this service are of a white ethnicity, so the use of the ratio format instead of the actual figures over-exaggerates a point that is already not entirely convincing. For example, for every 1,000 people of the Asian/Asian British population, approximately 26 are also receiving secondary mental health care. In actual numbers, this is approximately 69,000 patients—higher than the total of mixed ethnicity and other ethnic groups combined, and 16,000 patients more than the black/black British category.

I do not want to make it sound like a competition for numbers; it clearly is not. These numbers represent people. But the Bill currently makes it appear as though this is an issue that only affects one ethnicity, when that is quite clearly far from the case. The suggestion that there should be a conscious overview of regulating the diagnosis and treatment of a patient not according to their symptoms, but according to their ethnic background, may result in turning it into a competition. By putting in place such measures, the good intentions of stopping ethnic discrimination—the existence of which is already questionable—would instead create discrimination against those who are not of a BAME background or, more specifically, not of black/black British ethnicity. This would therefore generate another problem altogether. In the simplest of terms, asking to provide further intensive training on unconscious bias and diversity, on top of what has already been established at the core of the service that is currently being provided, not only creates an unnecessary segregation among patients but is patronising towards staff to an unwarranted level.

I draw a parallel with the stop-and-search issues in London. It seems to me that a very well-meaning intention to stop a disproportionate number of black people being stopped and searched has led—directly or indirectly—to an increase in the amount of knife crime in London and in the number of people who are dying as a result of knife crime in London. I might add that it is largely young black men who have been the victims of that well-meaning policy.

I fear that mental health staff, rather than being asked to treat people exactly the same irrespective of their backgrounds, may well—directly, indirectly or because they feel some pressure—start to treat people differently as a result. That will have serious consequences. I fear that it is some people from black and minority ethnic backgrounds will who suffer most and not get the treatment they should as a result.

Mr Reed: Surely the point about an unconscious bias is that it is unconscious. If we do not collect the data and evidence to show what is happening to a particular group, it will continue to happen because no one has interrogated the data to understand what the problem is. For instance, women are more likely to be restrained than men in mental health services. More women are restrained than men, even though there are more men present in mental health services. If we do not understand why that is happening, we cannot do anything to correct it.

Philip Davies: I understand the hon. Gentleman's point and I am not totally unsympathetic towards it. My fear is what will happen as a result of such a measure and the impact on staff, who have a very difficult job. Their job is difficult enough as it is and they do a great job. When we are passing legislation like this, it is important to say—at least in passing—how much we appreciate what staff do in many of these places. They are doing their best, often under difficult circumstances and with limited resources. I do not want these people, who are working their socks off, to think that we are trying to kick them in the teeth and tell them that they are not doing a good job. On the whole, they are doing a very good job.

My point is that their job is difficult enough as it is and I fear that it will be made even harder when, in effect, they are subconsciously given the message, "Oh, you'll want to be careful what you do with different minority groups, because you may be accused of being racist if you're using restraint on too many people from a particular background." That is exactly what happened to the police with stop and search, when they were told, "Even though you should be stopping and searching people, don't bother doing it with somebody from a particular ethnic background, because you might be accused of being racist if, when it's all totted up, you've stopped more black people than white people." We should not put people in that kind of situation.

Mr Reed: But nobody, in this Bill or elsewhere, is advocating proportionality in the way in which restraint is used. We are merely trying to ensure that the factors that may underpin unconscious bias are understood and articulated.

Philip Davies: The hon. Gentleman's motives are entirely honourable and decent, and I support them 100%. My fear is about what will happen in practice, because of the evidence of what happened with stop

and search in London, to be perfectly honest. Exactly the same thing happened in that case, so it is not as if we have no evidence on which to base this fear. If the hon. Gentleman speaks to police officers, they will tell him that they were petrified of stopping people from a particular ethnic background because they feared they would be castigated for being racist. That is absolutely what happened. All I am saying is that my fear is that that may well happen as a result of this legislation, although I accept that it is not the hon. Gentleman's intention.

Sir Christopher Chope: My hon. Friend is making an excellent point. Is it not also the case that substance and drug abuse has developed enormously, particularly in urban areas, as a result of this misguided policy on stop and search? It is then drug and substance abuse that so often leads to mental health issues.

Philip Davies: My hon. Friend is absolutely right to draw that comparison. It goes to show that well-meaning initiatives can often have the exact opposite result to what was intended.

In addition, diversity training programmes do not show any particular progress in the area that they are trying to improve. In fact, they have often proved to have the opposite effect. In a 2016 edition of the *Harvard Business Review*, an article entitled "Why Diversity Programs Fail" states:

> "It shouldn't be surprising that most diversity programs aren't increasing diversity. Despite a few new bells and whistles, courtesy of big data, companies are basically doubling down on the same approaches they've used since the 1960s—which often make things worse, not better."

The article says that companies have been heavily reliant on diversity training to reduce workplace bias, and bias during the recruitment process and employee promotions. It also says that studies have shown that this consistent and forceful approach to tackling diversity can

> "activate bias rather than stamp it out."

The article points out that social studies have found that people too often rebel against rules in a bid to assert their autonomy, and argues that companies—in our case, public services—will see far better results when they drop control tactics to make people conform. Even eminent people at Harvard are not particularly convinced that such a measure would have the result that the hon. Member for Croydon North intends.

On top of that, there are so many variations of diversity these days that there is a vast array of specifics to cover. For example, to my knowledge there are at least 71 variations of gender. I have a list here, but I will not test the patience of the House by reading them all out. Hon. Members who thought that there were only two genders are, I am afraid, well behind the times; there were 71 at the last count. I am sure that my hon. Friend the Member for Walsall North (Eddie Hughes) knows about this, as an esteemed member of the Women and Equalities Committee. I am sure that he can reel them all off from the top of his head, but most people could not.

Then we get on to the variations of religion that could be discussed. There are estimated to be approximately 4,200 different religions around the world, going far beyond those commonly observed in the UK. They include beliefs such as mysticism, paganism—which has, I think, 47 variants within it—Raëlism, Judaism, the ghost dance movement, chaos magic, and the happy science movement. The one that I personally liked most of all—I had not heard of it before but I am thinking about becoming a convert to it—is the Prince Philip movement. Being a great fan of Prince Philip, that sounds to me like a marvellous organisation.

10.30 am

Matt Warman (Boston and Skegness) (Con): I too am obviously a great fan of Prince Philip. In talking about his fears, my hon. Friend is, while of course still being orderly, discussing matters that go some way from the central intention of this Bill. Does he share my fear that some of his concerns might risk derailing what is, at its heart, a very important and sensible measure that we all surely, as he has said, support?

Philip Davies: I cannot accept that at all, Madam Deputy Speaker—it is a delight to see you in the Chair. My amendment is clearly pertinent to the Bill given that I am trying to remove something that is in it. If it was not pertinent, no doubt Mr Speaker would not have selected it. I am afraid that I cannot accept my hon. Friend's challenge to the authority of the Chair. I am sure, Madam Deputy Speaker, that were I to be out of order, you would be the first to leap to your feet and put me right.

Will all these different religions, genders and all the rest of it be covered in the diversity training that I am trying to remove from the Bill? We cannot ignore the fact that they exist and therefore have as much right, presumably, to be detailed in diversity training as anything else. Let us not forget diversity of ideological beliefs. Will that be covered too? This is a throwaway phrase—one of those things that everybody puts into everything. It is meaningless. There are lots of meaningless things in political discourse: social justice—nobody knows what it is but everyone is in favour of it; sustainable development—we are all in favour of it, but nobody has ever been able to tell me what it actually means; diversity training—let us shove it in as a little part of our Bill, but nobody really knows what it is trying to achieve. I am not entirely sure that there is any point to it, and if there is any point, it will be counterproductive. I cannot accept this aspect of the Bill, and that is why my amendment 9 tries to remove it.

Amendment 10 to clause 5 is about training on appropriate use of force. It would remove paragraph (k) on training on

> "ethical issues associated with the use of force."

I am trying to make sure that legal issues are the focus of the training, not ethical issues. How does one go about taking account of ethical issues in the use of force or restraint? As I said earlier, staff have a very difficult job as it is. When they are focusing on whether they should be using restraint with a particular patient, are we seriously saying that they have to start considering, at that moment, the ethical issues associated with it? Surely this House is about making sure that people act within the framework of the law, not about what I, the hon. Member for Croydon North or somebody else thinks are the relevant ethical issues. How do we decide what the ethical issues are that people should be considering? The ethical issue that I might think is particularly pertinent may be different from the one my hon. Friend

[Philip Davies]

the Member for Christchurch (Sir Christopher Chope) or the hon. Member for Croydon North thinks pertinent. What sort of a situation are we putting staff in when they have to be thinking about the ethical issues, as intended in this Bill? I would not be able to explain that to them. We should be removing these bits of flim-flam from the Bill and making sure that we are instead asking people to follow a legal framework.

Sir Christopher Chope: As always, my hon. Friend is making an excellent point. In his extensive research, has he been able to ascertain the source of the support for the flim-flam that he is describing with regard to the use of the word "ethical"? The Minister said earlier that the Bill has the support of all stakeholders—I do not think she used that word, but she might have chosen to do so. Where is the evidence that the stakeholders are behind the use of ethical issues being part of the training?

Philip Davies: I am afraid I cannot answer my hon. Friend's question. I do not know. The Minister was absolutely right to highlight the fact that although stakeholders do welcome this Bill, it would be wrong to say that they welcome every provision within it. That is certainly the feedback that I have had from my local care trust. While it certainly agrees with the thrust of the Bill and many of its provisions, there are still some it is not comfortable with. I cannot tell my hon. Friend about the genesis of this or any widespread level of support for it, because I am not aware of it. Perhaps the hon. Member for Croydon North or the Minister can help out. All I can say is that that definition of "ethical" is

"relating to moral principles or the branch of knowledge dealing with these".

I am not sure whether my hon. Friend is any more enlightened by that definition that members of staff may have to take into account. I have no idea what it all means, to be perfectly honest, and yet we are expecting members of staff who are dealing with patients in difficult situations to be weighing up all these things.

I think it can be established that everyone has their own individual take on morals, but surely we cannot start applying ethical and moral views in serious situations such as these. This will end up being the beginning of a long list of other factors that it will be demanded people be mindful of. My view is that healthcare should be provided in a legal and law-abiding way, and not with the addition of anybody's personal, individual ethical take on what is moral and not moral.

Eddie Hughes (Walsall North) (Con): My hon. Friend is making a fascinating speech that seems to be very well researched. Given that he considers this to be flim-flam, if there were other elements of law surrounding this topic that included the use of the term "ethics" or "ethical", might this need to be included in order to satisfy some type of uniformity across different pieces of legislation?

Philip Davies: My hon. Friend may well be right; I do not know. I have not been able to find any evidence for that, but it may exist somewhere. Perhaps the promoter of the Bill or the Minister will be able to enlighten us. If my hon. Friend has any evidence, I would be very happy to change my mind, but as it is, I cannot see any purpose to the provision.

The general thrust of my argument is that while this Bill should indeed be making staff and institutions accountable, it should also be helping them in their daily job, but it is making their life far more difficult than need be. I do not see that it is helping to protect the rights of patients, which is at the heart of what it is supposed to do.

Sir Christopher Chope: My hon. Friend has referred to the definition of "ethics" and "ethical". Paragraph (k), to which he is addressing his remarks, talks about the "principal" ethical issues—not all ethical issues but the "principal" ones. Does he have any insight into which ethical issues are "principal" and which are not?

Philip Davies: My hon. Friend makes a good point. I do not know the answer to that—who knows? It is a mystery to me, and therefore it will almost certainly be a mystery to any institutions trying to implement these measures. We have to bear in mind that this is not just meaningless. This will be the law of the land. Institutions and members of staff could well be taken to court over whether they have sufficiently taken into account these "principal" ethical issues. Surely it would be intolerable to put people in that legal uncertainty. I am not entirely sure that we, the people who are passing this piece of legislation, have any idea what it means ourselves, so how on earth are the people who are supposed to implement this meant to?

Surely laws have to be fit for purpose. I know that my hon. Friend the Member for Christchurch is an eminent lawyer by background, and no doubt his profession will be dancing in the aisles at the prospect of all this uncertainty, because they are the only people who will benefit. The patients will not benefit, the staff certainly will not benefit, and the institutions will not benefit, because they will probably find themselves facing expensive legal suits. Unless this is simply a benefit for the legal profession, I cannot see any point to it whatsoever.

I am confident of scoring a few more runs on amendment 11, because the hon. Member for Croydon North indicated that he supported it. As I indicated to Mr Speaker at the start, I may wish to press the amendment to a Division and test the will of the House on this matter. The amendment would insert new paragraph (l) in clause 5(2), which relates to training in the appropriate use of force, to include training for mental health staff about who is responsible, and the roles and procedure when the police are called to assist.

Some people may say—I would not necessarily dismiss this out of hand—that clause 5 is already too prescriptive. There is an argument for saying that we should take out this detailed list of things that people should be trained in and effectively leave it to institutions and local experts to sort out training for themselves, rather than putting every little element of what that training should consist of in statute. There is certainly an argument for saying that we should get rid of all these areas of training that are prescribed. Of course, the problem with prescribing everything is that what will happen is that everything prescribed will be covered, but nothing else will be. Something may well have been missed out from the list, but if it is not on the list, institutions will not bother

with it. That is my problem. Given that we are prescribing so much, it is essential that we get those things right, otherwise important things will be missed in the training. It seems to me that we go one of two ways: either we do not prescribe any of it; or we prescribe everything, because otherwise things will be missed out.

Norman Lamb: I suspect that the hon. Gentleman and I agree that it is really important to protect the individual against the overbearing power of the state, and the Bill is primarily about achieving that—protecting individuals who are often in very vulnerable positions against the potential misuse of power. Giving some detail about what the training must cover, so as to ensure that people are treated with respect and dignity, and their rights are protected, is surely something that he agrees is rather important.

Philip Davies: Absolutely I do—I am not sure that anyone would disagree with that. The issue is how we best ensure that the training is comprehensive and covers the necessary areas. My point is that there are two ways of doing that in law. One option is to simply say that training should be given and effectively leave it to the experts in the field to determine what that should cover. The Bill has gone a different way—I am not saying that it is necessarily wrong; we can argue it both ways—by literally prescribing in law what should be covered in that training.

Given that we are going down that route, it is essential that we include the things that are missing from that list, because if we do not include them, institutions will look at what it is their legal responsibility to cover, and then cover all those things, and that will be it. They will not cover anything else, because they will presume, not unreasonably, that what has been produced for them is an exhaustive list of what should be covered. My amendments 11 and 12 merely highlight that essential things to cover have been missed off the list.

When the hon. Member for Croydon North opened the batting, he kindly agreed that the things specified in amendments 11 and 12 are important and should be included in the training, and that he therefore supported them. His issue with including them in the Bill arose from the suggestion that they could be simply covered in guidance. The Minister might have something to say about that, but I do not understand this. It appears that the Government do not have the authority to agree to put these things in the Bill, but miraculously do have the authority to agree that they should go into guidance. If they have the authority to agree that these things should go into guidance, why on earth do they not have the authority to agree that they should go in the Bill? It makes no sense to me, but that is the beauty of the establishment.

10.45 am

Jackie Doyle-Price: I advise my hon. Friend that the guidance we will issue on the Bill will be subject to consultation. I fully anticipate that we can pick up the themes mentioned in his amendments as part of that consultation.

Philip Davies: I am grateful to the Minister. As I suggested, the Government have the authority to put these things in guidance, but not in the Bill. I do not understand that, but there you go, Madam Deputy Speaker—that is the vagaries of the establishment and the Executive for you.

The point that I want the hon. Member for Croydon North to note, given that this is his Bill, is that if we have 11 things in statute, putting two others in guidance does not really cut the mustard, because they will not be statute but guidance. Institutions will focus on what is in the law and what they can be taken to court for if they do not act properly. We cannot have a pick-and-mix effort, with some of these things in law and some in guidance because, by definition, the things that are in guidance are clearly not as important as those in law. My contention is that the matters specified in amendments 11 and 12, with which the hon. Gentleman said he agreed, are so important that they should be part of the list that goes into law. Guidance just is not good enough; it is not acceptable.

Amendment 11 would include in the Bill training for mental health staff on who is responsible, and on roles and procedures when the police are called to assist. The amendment would ensure that we have a structured approach regarding the involvement of the police when restraining a patient, and it goes to the heart of one of the purposes behind the Bill. This is one of the reasons why the hon. Member for Croydon North brought forward the Bill in the first place, in my opinion, so it would be extraordinary if the Bill did not include training on the thing that is central to it. The amendment stems from that inspiration.

The hon. Gentleman has detailed on several occasions in the Chamber the case of his constituent, Olaseni Lewis, and the treatment he received in the lead-up to his death. On reading through the inquest into Mr Lewis's death, alongside the coroner's report, a number of things stood out to me, but predominantly the fact—I believe it can be agreed—that the entire scenario that took place on the evening of his death was a mess. It was a shambles, and it should not have happened. There seemed to be a sudden shedding of responsibility from the medical staff to the police, which I believe caused the quality of medical care that Mr Lewis received to be compromised.

What I find most disturbing is that the police seem to be blamed for Mr Lewis's death, yet his cause of death was identified by the coroner as medical negligence. I therefore ask what responsibility medical staff have in such events and what responsibility the police have. That is fundamental to this particular case behind the Bill. Common sense suggests that if a patient is in a medical unit and experiencing an episode of mental illness, the priority is for medical staff to control the situation, due to the cause of the situation being medical, and the police are purely there to assist in giving someone appropriate medical care and treatment.

An interesting case is that of the former premier league footballer, Dalian Atkinson, who died in the early hours of Monday 15 August 2016. Police were called to attend a report of concern for safety. Neighbours had reported that Mr Atkinson was banging on and kicking his father's front door after

"flying into a booze-fuelled rage".

They had also reported that Mr Atkinson was trying to enter his father's property because he claimed that he was homeless. Mr Atkinson's father, who was not the person who called the police, stated of his son:

[Philip Davies]

"I don't know if he was drunk or on drugs but he was very agitated and his mind was upset…He was threatening and very upset."

At the time of the incident, Mr Atkinson was reported to have been suffering for some time from a series of illnesses that left him in a fragile state, with a weakened heart. Alongside pneumonia and liver problems, Mr Atkinson was also said to have undergone dialysis for kidney failure and to be battling depression. Mr Atkinson's brother Kenroy stated that, on the night of his death, Mr Atkinson

"had a tube in his shoulder for the dialysis",

which he had removed himself, leaving him "covered in blood". He also said that his brother had attacked their father, who was 85, and held him by the throat, telling him that he was going to kill him. He told their father that he had already killed his sister and another of his brothers, which was not true.

What makes Mr Atkinson's case different from Mr Lewis's is that, instead of force from person-to-person contact, Mr Atkinson was subject to the use of a Taser gun. With a combination of multiple health issues and a weak heart, this caused him to suffer cardiac arrest, which subsequently caused his death. In the days following his death, Mr Atkinson's nephew, Fabian Atkinson, said of his uncle:

"He had some health issues that he was trying to get through and that's why his heart was weak. When a Taser is deployed, as soon as a Taser is deployed, they need to automatically call an ambulance. How do they know the health of the guy or the girl that they are affecting?"

That is exactly my point.

When the police are called to an incident, they are not aware—they cannot possibly be aware—of a person's medical history. There is no briefing beforehand, because that is simply not possible when they are put into an urgent situation. Training is designed to help them attend incidents and de-escalate them quickly and efficiently. The question is: how is it possible for this to be done and for them also to be able to take on the additional task of medical assessment?

It might be assumed, from the medical setting, that there is the reassurance of a medical professional being present to monitor the person's health. In the Royal College of Emergency Medicine's best practice guidance, the advice is that when a patient is restrained in the emergency department, even if the police are providing that intervention, the ultimate responsibility for the patient's safety and wellbeing rests with the doctors and nurses of the emergency department. I think that that is absolutely crucial.

I appreciate that those guidelines are for a patient who is taken to an accident and emergency department, while Mr Lewis was in a specialist mental health unit where there were medically trained staff who should have been well versed in such situations. From reading the reports, it seems to me—other people may have a different interpretation—that the staff felt it appropriate to pass responsibility for Mr Lewis's medical wellbeing to police officers, who are not of course medical professionals. I believe that that was the most detrimental aspect of the last moments of Mr Lewis's life. That is why this matter should be one of the key focuses of the Bill.

In its memorandum of understanding, "The Police Use of Restraint in Mental Health & Learning Disability Settings", the College of Policing states:

"People who talked to us wanted mental health staff to be proactive and use their therapeutic skills to de-escalate situations and only call on the police when absolutely necessary…Each situation where the police are called for emergency assistance should be properly assessed on its merits…The police role is the prevention of crime and protection of persons and property from criminal acts."

This provides a very clear distinction between the responsibilities of the services. In case it was not already apparent, the police are responsible for crime, and the medical staff are responsible for health.

I do not want the police to have to be given a full medical briefing before assisting with the restraint of a patient—in most cases, there simply will not be time—so there needs to be understanding about the co-operation of the medical services and the police, with the medical staff giving direction to the police. I ask that amendment 11 be made to ensure that staff are given clear training to alleviate the possibility of a similar chaotic scenario arising when the police are involved in restraining a patient, and so that they are fully aware that the police are there to assist, not to take over additional responsibilities that the medical staff would otherwise have.

It seems to me that amendment 11 goes to the heart of what the Bill is trying to achieve: to prevent anyone from suffering in the same way as Mr Lewis suffered on that particular occasion. I do not understand how the Bill can be fit for purpose unless it specifically puts that aspect of the training into statute. If it does not cover that, I do not think we are being diligent in making sure that what happened to Mr Lewis is prevented. The hon. Member for Croydon North is quite right to bring that terrible situation to the attention of the House and to try to prevent such a scenario, but the provision in my amendment is what would most help to achieve that, and it is not right that it is not in the Bill. I hope that hon. Members will overcome the bureaucratic nature of the Government and insist that the amendment goes into the Bill. I would like to see that, and the promoter has said that he would also like to see that. It is our job to make the Bill fit for purpose.

Amendment 12 to clause 5—"Training in appropriate use of force"—relates to the same area. It would insert another new paragraph—paragraph (m)—with regard to training on acute behavioural disturbance, which is another really important thing that has been missed out of the list of areas that must be covered in training. The amendment would ensure that there was staff awareness training on acute behaviour disturbance, which can be life threatening when paired with restraint techniques on a patient.

I will again refer to the case of Olaseni Lewis, whose cause of death was detailed by the coroner as hypoxic brain injury caused by restraint in association with acute behavioural disturbance, or ABD. It states in the circumstances of death that Mr Lewis became agitated and fearful, resisting efforts to leave him alone in the seclusion room. Officers restrained him but were unable to regain control. Eventually, Mr Lewis became unconscious and suffered cardiac arrest.

Hypoxic brain injury, or hypoxia, is caused by an interruption to the constant flow of oxygen that the brain requires. The brain uses 20% of the body's oxygen

intake to survive, and that is needed to make use of glucose, which is its main energy source. Interruption of the oxygen supply causes a disturbance in the brain function and will therefore cause immediate and irreversible damage. A person can take as little as 15 seconds to fall unconscious due to a lack of oxygen, and damage begins to take place after four minutes.

Hypoxia is not easily identified at the beginning of an examination since the primary cause is often unrelated to the brain. Common causes can be low blood pressure, heavy blood loss such as a haemorrhage, suffocation, choking, strangulation, asthma attack, drowning, exposure to high altitudes, smoke inhalation, carbon monoxide inhalation, poisoning, drug overdose, electric shock, and predominantly—as was the case with Mr Lewis—cardiac arrest and heart failure. It is the acute behavioural disturbance element, which was referred to by the coroner in Mr Lewis's case, that I feel would be most beneficial to add to the training, and I want to explore it further.

According to guidelines written by the Faculty of Forensic & Legal Medicine, acute behavioural disturbance may occur secondary to substance misuse, such as intoxication and withdrawal; physical illness, such as following head injury or hypoglycaemia; and psychiatric conditions, including psychotic and personality disorders. Of all the forms of acute behavioural disturbance, excited delirium is the most extreme and potentially life threatening. Similar to abnormal brain function, it can cause a loss of consciousness, confusion, stupor and agitation, which is the contributing factor to causing the characteristic outburst of violence.

The agitation element of the symptoms can stem from several causes, as stated in module 4 of the College of Policing's personal safety manual. The causes are acute brain inflammation such as meningitis; limited oxygen supply to the brain, such as through acute pneumonia or heart attack; metabolic problems, as diabetes can cause high or low blood sugar levels, both of which can cause severe changes in personality and behaviour—from sleeping to agitation—and can be lethal if untreated; and general illness, in that severe sepsis can cause confusion.

It then goes on to list the symptoms associated with more severe agitation, which are as follows:

"Psychiatric illness…

Acute intoxication with a broad range of drugs or withdrawal from them"

or an

"Acute brain injury (such as a 'stroke'"

Aside from violent behaviour, other clinical symptoms may include impaired thinking, disorientation, hallucinations, acute onset of paranoia and panic, shouting, unexpected physical strength, sudden tranquillity after frenzied activity or vice versa, high mental and psychological arousal, aggression and hostility, and insensitivity to pain and incapacity.

11 am

Reading through the transcripts of the coroner's court inquest, it is apparent that those symptoms were present in Mr Lewis at the time. He appeared to be demonstrating signs of hyperpyrexia—an extreme fever, usually more than 106°, which one of the police officers on the scene, PC Michael Aldridge, commented on in the inquest. He said:

"I came onto the ward and saw Mr Lewis sweating profusely. His clothing was soaked."

Mr Lewis would have been terrified. He had experienced psychosis; he was being held in a hospital and he wanted to leave. He was surrounded by several uniformed officers and medical staff, so sweating would have been understandable. But if he were sweating to the point that his clothes were soaked through as though he had just stepped out of a shower, I am sure that would have been noticeable to anyone, particularly medical staff who, I believe, should have been looking out for such symptoms. Mr Lewis was already established as having been violent and aggressive, which were symptoms of his psychosis. He had kicked and broken a door, and was said to have been aggressive towards staff who claimed to have been in fear for their own safety. To reiterate that, the hospital night site manager, Hilda Abban, stated at the time:

"I told staff to give him intramuscular medication because he was apparently refusing oral medication, and because of his level of violent aggression it was decided during the staff handover that he would be sectioned, and that was so that the intramuscular medication could be given against this wishes."

The nursing assistant stated that Mr Lewis

"was physically violent and would put me and my colleagues in danger."

PC Michael Aldridge said:

"On sighting us he moved at speed to our position, crouched forward, shouting he wanted to get out, it was nearly all over, repeating it again and again. Mr Lewis presented a possible risk to others on the corridor and he damaged the door. He was really strong."

Mr Lewis was showing at least four of the 14 previously mentioned symptoms for ABD: violence, aggression, agitation and hostility. Along with the previously mentioned hyperpyrexia, his apparent state of panic, shouting, paranoia and heightened physical strength makes that nine out of the 14 symptoms, prompting the question why medical staff did not pick up on the fact that Mr Lewis was experiencing ABD. Further glaring signs of ABD being present in Mr Lewis were revealed by another police officer, PC Adam Mitchell, who stated:

"He was growling with every breath he exhaled. The sound and tone didn't suggest he had difficulty breathing, more something on the inside of him, an aggression and a ferociousness that couldn't be controlled."

To put that into context, by this point Mr Lewis was being restrained on the floor by several police officers. He had on two sets of handcuffs and two sets of leg restraints. He had been struck with a baton during a compliance procedure, yet he appeared not to be in pain. I believe that he was therefore demonstrating the insensitivity to pain that is one of the clear symptoms of ABD.

The terms ABD or excited delirium were reportedly never mentioned during the events leading up to the death of Mr Lewis, yet it was plain that he was experiencing that. Had ABD been identified at the time, the outcome certainly could—and probably would—have been very different. For example, referring back to the ABD guidelines from the Faculty of Forensic & Legal Medicine, the suggested steps to take when dealing when ABD are as follows:

"Ideally, individuals with acute behavioural disturbance should not be taken to a custody suite but directly to an emergency department. However, on occasions, individuals will be detained by the police and taken to the police station, when the forensic physician will be called for advice. In these circumstances, the forensic physician may consider that immediate hospitalisation is

required and advise the police to telephone 999 for an ambulance. Otherwise, the HCP should attend and assess the detainee… The forensic physician should endeavour to establish the underlying diagnosis behind the acute behavioural disturbance before making any treatment decision."

The doctor should then consider allowing a period of de-escalation where the detainee may calm down away from arresting officers. The forensic physician should avoid responding to aggression and adopt a reassuring and non-judgmental attitude, and

"Only when de-escalation has failed to curb the disturbed behaviour should the forensic physician consider giving medication."

Looking through the coroner's court inquest into police and custody-related deaths, I found another case that mentioned acute behavioural disturbance as the cause of death—that of Michael James Sweeney in April 2011. Unlike Mr Lewis, Mr Sweeney was a sporadic user of cocaine on a recreational basis. The coroner's report into Mr Sweeney's death stated:

"Following the cocaine ingestion, Mr Sweeney entered a public house with a knife. He was extremely agitated. The Metropolitan Police Service was called and officers attended shortly thereafter. Police officers almost immediately identified Michael as being unwell, suspecting that he was suffering from what had been described in their training as excited delirium. They correctly categorised his condition as a medical emergency and asked police control to arrange for an ambulance to be sent. Police control contacted ambulance control.

London Ambulance Service categorised the call as C1 Amber, rather than Red One or Red Two. At the time, there were no paramedics located in the ambulance control room (who could have recognised the seriousness of the condition and upgraded the call), but that has since changed… Twenty minutes after police first asked for an ambulance, they took the decision to transport Mr Sweeney to the Royal London Hospital in a police van.

Once at hospital, police officers, medical and nursing staff were very challenged by the situation. Mr Sweeney remained violently agitated, and demonstrated extraordinary strength in trying to hurt himself and resisting efforts to help him.

He was restrained prone until sedation was effective and was then turned over. Unfortunately, he arrested within a minute and then died less than two hours later."

Like Mr Lewis, Mr Sweeney was subjected to a lack of knowledge about his medical situation. Although he was fortunate to have police officers to attend to him who had been given good training in identifying ABD, it was again the medical services that failed him. Ambulance services that were responsible for categorising the severity of medical cases failed to identify Mr Sweeney as an emergency and thereafter left it to the police to transport him to hospital.To reiterate my early point about the roles and responsibilities of the involvement of police assistance,why should it be the responsibility of the police to conduct the work of medical emergency staff?

In response to Mr Sweeney's death, the coroner detailed his concerns in the report:

"Police officers had clearly been trained in the condition described to them as excited delirium. The training was effective in facilitating their understanding of Mr Sweeney's condition as a medical emergency. However, this term is not widely used in this country, and neither ambulance, nursing nor even some of the medical staff had heard of it in April 2011. It would be possible to give ambulance and hospital personnel an understanding of the term excited delirium. However, given that this describes a medical condition, it seems more logical for the police to follow health services in this, rather than the other way round."

That is correct: it would be more logical, but lessons have clearly not been learned. Like Mr Sweeney, Mr Lewis was failed by medical professionals and, even worse, by those who were supposed to be specialists in mental health, because they did not have knowledge about these key mental health areas and the use of forms of restraint—the core focus of the Bill—for that condition. That area must definitely be brought to the forefront of mental health training, and it is something that other services have already started to address.

In May 2016, changes to standard operating procedures were introduced in police forces across the UK to reflect new mental health procedures and help officers to identify ABD in people. The procedures state:

"The purpose of the procedure is to ensure that officers and staff recognise the heightened risks associated with Acute Behavioural Disturbance/Excited Delirium during and post-restraint, including the immediate emergency actions that need to be taken. Officers and staff are requested to ensure that they familiarise themselves with symptoms and a Summary of Guidelines for restraint and the management of this condition.

Acute Behavioural Disturbance is to be treated as a medical emergency. ABD/ED is a rare form of severe mania sometimes considered as part of the spectrum of manic-depressive psychosis and chronic schizophrenia. Persons suffering from ABD/ED are highly vulnerable to sudden death from cardiac arrest, during or shortly after a strenuous struggle."

This is a development in training where predominantly ABD or ED, I understand, were not commonly mentioned. I have been told that most police officers have never heard of ABD and were not aware of the symptoms. The police officers who had had joined the force more recently than those who had not heard of ABD and knew very little of the disorder's consequences. Police officers have often identified the symptoms of ABD as simply that of alcohol or drug misuse and therefore characterised these incidents simply as violent and aggressive behaviour.

It is important to know that ABD can stem from several other contributing factors to agitation, aside from psychosis and substance abuse: metabolic problems—diabetes, for example—can cause changes to blood sugar levels, causing severe personality changes; acute brain inflammation; limited oxygen supply to the brain, which can be caused by conditions such as pneumonia; and broader, more general illnesses such as severe sepsis. This means that acute behavioural disturbance could be a far more common issue than people think, particularly when we tot up how many people have those conditions.

Referring back to the revised procedure on this, a concerted effort has been made to ensure that officers are better equipped with the knowledge of how to recognise these symptoms more readily so that they are less likely to be confused with general aggressiveness. It states:

"Many of the signs indicating ABD/ED are common to anyone behaving violently. Therefore, it is important for officers and staff to recognise the difference between Acute Behavioural Disorder and a violent outburst."

It then goes on to list the symptoms that I have principally mentioned, along with additional ones, such as

"constant physical activity without fatigue",

and

"excessive strength/continued struggle despite restraint",

as well as

"acute psychosis with fear of impending doom; hyperthermia …abnormally rapid breathing… abnormally rapid heart rate".

It states:

"Officers and staff must recognise the heightened risk factors: A person is intoxicated with alcohol or drugs; A person is substantially overweight; A person is suffering respiratory muscle fatigue (exhaustion)."

My point is that if other public services, such as the police, are making an effort to do awareness training on this issue, why is the primary service dealing with these things not making such an effort? I would go so far as to say that I do not know, in many respects, whether it is laziness or ignorance, but it is absolutely unacceptable that training is not given as a matter of routine to people in mental health institutions, given the issues that I have raised. It is deplorable that a potentially life-saving training topic is being left to the police to deal with. Are we really going to end up in a country where we have to rely on the police to aid in these medical ailments? I sincerely hope not.

11.15 am

Mental health has already been highlighted as an area with a lack of knowledge surrounding it. The amendment is not one that is simply nice to have—it is absolutely crucial in the evolving area of mental health. It is impossible to argue that it should not be in the Bill. I know that the hon. Member for Croydon North agrees about how beneficial it would be. Is there anyone else in this House who could disagree that this should be covered in the list of areas in statute for training among staff? How can the two most important areas of training that the Bill seeks to deal with, in the case of Mr Lewis, not even be covered? The idea that we may put it in guidance at a later date is not good enough. These things must be in the Bill.

I hope that the Government make sure that the amendments are included, and I am grateful that the hon. Gentleman accepts that they should be. Our job in this House is to make sure that the Government put them in the Bill, given that, I suspect, if they had had the time to consider it, they would have agreed to do so. Let us force them to do it. I hope that the Minister, having listened to those cases, will decide that never mind the write-rounds, these things need to go in the Bill today.

Sir Christopher Chope: I certainly agree with my hon. Friend about the necessity of putting the two amendments in the Bill, and I think that everybody who has been listening to his speech will be of the same opinion. I wonder whether he would be able to tempt the Minister to intervene now and say that, having heard my hon. Friend's compelling case, the Government will indeed accept amendments 11 and 12.

Philip Davies: I am grateful to my hon. Friend. If the Minister wishes to intervene, I will not stop her.

Jackie Doyle-Price: I am happy to give some clarification on the Government's position on this issue. When I discussed the amendments with my hon. Friend, I emphasised to him that we did not feel that his amendments were necessary. I advise him that a memorandum of understanding about police involvement is already in existence. The Mental Health Act 1983 has been amended to emphasise that people in mental health settings should be in clinical settings with clinical care. The Angiolini report states specifically that agreement should be in place between health partners and police, which emphasises that health takes the lead on the use of force, in line with the principles of the already existing national memorandum of understanding. I say again that I do not believe that my hon. Friend's amendments are necessary.

Philip Davies: There you go, Madam Deputy Speaker. What can you say? The civil service script has been brandished. There is always a reason in the civil service why anything should not be done, but all I can say to the Minister is that, to be perfectly honest, the idea that it is not necessary could apply to every single individual thing that is already listed. If we wanted to go down that line, we could say that all these things are being done anyway individually by this person or that person. Either there has to be a comprehensive list of things that the Government feel are essential, which must be covered in the training, or they do not. How on earth, knowing what happened to Mr Lewis and in the other cases that I have mentioned, can anybody stand up and say, "Having listened to that, we do not think these things are absolutely necessary."? It is literally beyond belief. We literally could not make it up. It is a shameful situation that we have got ourselves into, to be perfectly honest. I will let people decide which side they are on. I hope that we can test the will of the House on those amendments, so we can see what people make of them and whether they want to be in the civil service box of deciding that nothing needs to be done, having listened to those cases. We will let the House make its mind up, and that is that.

Sir Christopher Chope: Looking at the amendments on what should be in the training, has my hon. Friend had a chance to look at my amendment 98? It would introduce into clause 5(2)(a) the involvement of "patients" and "their families" in the planning, development and delivery of care and treatment. It seems that with the cases that he has cited, family involvement can be crucial, and this should also be part of the training.

Philip Davies: The answer to my hon. Friend's question is yes—I have looked at his amendment and agree with it. If he would allow me, I had planned to go through my amendments first, before moving on to other people's. I have his amendment in my sights and I will come to it later. I have read it and very much agree with him.

My next amendment—amendment 14—moves us on to clause 7(2), which states that reporting the use of force

"does not apply…where the use of force is negligible".

My proposal would amend it to include restraint that does not include physical contact. The amendment would ensure that there is a not a series of pointless recording of every interaction with a patient that falls under the category of restraint. I am still using the word "restraint", but I am appreciate that I am in danger, at the end of these amendments, of losing the battle, and that it will be called "force". However, for the purposes of putting forward my amendments, I will still call it "restraint", as I am seeking to do. Restraint is defined in the dictionary as the

"deprivation or restriction of liberty or freedom of action or movement".

It must be reiterated, however, that it can be conducted in the most subtle of ways. The law entitles people to freedom of movement provided that they are not harming others or themselves while exercising that right. The policies of NHS services vary between trusts. Overall, the guidance for all medical staff follows the same basic principles, but specific details are more varied.

[Philip Davies]

It would be fair to say that health trusts across the board consider physical restraint to be a last resort that should be used only following the exhaustion of all other methods. Staff are advised to call for the assistance of security when physical restraint is considered, as they will have been trained in restraint techniques. Bradford District Care Trust advises that the assistance of police be called upon only as a final resort when usual restraint methods have failed and there is a serious concern for the safety of the patient, staff or other patients on the ward. I have been told that as a general rule a patient would have to be exhibiting sustained high levels of physical aggression, often involving some kind of weapon, before the police were called.

Some services, such as the London Ambulance Service, apply a different approach and advise that police be called at the earliest sign of physical restraint being required. That is due to the service not providing its staff with training in physical restraint and therefore leaving them vulnerable without the back-up of police services. In all cases of restraint, staff are required to apply the principle of using the least restrictive and most proportionate option to control behaviour, for the least time possible. Again, the word "proportionate" is reiterated through the guidelines on restraint, which reminds us that it is consistently a consideration when restraint is conducted.

The types of restraint fall into three categories: low-level restraint—interventions that prevent a person from behaving in a way that threatens to cause harm to themselves, others or trust property and/or equipment; physical restraint—any manually applied method, be it physical, mechanical, material or equipment, that immobilises or reduces the ability of a person to move their arms, legs, body or head freely; and chemical restraint—a drug or medication used to manage a patient's extremely violent or aggressive behaviour that can be administered, if necessary, against the patient's wishes. Such drugs might, of course, also be used when the threat of harm is less immediate, with the patient's consent, or if it is in the assessed best interests of a patient who lacks capacity.

Low-level or psychological restraint methods are the initial exercises conducted to try to prevent a situation from escalating quickly. Most often, this will be a variation of calming methods, which are less restrictive than methods in other categories, and which can ultimately allow the patient to have a timeout in isolation to calm down. Essentially, that can be as simple as telling someone not to do something or depriving them of equipment or possessions that may enable them to do what they otherwise would do—for example, removing glasses, hearing aids and mobility aids. It is less invasive and more frequently used with those who suffer with dementia.

Those less invasive approaches to patients allow them to retain a certain element of control over the outcome, but it is precisely those approaches that I fear will fall through the loophole of being constantly recorded, which will take the time of carers and care trusts away from the patients who actually need help. The key restraint methods the Bill is concerned with are those that require an element of physical contact, which should be reported appropriately. It is important that we remove the need to report minor interventions, which are not really at the heart of the Bill.

In the interests of time, I will group the next few amendments together. Amendment 15 to clause 7, on recording the use of force, would remove paragraph (k). Amendment 17 to the same clause would remove subsections (9) and (10), which require the recording of relevant characteristics of the patient—race, sexuality and so on. Amendments 21 to 30 are to clause 7 and amendment 31 is to clause 8, on statistics prepared by mental health institutions. Amendment 21 would insert new paragraph (q), which would add

"the relevant characteristics of the staff involved (if known)"

to the list of relevant characteristics in subsection (9). The other amendments would change the list to include the relevant characteristics of both patients and staff, make the list plural to cover both patients and staff and include the relevant characteristics of the staff involved.

Amendments 32 to 35 to clause 7 would remove paragraphs (c), (e), (f) and (h), which deal with a patient's marriage status, race, religion and sexual orientation. Those amendments would remove such unnecessary labelling of patients. I am not one for putting people into categories, and I am not a fan of labels. All these things are irrelevant to the treatment of people with mental health problems, and we should not be getting bogged down listing everybody's gender, race, sexual orientation, marital status and so on. It is all irrelevant to the treatment of people with mental health problems, and we should not be bogging down the staff with all this political correctness.

Sir Christopher Chope: Is it not extraordinary that the list to which my hon. Friend refers makes no reference to whether the patient has any family or relatives?

Philip Davies: Again my hon. Friend is absolutely right. One could argue that that is important and should be logged. I am sure we would all want to involve the family in discussions about the treatment of family members. That might well have helped in the case of Mr Lewis. Yes, it is extraordinary that the bit that could actually be relevant to the treatment of the patient is not included and all this other stuff, which is completely irrelevant to their treatment, is included. It seems like unnecessary political correctness.

In recording the use of force, the inclusion of race to help tackle racism, of sexuality to tackle homophobia, and of gender to avoid sexism, will do nothing to aid the patients. Surely, if we believe in equality, all those things are irrelevant. We should not be pointing out people's differences. Those things cannot be changed and are not relevant, and we should not be passing legislation that tries to make them an important part of treating people with mental health conditions.

If we will insist on going down this route, however, I am confused about why the Bill requires only the recording of the patient's characteristics, and not those of the person giving out the treatment. If there is institutional racism, or whatever it is that people try to hang a hat on, surely the characteristics of the person using the force must be relevant. Surely a complete picture can never be grasped only by recording the characteristics of the patient. If we are trying, as I think the hon. Member for Croydon North is, to uncover unconscious bias, institutional racism, or whatever he wants to call it—people have their different terminology to hang their hat on—surely it cannot be done without amendment 21.

He indicated in his opening remarks that he had sympathy with it, and I am grateful to him for that. I hope he agrees that it is not just useful but essential if we are going down this route.

The Bill also asks that the police wear body-worn cameras so as to literally give a full picture of their involvement in these cases. Why are we only reporting one side of the story when the police are not there? If the relevant characteristics of the staff are included in the report, the recorded statistics might give a better representation of the matter. I feel that the provision I suggest in the amendment was not originally added because it might highlight a very different narrative from that which some would like to present. One particular concern I have is that these reports will be used to try and back up the questionable argument of institutional racism in the health service, despite studies showing a lack of early diagnosis of mental health illness and psychosis because of a lack of trust in mental health services among people from BAME communities.

It is consistently documented that BAME patients, particularly those with African and African-Caribbean backgrounds, are more likely to be diagnosed with a form of psychosis, and to enter the mental healthcare system via a more confrontational approach than would be the case through a routine appointment with a GP. That is the basis for the institutional racism argument. However, it should be considered that the suggestion of institutional racism in the mental healthcare system is what is preventing people from seeking early medical help in the first place. It is not helping the situation; it is making the situation worse. People are being told, "Don't enter these services, because there is institutional racism", and that is not helping anyone.

11.30 am

The genuine, present issues that need to be addressed are whether patients are being treated early enough in their illnesses, and whether the treatments are sufficient to enable them to sustain mental wellbeing in the future. It strikes me that a huge section of the Bill is bogged down in stuff that is not important at all. I am not sure whether it was just an afterthought—"We'll lob this in as well"—or whether it was intended to be central to the Bill, but I do not think it will help anyone's mental health treatment. It will merely help lots of politically correct organisations around the country, which will start stamping their feet and saying that the public sector is institutionally racist. I do not believe that that is the case, and, as I said at the outset, I do not think there is much evidence to suggest that it is.

Amendment 16 would insert a new subsection (6A) in clause 7, which is entitled "Recording of use of force". It would require records of use of force to be added to the patient's medical records. I would like to think that that is a rather obvious and sensible measure, and I have a feeling that the hon. Member for Croydon North would be quite sympathetic to it. It would ensure that the use of restraint against a patient was documented on the patient's records, which would help people to know how to deal with the patient in the future. Someone who did not happen to be present at the time, or a new member of staff, would more readily have access to information that I think is crucial to the way in which people should or should not be treated in any particular circumstance.

It is worth bearing in mind that a key argument in favour of the Bill is that there is currently no consideration of whether a patient has experienced a history of abuse or violence, and whether there are therefore some forms of restraint to which he or she should not be exposed. The one thing that is missing in the middle of all the reporting, statistic taking and analysis is the patient's care plan. The purpose of restraint techniques is to prevent patients from causing harm to themselves and others around them when they are experiencing what could arguably be a very dark and turbulent period of their lives. Those methods are being branded tactics to control and humiliate patients, when in fact they are part of a broader care plan to protect the patient. That often seems to be forgotten. To put it in simple terms, they can form part of the patient's overall treatment. I find it astounding that unless the Government change their mind, these instances will not be documented in individual medical notes as they should be.

Sir Christopher Chope: I think we have all encountered constituency cases in which people suffering from mental illnesses are shifted from one location to another—from one clinical commissioning group area to another, or from one part of the country to another. In one of my constituency cases, someone is being told that they must go up to Manchester to be treated for a mental condition. If people are being dealt with in different locations, it is all the more important for there to be one set of medical notes that records everything that has happened.

Philip Davies: That is a very good point. I had not mentioned that people might be moved from one institution to another, but that, of course, makes the amendment even more important. I am not in favour of excessive bureaucracy, but that strikes me as being an essential part of what the Bill is intended to achieve. The purpose of my amendment 16 is to deliver the Bill's original aim. In fact, that is the theme of all my amendments. They are certainly not intended to weaken the Bill; if anything, they are intended to encourage the hon. Member for Croydon North to go further. The amendment is not just something nice to tag on to the Bill. I think that it goes to the heart of what the Bill should be about. Restraint techniques should be documented in medical notes to provide other medical practitioners who are treating the same patient with an overview of how that individual patient responds to the use of that form of restraint. I cannot see why that should not be part of the Bill.

Mr Reed: I am sorry to intervene on the hon. Gentleman—I know that he is trying to be as brief and succinct as he can possibly be. *[Laughter.]* I take his point about medical records. I—like him, I suspect—believe strongly in patient empowerment, and I think that there is a case for the inclusion of records of restraint in patients' medical notes. However, I am loth to support changes in the Bill when we have not consulted either patient groups or medical professionals. Given that it is possible to make this change through guidance after the Bill is enacted, if the Minister will give an assurance to that effect, I shall be content to deal with the issue in that way, because that would meet the objective for which the hon. Gentleman is arguing.

Philip Davies: As I said at the start, I genuinely appreciate the constructive way in which the hon. Gentleman has approached the Bill, and he has just given another indication of that. The question is—this is the dilemma that we always seem to have on a Friday—whether we should rush through legislation that we know is not as it should be, and try to patch up little defects with a bit of sticking plaster here and a bit of sticking plaster there, or whether we should make an effort to ensure that the Bill is in a fit state in the first place.

The hon. Gentleman is arguing—it is a perfectly respectable position to hold—that it is all right to gloss over the fact that lots of really important things are missing and to provide a big sticking plaster called guidance, telling people, "Here is some guidance. We forgot to put this in the Bill, by the way. It should have gone in, but we did not sort it out in time. Parliament couldn't be bothered to do its job properly, so here is a list of all the things that you should and should not be doing." That is a perfectly reasonable case to make, but I take the view that when we pass legislation in the House, we should be a bit more mindful of the people who will have to implement it, and make sure that it is fit for purpose the first time round.

It seems to me that it is possible for everyone to be satisfied. The last thing that we want is for the Bill not to go on to the statute book. It is broadly a good piece of legislation—although, as I have explained, I have reservations about it—but I think that we have an opportunity to make it better. We have three options. The first, which is the ideal option, is for the House to put the Bill into proper shape and accept some of my amendments, which I think are clearly necessary. The hon. Gentleman himself accepts that some of them should have been in the Bill originally. Secondly, we can opt for the sticking plaster route: we can cock it all up ourselves, then put a sticking plaster called "guidance" over it and hope that someone will be responsible for sorting it all out. Thirdly, we can give the Bill another slot at a future date so that the Government have time to consider and do their write-rounds, and the hon. Gentleman can do a bit more consultation. Hopefully we can deal with the Bill later in the year, along with some of these amendments—either agreed or not agreed—on the basis of the write-rounds and the consultation. That seems to me to be the most sensible way of going about it.

I think that what is important is for a sensible piece of legislation to go on to the statute book. There are plenty of days left in the current Session on which we could deal with the Bill. Putting everything that should be in the Bill in guidance at the end does not really do it for me. It might do it for the hon. Gentleman, it might do it for the Minister, and it might get us over a little hurdle, but I do not really think that it is the best way to pass legislation in the House.

Sir Christopher Chope: My hon. Friend sets out the three options very clearly, and if we went for the last of them that would give the Government an opportunity to produce the draft guidance so we can see what will be in it. What has concerned me so far is that the Minister has said that quite a lot of the things my hon. Friend and I think should be in the Bill are not necessary, and the Minister is not even saying they should be in the guidance. If we get the draft guidance, we will be able to see where we stand.

Philip Davies: My hon. Friend is right. The Minister is doing her best; she does not decide the Government's bureaucratic nonsense of decision-making strategies and all the rest of it. This is not her fault; she is left in a difficult situation, and I am the first to appreciate that. But as my hon. Friend says, at present we are not even getting a guarantee that these things will be in the guidance; we are being told they might be dealt with in the guidance, and even that there is an expectation that they might be. But I have been here long enough; I have been shafted before on private Members' Bills where I have been promised that an amendment will be tabled in the Lords to deal with something and then it never arrives. So a bird in the hand is certainly worth more than two in the bush, particularly when it comes to Government promises on amendments and guidance in my experience. That is not a party political point; both sides have been guilty of that in the past. I am therefore looking for a bit more than a waft here and a waft there suggesting this might be covered in guidance; I am looking for something a bit more concrete than that. Indeed, I do not think it does the Bill justice if it goes through Parliament when it is not in a fit in a state; we all want to see it in a fit state.

My amendments 18 to 20 to clause 12 relate to police body cameras. I propose to change subsections (1) and (2) to say that police "should…try to", rather than "must", take a video recording. I also want to remove subsections (4) and (5) which make police "liable to criminal…proceedings" if they fail to take a video.

As the College of Policing has stated, it is an indisputable fact in today's society that law enforcement officers carrying out their duties, and the tactics they use, are under greater scrutiny than ever before. That is a good thing, and I am a massive fan of police body-worn cameras; they are fantastic for the interests of justice, and they safeguard the interests of police officers, who often face vexatious complaints. The footage can be produced to show that what they did was absolutely right, which is almost always the case. That is fantastic for the courts, too, because they can see at first hand what actually happened, rather than have to deal with conflicting accounts and have to choose to believe one witness over another and so forth. I am therefore a big fan of body-worn video cameras, and they are often the modern method of detailing interactions with the public by the police. Their aim is to improve the accountability and transparency of police conduct when police officers encounter the public. This is a move that the Home Office highlighted at the time of their launch as being the technology of the future, and as a means to help save police time and improve working practices.

General procedure for using the devices is that they are to be used only for recording encounters with the public and are not to be constantly recording for the duration of a shift. The policy of West Yorkshire Police, which covers my area, on body-worn camera video advises that it is to be used where a degree of investigation or exercising police powers is required unless there is a good reason not to. The rationale for not using body-worn video cameras may need to be explained at a later stage, and justified to a supervisor and/or during court

proceedings. The recording must be proportionate, and the effect it may have on individuals and their privacy must be taken into account. It is advised that the cameras be switched on the moment the incident becomes apparent, and in some cases this may be en route for the incident. However, it is stated that officers must announce that they are using the recording equipment in clear wording: for example by saying, "I am wearing and using body-worn video. I just need to tell you that; you are being videoed and audio recorded." The recordings taken are stored on the camera until they are returned to their docking station at the police station. From there, clips are downloaded and sent to the central system for viewing. These clips cannot be altered, changed or deleted by the officer in any way, which keeps them completely authentic for evidence purposes.

11.45 am

The cameras differ between forces. At present there are a couple of different ones available and their performance is equally varied. Most common among forces, including West Yorkshire Police, are the reveal cameras. The device is rectangular in shape with a large proportion of it being a screen showing the other person that they are being recorded. The camera at the top of it is on a rotating axle so that it can be adjusted and repositioned each time it is used. It also has a switch at the side to flip up and down to switch it on, and that operates a red light that flashes to draw attention to the fact that it is recording. Alongside the flashing, it is also said to make a loud beeping noise for the same purpose as the flashing light, which I have been told is irritating and probably unnecessary. In essence, it is designed to be simple to use at short notice.

The effectiveness of such technology is clear. Results from randomised control trials have shown improved efficiency in delivering criminal justice by an increase in early pleas or higher prosecution rates. Alongside that, it is noted that the benefits of using these cameras may include improving public confidence, reducing crime, and reducing the number of complaints against police officers, and that they provide a useful tool for the training and professional development of police officers.

A US study of the use of these cameras, published in a scientific journal, was conducted in California in 2014. It examined the impact of body-worn video by measuring the number of incidents of police use of force and of complaints where officer shifts were assigned to either an intervention with cameras recording all contact with the public, for which there was a total of 489 shifts, or a control without cameras, a total of 499 shifts. The main findings were that body-worn video reduced police use of force by 50%. This was also reflected in the number of complaints falling from 24 in the previous year to just three in the year of the study. The authors of the study speculated that the video-taping of police-public interactions may result in socially desirable responses: when people know that they are being recorded, they tend to exhibit more desirable behaviours and are more likely to follow the rules of contact.

In the UK there were several trials of body-worn video ahead of a wider roll-out. Hampshire Constabulary conducted trials in 2013-14 and overall its findings were relatively positive. It noted a small reduction in overall incidents classified as crimes when compared with before and after pilots in other regions. When interviewed, police officers recommended that they should focus on incidents most positively affected by body-worn videos such as low-level and high-volume incidents of public order and antisocial behaviour. In a public survey following this, it was found that 90% of people thought these cameras would help the police gather evidence, identify criminals and increase the likelihood of successful convictions.

At a trial in 2006-07 in Renfrewshire and Aberdeen there were also some positive outcomes. As in Hampshire, there was praise for the technology for making the public feel safer and improving public confidence in the police. There were more technical issues with the cameras then, however, and since 2013 Police Scotland officers have recorded a total of 302 faults with the equipment, with the total number of problems reportedly doubling from 57 in 2014 to 120 in 2016. It is estimated that the cameras are deployed up to 50,000 times annually in Scotland alone, and it is claimed that the number of reported incidents each year is approximately 0.03%. That percentage may not seem high, but in real terms it still represents a large number of incidents that are not being recorded because of problems with the equipment.

The faults include an inability to download videos, digitally assigning cameras to officers, and recordings from previous shifts still being present on the camera, alongside more functional issues such as short battery life and cameras taking a long time to warm up when they are switched on. These factors are all pertinent when putting provisions in a Bill such as this one. More recent generations of the technology have worked towards combating these issues. The on switch now goes on automatically with virtually no warm-up time. Battery capacity is now designed to cover the recording requirements of an entire shift, with the recording capacity to support two to three-hour video. Officers are also being given an option to charge the camera remotely via a USB.

The success of body-worn video has prompted other services to review how it could play a part in their working life. Recent trials have taken place in the Barnsley Hospital NHS Foundation Trust's security department. The main issue is trying to combat antisocial behaviour and aggression towards staff, which the trust identified as generally coming from disruptive patients, who were the primary force behind the decision to use the cameras. Aggressive behaviour was divided into two categories: medical and non-medical—that is clearly unique to the NHS—and the vast majority of assaults on staff involved non-deliberate or medical violence, which derived from patients who were unwell. The trust stated that the move was taken to collect evidence, when needed, to share with the police.

During the pilot phase, one of the on-site hospital shops was burgled. The security officer present had used a body camera to record the incident, and the footage was shared with the police. The trust found that the cameras provided excellent support as a deterrence measure. Security staff reported that violence towards them had decreased dramatically as a direct result of wearing body cameras, with violence and aggression issues decreasing by 80% across the Christmas period. After the full 12-month trial, it was reported that medical and non-medical violence and aggression had decreased by 12%, and it was believed that this was due to the use of video cameras.

The Queen Elizabeth Hospital in Birmingham also conducted a trial with the aim of reducing violence and aggression. During that study, the hospital encountered one particular patient who was known for fabricating allegations of being touched inappropriately while being assisted by staff. The hospital found that the camera provided a useful tool for protecting both staff and patient from any potential threat of sexual assault and from any allegations of sexual assault.

In short, I agree that the use of body-worn cameras is beneficial to the public and to the professionals who use them. Trials conducted by the police have shown that the benefits of using the equipment far outweigh any disadvantages. With technology developing at such a rapid pace, the opportunities for recording detailed accounts will give our services the ability to conduct their work with the security of reliable and unlimited technology. What must be considered, however, is the extension of the use of body-worn video fully to other services beyond the police. The trials in the NHS, to which I have just referred, show that there is a clear need for this, and it should be considered as part of this Bill.

To reiterate, I do not mean that all NHS staff should be equipped with a camera. They should be issued for use by those who are trained to conduct restraint of patients. The video should then be downloaded to a centralised system and added to the restraint data that the trust collects to be viewed. Again, it must be observed that written data on restraint are collected by hospital trusts. As I have previously mentioned, the video of such restraint would allow a full picture of the restraint to be observed for the evidential justification of such actions.

My point is that varying factors need to be taken into account in relation to the absence of a police video. I do not feel that they have been taken into account in the Bill. Stating that officers "must" take a video does not factor in the possibility of a scenario in which it is simply not possible to do that, or that there could be mitigating circumstances that will prevent them from doing it. Body-worn video has resulted in a marked improvement in reporting crime, and it has been rolled out to other services. Further to this, simple technology failures could make it difficult to produce a video. Making a police officer liable to criminal proceedings because they have not taken a video is excessive and absurd.

Kevin Foster: I thank my hon. Friend for giving way. It is always a pleasure to have an extended opportunity to hear him speak on a Bill. His amendment proposes to replace "must take" with "should consider taking", when the words "if reasonably practical" are already in the Bill. Similarly, his amendment 19 would introduce the rather vague concept of trying to do something. Hon. Members are usually rather doughty in wanting to take vague provisions out of legislation, but in this case my hon. Friend wants to put some in.

Philip Davies: I understand the point that my hon. Friend is making. Equally, I am not keen on unnecessarily criminalising decent police officers. My fear, which I know my hon. Friend does not share, is that that could well happen. It could also be the case that the officer would be acquitted following a long disciplinary process and trial. That often happens to police officers, but we should not underestimate the hurt that results from their having to go through all that. I am trying to prevent unnecessary disciplinary and criminal proceedings being taken against police officers.

Kevin Foster: I thank my hon. Friend for giving way again. He gave the example of the pilot schemes, and body-worn cameras have led to a reduction in complaints against police of over 90%, which deals with the point he makes.

Philip Davies: I made it clear that I support and encourage the use of such cameras, but there may be occasions when, for whatever reason, they cannot be used, and the wording says "must".

Jackie Doyle-Price: I completely agree with my hon. Friend's points. It was precisely to address such concerns that the phrase "if reasonably practicable" was placed on the face of the Bill. To clarify, we do not want the fact that a police officer is not wearing a camera to impede them from doing what is right in this context. My hon. Friend raises concerns about the potential for the criminalisation of police officers, but that is not our intention. The subsections to which he refers are consistent with those in the Police and Criminal Evidence Act 1984, and they are there just to remind the police of their obligations. He rightly draws attention to the fact that cameras protect police officers as well as patients. As a force for transparency, they are an effective tool. I reassure my hon. Friend that his concerns are addressed in the Bill.

Philip Davies: I am grateful to the Minister for that, and I am sure that police officers will be grateful, too. However, I just feel that there are occasions when it may be practicable to wear a camera, but for whatever reason—the pressure, time or the heat of the situation—they forget, and I wonder what will happen in such cases. There could be a situation in which it is practicable for them to wear a camera but, owing to the noises they make and the flashing lights or whatever, they think, "You know what? In this circumstance, I'm unsure I'm going to do that, because it might make this patient worse." I worry that there are insufficient loopholes, so to speak, for police officers who are trying to do the right thing in difficult situations and that we are in effect trying to make things more difficult for them. I fear that, as a result of this Bill, criminal proceedings will be brought against a police officer that never should have been brought. It is all right to say, "We don't think that that will happen," but these things do happen. I want the law to be worded to make that as unlikely as possible. That is my only concern, and we will see whether my fears are realised.

Sir Christopher Chope: Is there any evidence to suggest that the police will not want to protect themselves by taking body-worn cameras to such incidents? Why do we need this measure in the Bill at all?

Philip Davies: My hon. Friend makes a good point. The evidence is that police officers are the biggest supporters of body-worn cameras. They are crying out for them and want to use them more often, and they want the cameras to have a longer battery life. I agree

that it is entirely unnecessary, so do we need to go down the road of criminalising police officers because they forgot to wear a camera? It might have been entirely practicable, but they may have simply forgotten. Should that really be a criminal offence? I am dubious. We ought to be giving our police officers more support, not trying to make their lives harder.

I have been discussing my amendments, but other right hon. and hon. Members have tabled several amendments, and I want to start on those by discussing new clauses 1 and 2, tabled by the hon. Member for Croydon North. I understand what he is seeking to do, and it was perfectly reasonable for him to say that if there is death at the hands of the police, the Independent Police Complaints Commission—although I think it has a new title these days—will get involved and all the rest of it, so why should other deaths not be subject to a similar procedure? That is a perfectly respectable point, and I have every sympathy with that view.

12 noon

I contacted my local trust, the Bradford District Care NHS Foundation Trust, about these points, and it is worth putting on record the fact that it said:

"The death of a patient under the circumstances"—

covered by the Bill—

"would be investigated as a Serious Incident…in line with NHS England's "Serious Incident Framework". Once an SI has been identified we have 12 weeks in which to complete our root cause investigation and report. The family of the deceased would be invited to be involved in that process from the outset…the only thing that might prevent us from proceeding with an SI investigation would be if the police told us not to for fear of prejudicing their own investigation. In other words, the initial NHS-led investigation would be very quick. I cannot speak for the police's internal investigation. If an independent, external review is also required that can take a very long time (which might be an unintended negative effect of insisting that all inpatient deaths are automatically subject to external review)."

Mr Reed: I look forward to hearing the Minister address that point because I believe that she has proposals on how we take this forward. May I just take this opportunity to welcome to the Chamber Seni Lewis's parents, Aji and Conrad Lewis? Following the tragic death of their son in 2010, they had to fight for seven years, because of a botched internal investigation, to secure an inquest to find out what had happened to their son and why he had died, and to secure the modicum of justice that surely they, as bereaved parents, deserved right from the start.

Philip Davies: I am very grateful for that intervention, and I also very much welcome them and salute them for everything they have done in Mr Lewis's honour. I would just say two things to them. First, they have a fantastic Member of Parliament who has done a great job representing their interests in the House—they should be very proud of their Member of Parliament. Secondly, we are all agreed that it is essential that this House passes laws—through this Bill, we hope—that will ensure that what happened to Mr Lewis will never happen to anybody else ever again. That unites everybody in this debate, whatever our individual views on any particular amendment.

Norman Lamb: I am conscious of the fact that the hon. Gentleman has been speaking for two hours. He is raising legitimate points, but I feel passionately that the Bill has to be passed into law, and I know that many other hon. Members share that view. I have a real concern—I do not think this is his intention; I hope it is not—that we could end up with the Bill being talked out today, which would risk it being lost. It would be a tragedy if that happened, and I urge him to allow other Members to contribute to this debate so that we can reach a conclusion.

Philip Davies: I hear what the right hon. Gentleman says, but clearly he has not heard what I have said. The Bill would not be lost, as he well knows. He has been here long enough to know exactly how procedure works in the House. As the Bill has already started its Report stage, it would very easily slot to the top of the queue on a future date, when it could go through. I hope that it would go through in a better state, once the Government have had time to look at the amendments that they need to consider in order to make the changes to the Bill that the hon. Member for Croydon North has agreed should be made. All I am trying to do is to deliver what the hon. Gentleman wants in the Bill.

Mr Reed: Although I agree with the hon. Gentleman that I would like to see changes, I am perfectly happy to accept the Minister's assurances about dealing with them through guidance.

Philip Davies: We have been around that issue, so I do not intend to revisit it again. The fundamental amendments 11 and 12, which I have addressed at some length, go to the heart of what happened to Mr Lewis on that terrible occasion. They would ensure that training was given to staff to ensure that those things could not happen again. It is therefore essential that those amendments are made to the Bill and that these things are not just dealt with as part of guidance, which may or may not then be covered off by individual trusts. We have a duty to make sure that the things that happened to Mr Lewis are absolutely covered in the training given to staff.

Sir Christopher Chope: My hon. Friend is absolutely right not to fall foul of the scaremongering, because we are fortunate to be in a much longer Session than usual, and the Government are still to announce the extra Fridays that will be available to discuss private Members' Bills. If a Bill such as this is supported by everybody in the Chamber—by the Government and the Opposition—but there is need for further improvement, why not improve the Bill, rather than putting it on the statute book in an imperfect state, given that we know jolly well how difficult it would be to amend it later through a further private Member's Bill? Let us make this a good Bill.

Philip Davies: The Bill will definitely conclude its Report stage at some point, but if it does not pass today, it will not be my fault. For goodness' sake, we still have two and a half hours to go. The Government still have plenty of opportunity to say that they will accept amendments 11 and 12, and if they do so, the Bill will go through today. If they need more time to do a write-around before those amendments can be agreed, that is literally in not my hands, but the Government's. If they want the Bill to get through today—

Jackie Doyle-Price *rose*—

Philip Davies: I hope that the Minister is going to make us all happy.

Jackie Doyle-Price: My hon. Friend is again mischaracterising the Government's position. Our position is that the amendments are not necessary. I have already outlined to the House that the specifics of the role and responsibility of police officers on these occasions are subject to a memorandum of understanding on which the College of Policing, which my hon. Friend has praised, has led. I ask him again not to press his amendments, because they are not necessary.

Philip Davies: Perhaps when the Minister responds to the debate she can tell us which amendments the Government would accept if they could get their write-around sorted out in time—*[Interruption.]* The Minister indicates "none" from a sedentary position, but that is absolutely not what the Government communicated to me yesterday. They said to me yesterday, "I wish we had seen these amendments earlier." The Minister's indication flies in the face of that.

Sarah Jones (Croydon Central) (Lab): Members have had six months to table amendments, so perhaps the hon. Gentleman could have speeded up the tabling of his.

I support my hon. Friend the Member for Croydon North (Mr Reed) and his Bill, but there is a suggestion that it needs to be improved, and we must of course all look into what improvements could be made. I should point out, however, that the organisations that support the Bill in its current form include the Royal College of Psychiatrists, the Royal College of Nursing, the Care Quality Commission, NHS England, YoungMinds, Mind, Agenda, Rethink Mental Illness, Inquest, the GMB and Unison. With all those very good organisations supporting the Bill, perhaps we can try to make progress today.

Philip Davies: I do not believe the hon. Lady has been present throughout the debate; had she been, she would have appreciated that we all support the Bill. The hon. Member for Croydon North supports the Bill in its current form, but it has become apparent during the debate that he actually agrees that it would be improved by the inclusion of amendments 11 and 12. It is a question not of whether we support the Bill—we all support it—but of whether we get a Bill that is fit for purpose, and if we pass the best possible Bill. The point is that once these provisions have passed through the House, that will be it: the Bill will move off the House's agenda, and we will not have another chance to do the great things that the hon. Gentleman is trying to achieve. We have to get it right this time, because otherwise the opportunity will pass. Those two absolutely key bits of training to prevent what happened to Mr Lewis from happening to other people need to be provided for in the Bill. To be perfectly honest, it is blindingly obvious to anybody that they need to be in the Bill.

Will Quince (Colchester) (Con): Are we not in danger of allowing the perfect to be the enemy of the good?

Philip Davies: On that basis, my hon. Friend is basically saying, "Let's get a Bill with a nice title, with any old nice-sounding provisions in it, and bang it on to the statute book without any scrutiny whatsoever." The whole point of Report is to try to improve Bills. I am still confident that people will decide that what I am saying is sensible, because the amendments are sensible improvements to the Bill. It is not my fault that the Government cannot carry out their decision making in time. To address the point raised by the hon. Member for Croydon Central (Sarah Jones), the whole point of requiring amendments to be tabled by Tuesday evening prior to their being debated on Friday is to give people time to consider them.

Mr Reed: If the hon. Gentleman were generous enough to draw his remarks to a close within a reasonably short period of time, the Minister would be able to put on record how the Government intend to deal with some of the issues that he quite rightly and legitimately raises. My belief is that there are other ways of dealing with them that would allow the Bill to proceed today.

Philip Davies: Yes, that point has been raised. Basically, we are going to cover everything that is not in the Bill but should be in guidance. It seems that the Minister has made it abundantly clear that she is hardening her position as every minute goes by. We have gone from a situation of her saying, "If only we'd had the amendments earlier, we would have done something about them," to, "They're not necessary," and now to, "We don't agree with any of them." The latest indication is that the Government do not agree with any of them.

Jackie Doyle-Price: Again, I would have appreciated sight of the amendments earlier, not least because we could have had a sensible discussion about how to achieve the outcomes that my hon. Friend wants. I am very clear that we can achieve that through guidance, which we will bring forward in consultation—we have consulted throughout the passage of the Bill—with the sector. I am talking about statutory guidance, and all institutions will need to have regard to it. We are in this position following dialogue with the sector and we have carried out parliamentary scrutiny. The Bill is not the only opportunity to bring forward legislation in this sphere because consultation on Healthcare Safety Investigation Branch legislation and the review of the Mental Health Act 1983 are taking place as we speak. This will not be the only opportunity for my hon. Friend to bring forward legislative proposals.

Philip Davies: Well, the only problem with that is that we will end up in the same game in which I table an amendment and the Government say that there is not time to do a write-around about it. I do not even follow the Government's position any more. We have gone from them saying, "We wish we'd had these amendments earlier," which the Minister has just reiterated, to then saying that they are not necessary—*[Interruption.]* The Minister says, "No they are not," and then she says that they will be covered in guidance. Well, if they are not necessary, why would she put them in guidance? We will have to start getting our story straight. Are these things necessary or not?

Jackie Doyle-Price: My hon. Friend has been a Member of Parliament for a lot longer than I have, so he will be aware that Bills set out the principles of legislation, and it is standard practice for the detail under a Bill to be enshrined in guidance.

Philip Davies: But we do not know what will be in this guidance. I am making the case that it is absolutely essential that amendments 11 and 12 are made to the Bill. The hon. Member for Croydon North said quite clearly that he agreed with them and that he also thought they should be made to the Bill. I appreciate that he is trying to find a compromise but, strictly speaking, he would be happy for the provisions to be in the Bill. I think they should be in the Bill; he thinks they should be in the Bill. The Minister has not even made a commitment that these specific amendments would be reflected in the guidance. I am literally being offered nothing, apart from her saying, "Oh, we know this Bill is not good enough. We will try to sort out a bit of guidance here and there. It's not perfect, but just let it through because it has a worthy sentiment behind it." We must start treating legislation with a bit more respect in this place. The Minister says that the Bill has gone through parliamentary scrutiny, but this is parliamentary scrutiny. This is the Bill's Report stage for goodness' sake.

Sir Christopher Chope: The Government's line seems to be that this legislation is an urgent measure. If it is so urgent, may I ask the Minister—through you, Madam Deputy Speaker—what state the guidance has reached?

Madam Deputy Speaker (Dame Rosie Winterton): Order. The hon. Gentleman is making an intervention on the hon. Member for Shipley (Philip Davies), not the Minister.

Sir Christopher Chope: I invite my hon. Friend the Member for Shipley (Philip Davies) to ask the Minister whether she agrees that, because of the urgency of this legislation, the guidance is ready in draft form in her office and can be laid before the House tomorrow or in the next couple of weeks. I suspect that the Government have not even begun to draft the guidance, but we need the guidance before this legislation would ever be able to take effect.

12.15 pm

Philip Davies: Absolutely. It appears, to me at any rate—I do not know about anyone else—that the Government are just making things up as they go along, desperately trying to get this Bill through in any form whatever. Whether it is good, perfect or indifferent is neither here nor there. They just want to get it through, presumably so that they can say at next questions, "We got the Mental Health Units (Use of Force) Bill through Parliament." Well, perhaps they just want to pass any old legislation, include a few decent clauses and hope that it will do the job, but I am afraid that is not what this House should be about. It is about saying that we have identified areas where the Bill should be strengthened, and we therefore have a duty to find a way to do that. If the Government will not agree to do it today, I am afraid that we will have to try to ensure that they do it in the future.

I am determined that the Bill will go through in a proper form that will help to stop what happened to Mr Lewis ever happening again. We have to get back to the central reason for the hon. Member for Croydon North introducing this Bill in the first place. The points on which I am focusing are not just useful add-ons here and there; they are at the very heart of the purpose behind the hon. Gentleman's Bill. I do not really see why he should be so complacent about letting it through without these things being included.

Anyway, hon. Members have tabled amendments that deserve to be scrutinised. The right hon. Member for North Norfolk has tabled quite a few. With amendment 40, he wants to include the threat of force as part of the use of force, so that the threat of restraint would be considered the same as the use of force. I am afraid that I cannot agree with that. We do not want to deter people from warning of the threat of force, when warning of the threat of force may actually stop them having to use it in the first place. I do not really see how the threat of force can be treated in exactly the same way as the use of force. Often, threat of force seems to be a legitimate restraint technique. If staff are not threatening to use force before they actually use it, the use of force might become more likely. I do not agree with that amendment.

Sir Christopher Chope: And, of course, every threat of the use of force would have to be recorded, would it not? The threat of force was actually included in the original drafting of the Bill and was taken out in Committee, so I do not understand why the right hon. Member for North Norfolk (Norman Lamb) wants to include it again.

Philip Davies: I agree. The same applies to amendment 41—also in the name of the right hon. Member for North Norfolk—which would include the "threat of isolation" alongside isolation itself, and to his amendment 42, with which he wants to include the "coercion of a patient". I am not entirely sure why such an amendment is needed, to be perfectly honest. He includes a definition of coercion in amendment 43, as

"the use or threat of force, with the intention of causing fear, alarm or distress to control a patient's behaviour or elicit compliance with the application of a use of force."

I am not really sure what that adds to the Bill, to be perfectly honest. I do not think that anything it does add to the Bill is something that I could support anyway. I think that he is taking these definitions a bit too far given the Bill's purpose.

The right hon. Gentleman's amendment 37 would insert into clause 3:

"A policy published under this section must set out that the use of force will only be used without the sole intention of inflicting pain, suffering or humiliation, or subjecting patients to tortuous, inhumane or degrading treatment, or without inflicting punishment or intimidation."

With regard to using force with

"the sole intention of inflicting pain, suffering or humiliation",

I look to people who are more legally qualified than me, but surely that must already be illegal. I cannot believe that that can already be lawful in this country. Therefore, this amendment is not necessary either.

Amendment 36 refers to a

"description of each of the methods of restraint that may be used…what steps will taken to reduce and minimise the use of force"

and

"a description of the techniques to be used".

Paragraph (d) is the worst bit. It refers to

"a commitment to reducing the overall use of force in the mental health unit."

[Philip Davies]

Would that potentially mean that restraint and force is not being used when it should be used because somebody had a commitment to reduce its overall use? Surely, we should be seeking to make sure that restraint and force are used appropriately—at the right times, in the right situations, with the right patients. As long as that is being done, the number of cases is neither here nor there. It is the appropriateness that matters, not the numbers. This amendment would mean that restraint would not be used when it should be used. The lack of trust in staff in this is something that I cannot possibly support.

Amendment 38 says that

"subsection (1) must include a patient's right to advocacy and how to access an advocate."

Again, this may deter staff from using restraint even when it is necessary, thinking that they are going to get into a compensation culture with vexatious legal claims being made against them. We should not be passing laws that encourage that.

Amendment 79 says:

"The Secretary of State must publish quality standards for training"

and

"The Secretary of State may delegate the publication of quality standards for training".

There is already a requirement to have standards for training; the right hon. Gentleman seems just to want to add the word "quality". I am not sure that there is any indication that the standards for training would not be of quality anyway. It goes without saying that we want quality standards of training; we do not need to put that into the Bill.

Amendment 80 refers to "trauma-informed care". I do not have a particular problem with that. Again, it is an issue of how prescriptive we should be in relation to the training. I have already spoken at length about that. The right hon. Gentleman makes some fair points.

The right hon. Gentleman's other amendments include amendments 83, 84 and 85. Amendment 83 says:

"The Secretary of State must make a statement to Parliament, as soon as practicable following the publication of report under subsection (2)."

It is difficult to disagree with that, to be honest. I do not see why that should not happen. I would be perfectly happy about it.

My hon. Friend the Member for Christchurch has also tabled some amendments. His amendment 88 would

"leave out 'mechanical or chemical' and insert 'or mechanical'."

I think that he wants to get rid of the chemical type of restraint from the Bill. A chemical restraint can be described as a medical restraint to restrict the freedom of movement of a patient. Such chemical restraints can sometimes also be used to sedate a patient if necessary. I think that his amendment is understandable. My only concern is whether it might lead to perverse outcomes whereby chemical means of force are used more often than they should be to get round the Bill. I am a bit nervous that that may happen. I would therefore deter him from pressing ahead with it, although I certainly understand where he is coming from.

Amendment 90 to clause 1 seems to be a consequential amendment, so we do not need to deal with that. Amendment 89 would leave out paragraph (b) from clause 1(6), to remove the isolation of a patient from the list of things referred to by "use of force". I am much more sympathetic to this amendment, because my hon. Friend makes a good point. I am sure he will express his own opinion when the time comes on why he feels so strongly about that, but my view on first reading is that it is perfectly sensible. Amendment 91 is consequential to that.

Amendment 98 is one to which my hon. Friend referred in an earlier intervention. It would insert the words "and their families" after "patients", to allow patients and their families to plan, develop and deliver their care and treatment in a mental health unit. This is an excellent amendment. It is essential that families are involved in the treatment of their family members. In many cases, if the family could have been more involved from the start and been able to help and warn what the situation was, such problems and terrible situations would not have happened. It is a very sensible amendment, and I hope that he will pursue it with vigour, because it is really important that we involve family members in treatment.

Amendment 100, which would ensure that guidance is published no later than six months after the Act is passed, is particularly pertinent to the discussions we have been having. My only quibble is that six months may be too long, but I certainly agree with the thrust of it, which is that there should be a time limit.

Sir Christopher Chope: It all depends on when the draft guidance is produced. My amendment is referring to the guidance that emerges after any consultation. As I said earlier, I think that the consultation should take place very early, but six months is a maximum.

Philip Davies: My hon. Friend is on to something with that, and I certainly agree. It is quite extraordinary that we do not have the draft guidance already, but I will not go over that again.

Amendment 101 is sensible. It would insert the word "significant" after "any", to require a record to be kept of any significant use of force on a patient by a member of staff. That is sensible because we do not want to include other things that should not be included. The point I make is that the word "significant" is rather subjective. One person's "significant" may not be another person's "significant", and it might be a bit difficult for trusts and staff to understand what counts as "significant". My only concern is whether that adds confusion.

Sir Christopher Chope: At the moment, clause 7(2) states that subsection (1) does not apply to cases where the use of force is "negligible". That is refined in subsection (3). I am effectively saying in my amendment that "significant" is non-negligible.

Philip Davies: I hope that my hon. Friend will expand on that later. He makes a good point, and I am broadly sympathetic to it.

I have now gone through the amendments on the amendment paper. Different Members have tabled quite a few amendments, and therefore it takes a bit of time. I would like to think that, like the hon. Member for

Croydon North, people have been convinced of the necessity of amendments 11 and 12, which go to the heart of what the Bill is supposed to be about.

Sir Christopher Chope: Some people looking at today's proceedings may say that my hon. Friend has been speaking for a long time, but we need to remember that when Bills are considered, the amendments are often grouped so that we do not consider all amendments in one discussion. Today, we are considering all the amendments to the Bill in one group, which I think explains why he has spoken for a bit longer than he might sometimes do.

Mr Deputy Speaker (Sir Lindsay Hoyle): Order. May I just say that we do not need to be reminded of how long the hon. Member for Shipley (Philip Davies) has spoken? All that does is use up precious time, and I know you would not want to do that, Sir Christopher.

12.30 pm

Philip Davies: My hon. Friend the Member for Christchurch will have noticed that at no point did anybody in the Chair say that I was off-subject, and there were over 100 amendments to consider.

I would like the Government to take responsibility for my amendments 11 and 12, which the hon. Member for Croydon North, the promoter, wants to include in the Bill. I hope that we get the opportunity to test the will of the House on those amendments, especially if he supports them, and we will see what Members make of them. If we do not include amendments 11 and 12 in the Bill, we are doing a really big disservice to the people we are trying to help and we are doing a disservice to the honour of Mr Lewis, which is what the hon. Gentleman's Bill is all about. Those two amendments go to the heart of what he is trying to achieve with his Bill, and I hope that Members will reflect on that before we vote on them.

Norman Lamb: In speaking today, including about the amendments I have tabled, I take a different view from that of the hon. Member for Shipley (Philip Davies), in that I want the Bill to proceed. It is not perfect—there are things that I think should be included, which is why I have tabled amendments—but it is more important to get on the statute book this very important staging post in changing the culture in many mental health trusts than to delay it further.

I congratulate the hon. Member for Croydon North (Mr Reed), who has done a brilliant job in advocating the case for this reform, as he has in his advocacy on behalf of Mr and Mrs Lewis. It is an enormous pleasure to support him today in that endeavour. I particularly note the role that Mr and Mrs Lewis, who are present in the Gallery today, have played in all of this. They have fought their campaign with enormous dignity and with absolute determination to secure justice for the loss of their dear son. They have had a willing Member of Parliament working with them, but if the Bill reaches the statute book, it will be to their enormous credit for the battle they have fought, and we should all applaud them for the contribution they have made in achieving that.

I met Mr and Mrs Lewis when I was the Minister responsible for mental health. I remember a debate in this place in which the hon. Gentleman raised their case. I was horrified by what I heard while sitting on the Front Bench, and I agreed to meet them. I met Mr and Mrs Lewis in my parliamentary office, and I took up their concerns with the Independent Police Complaints Commission, because the case did not appear to me to have been properly investigated. They have continued to fight stoically for justice, and I pay enormous tribute to them for doing so.

My interest in this issue as a Minister arose back in 2013, when Mind did a survey showing that the use of force—I use that term advisedly—was endemic across in-patient mental health settings around the country. Not only that, but the use of force varied incredibly from one unit to another, without any apparent justification. As a result of the Mind survey, I decided that we had to review the guidance. In due course, that led to the non-statutory guidance on "Positive and Proactive Care", which was issued in 2014.

The purpose of the guidance was to end the use of face-down restraint, which was the sort of restraint used on Seni Lewis. At the time, I was confronted by a lot of people in the sector who said, "You're not being realistic. You can't reduce force. You can't stop the use of face-down restraint, because we deal with very difficult circumstances." Yet when I listened to progressive practitioners who had worked in such units, they demonstrated that we could end the use of inappropriate forms of restraint. Tim Kendall, national clinical director for mental health, announced that his unit in Sheffield would end the use of face-down restraint, and it did. If those progressive practitioners can do that, others can as well. I was frustrated that guidance issued by the National Institute for Health and Care Excellence in 2015 in some ways contradicted the 2014 guidance by not ruling out the use of face-down restraint. I think that was a big mistake by NICE. I realise its independence, but I question its methodology in reaching that conclusion.

Why is this issue so important? It is because many people, not only Olaseni Lewis, have lost their lives as a result of the use of face-down restraint in mental health settings. Along with those awful losses of life, too many people who experience the use of restraint see and feel it as an assault on them. In many cases, people have experienced abuse earlier in their lives, including sexual abuse, sometimes as children. For a woman in a mental health setting, to be held to the floor by several men who are acting to restrain her is likely to make her experience an extraordinary sense of trauma. In many cases that results in a loss of trust between staff and patients. Units that have confronted the culture of a heavy use of force have found that when time is used for creative activity, that reduces the need for force to be used in the first place. Staff end up being safer, as well as patients in their unit, and the unit becomes a more therapeutic environment and everyone benefits.

The bottom line is that since the 2014 guidance there has been very little change—that is why the Bill is so important. The use of face-down restraint is down a little, but the overall use of restraint appears to be at pretty much the same level. That may in part be due to better recording, but the report in *The Observer* on Sunday suggested that injuries are up. In 2016-17, 3,652 patients and 2,600 staff were injured as a result of the use of force. In many cases, units have close to 100% occupancy and a heavy use of agency staff. They are under enormous strain and stress, which is not a therapeutic environment for patients, and the use of

[Norman Lamb]

force becomes almost inevitable because of the strain that everyone is under. That is why training is so important in changing the culture.

Let me deal briefly—briefly!—with my amendments. I tabled them because I wished these important issues to be included in the Bill, and it is a pity that they are not. I do not want to delay the passage of the Bill, so I will not seek to divide the House, but I hope that the Minister will give the strongest possible indication that she supports the issues I seek to raise—I think she probably does.

Clause 1 includes a definition of the "use of force", and it is important to extend that to cover threats of the use of force, and coercion, which means

"the use or threat of force, with the intention of causing fear, alarm or distress to control a patient's behaviour or elicit compliance with the application of the use of force".

Such coercion can be enormously traumatic for individuals who have experienced trauma in their lives, and it is important for that to be recognised in the Bill.

Amendment 37 to clause 3 states that the policy on the use of force

"must set out that the use of force will only be used without the sole intention of inflicting pain, suffering or humiliation, or subjecting patients to tortuous, inhumane or degrading treatment, or without inflicting punishment or intimidation."

That is in line with the Mental Health Act code of practice and the UN convention against torture. I am pleased that the Minister has indicated that she will deal with that in guidance, but I hope very much that it will be very clear in that guidance. If it had been on the face of the Bill, it would have helped to address the concerns of the special rapporteur on torture.

Amendment 36 would ensure that mental health units committed to reducing the overall use of force—surely that is ultimately the central purpose of the Bill—and it would increase transparency about how they intended to achieve that and what types of force were permissible in the unit. All that is absolutely central to more personalised care whereby people are informed about what might happen to them in in-patient units.

Amendment 38 to clause 4 would ensure that people's legal rights to advocacy were properly communicated to them in relation to the use of force. People often simply do not know what their rights are, and the amendment would assist by ensuring that they did.

Amendment 79 to clause 5 addresses the importance of training in the appropriate use of force. It makes it clear that the

"Secretary of State must publish quality standards for training".

That is important because training practices are variable around the country. My preference would be for accredited trainers, so that we know that they meet the right standard and are training staff in the right way. My proposal would at least ensure that there was a national standard that people should abide by.

Amendments 80 and 81 are intended to ensure that training requirements for staff include training in trauma-informed care. That comes back to the absolute importance, when we are caring for people, of recognising the impact that trauma has had on people's lives. It is great that clause 5(2)(g) covers training on experience of trauma, but it should be strengthened to cover not only the impact of trauma on patients' mental and physical health, but how the use of force itself can re-traumatise people—the very opposite of what should be happening when they are receiving mental health care and treatment. Trauma-informed care is a model of care that is

"grounded in and directed by a complete understanding of how trauma exposure affects"

a person's

"neurological, biological, psychological and social development".

In clause 7, on the recording of the use of force, amendment 39 would improve the transparency and accountability about the use of force by ensuring consistency in the recording of all uses of force, not just those above a threshold set in statutory guidance. The Bill as it stands states that records should not have to cover the "negligible" use of force. I understand entirely why that is in the Bill, but the concern is that guidance will be interpreted differently. That is why the way the guidance is framed will be of critical importance. There is a risk of low-level micro-aggressions—uses of force in a minor way but on a continuing basis below the radar—which can have an impact on people's wellbeing and their potential for recovery, which is out of step with the Mental Health Act code of practice.

Clause 9 is on the annual report by the Secretary of State. According to the related amendments, the annual report should

"make reference to the annual statistics"

published by NHS Digital, including relevant characteristics, so that we can monitor the ethnicity of people against whom force is used, and they state that the Secretary of State should report on that and that there should be a statement to Parliament.

I do not want to take up any more time. I will end by saying that I absolutely hope that the Bill gets on to the statute book as quickly as possible. I hope that the Minister will respond to it becoming law by going on a drive nationally to proselytise and make the case for a change of culture, so that we can see a radical reduction in the use of force across mental health settings. There are very many inspiring practitioners who have demonstrated how that is possible, but we need to make sure that it is the standard and not the exception. The Minister could go down in history for achieving a dramatic cultural change if she takes the Bill, when it is passed, and really goes out and makes the case for it.

12.45 pm

Jackie Doyle-Price: First, I thank and congratulate the hon. Member for Croydon North (Mr Reed) on his tireless work getting this important Bill to Report, and I hope it makes further progress. It is an important reform that will significantly enhance the rights of patients in mental health settings and will be a force for justice. We have had numerous references to its inspiration, and I pay tribute to the dignified and determined way in which Olaseni Lewis's family have pursued an important reform that will materially improve the treatment of patients.

The Government welcome the measures on monitoring and reducing the use of force in mental health settings. The Bill will provide clarity in several areas, including on recording and reporting, and is very much in the spirit that sunlight is the best disinfectant—that transparency is the most effective tool for ensuring

good treatment and performance. It will facilitate better and more consistent data collection, which in turn will give us better evidence by which to measure the success of the Bill and these reforms in minimising the use of force in mental health units. I take up enthusiastically the challenge from the right hon. Member for North Norfolk (Norman Lamb). We who believe strongly in these issues owe it to the public to campaign for the adoption of best practice and the minimisation of restraint. I will say more about his amendments later.

The Government have tabled amendments to clause 4 to remove an unintended consequence of amendments made in Committee, where we unwittingly inserted a loophole that might have enabled providers not to inform patients of their rights. We have made amendments to close that loophole, while still enabling an element of discretion in the system where advising patients might cause them further distress. I notice that my hon. Friends the Members for Shipley (Philip Davies) and for Christchurch (Sir Christopher Chope) tabled similar amendments. I hope they will support at least the action I have taken in response to those concerns.

The Government agree that it is important that patients have access to advocacy services, which are very much a part of the right to information on rights and something that the hon. Member for Croydon North and his stakeholders have repeatedly raised with me, but we do not want to put this provision in the Bill. That said, to reassure them about how we are treating the issue of advocacy, which we recognise is important, I remind the House that the independent review of the Mental Health Act 1983, which was set up to look at how its provisions were being used and how practice could be improved, will examine this issue. The interim report was published in May and the final recommendations will appear in the autumn. Following that, we will develop guidance through consultation. The report and recommendations will give us another opportunity to discuss this and ensure we are happy with the standards of advocacy in place. I hope the hon. Gentleman will understand why I cannot accept his representation.

I turn now to the hon. Gentleman's amendments on the independent investigation of deaths and legal aid. I am grateful for the opportunity to address these points, which go to the heart of what he is trying to achieve in the Bill. The appalling, dehumanising experience suffered by Seni's family during the investigation, which went on for an unacceptably long time, is really the test by which we should measure the effectiveness of the Bill.

Let me now explain why we would resist the amendment, describe the steps that we have taken to improve investigations of deaths in custody, and, hopefully, give the House some reassurance that the experience we are discussing today will not be repeated under the current regime. That is at the heart of the Bill: we want to ensure that what was experienced by Seni's family is never repeated.

Clause 10 in its current form requires that when a patient dies or suffers a serious injury in a mental health unit, the responsible person must have regard to the relevant guidance relating to investigations of deaths or serious injuries, published by a list of organisations that are responsible for regulation: for example, NHS Improvement and the Care Quality Commission. That means that in the current NHS Improvement guidance, the NHS serious incident framework, which was last revised in 2015, will be put on a statutory footing. The framework outlines the process for conducting investigations of deaths and other serious incidents in the NHS for the purpose of learning to prevent recurrence. It requires the treating clinician to report an unexpected death when natural causes are not suspected. All deaths of detained patients must be reported to the coroner, the CQC and the provider's commissioner as serious incidents. That will ensure that all deaths in custody are automatically reported.

If the death occurred in a mental health in-patient or hospital setting, NHS providers are responsible for ensuring that there is an appropriate investigation into the death of a patient detained under the Mental Health Act, or where the Mental Capacity Act 2005 applies. The death of a voluntary in-patient will also be investigated by the coroner, and under the NHS serious incident framework, if it was violent or unnatural. These are not inquiries into how a person died, as that is a matter for coroners, and they are not conducted to hold any individual or organisation to account. Other processes exist for that purpose, including criminal or civil proceedings, disciplinary procedures, employment law, and systems of service and professional regulation. That is an important point, because overlapping interests will need to be managed. I hope that I can give the hon. Gentleman some comfort, and reassure him that we are tackling the real problem that the Bill is intended to tackle.

Independent investigations within the framework are commissioned and undertaken independently of those directly responsible. I know that throughout our discussions on the Bill, the issue of independence was extremely important to everyone with an interest. It will be normal for the provider to conduct its own internal investigation, but that investigation will be reviewed by the relevant commissioner, and it will be for the relevant commissioner to commission an independent investigation. Commissioners must satisfy themselves that the investigation is clearly independent, and that there is no potential for conflicts of interests and no previous relationships. It will be their responsibility to establish that.

We expect commissioners to ensure that the family is properly informed throughout an investigation, and that all agencies involved in an investigation are held to account for their roles. We expect them to take the lead in commissioning an inquiry, and to take a number of steps including listing all the agencies that have had a stake in the care of those involved with the incident, and ensuring that they are aware of the process and their responsibilities in relation to the inquiry. It is up to them to identify all legal issues that may be relevant to the independent investigation or court proceedings and obtain appropriate legal advice. It is for them to co-ordinate meetings and discussions between the investigation team, the trust representatives, the police representatives and other agencies with an interest that have agreed to participate, so that all are agreed as to what their responsibilities are. They are responsible for early discussion with the local coroner. Crucially, they are responsible for informing the patients, carers and families about how the process will work and how they can be involved.

It is extremely important that as part of the investigation process the families' needs and wishes are properly respected and they feel some ownership and accountability and can hold the process to account if dissatisfied with how things are progressing—that is extremely important.

[Jackie Doyle-Price]

It will be for the commissioner as well to ensure they have access to the investigation team if they so wish. I also expect the commissioner to agree the timescale for the investigation together with timings and setting a date for the report. As much as I would like to be able to say that we will never have such a situation ever again, we can never say never, and if there were to be any delay the reasons must be clearly explained to the patients and families involved as part of keeping them fully informed and making sure they are fully supported.

The serious incident framework sets out clear guidance on who should be involved in the independent investigation team and that the healthcare commissioner is to identify a lead investigator who appoints the investigation team. The framework says the following, and I will quote directly again to underline the real independence of these investigations:

"In order to ensure independence and avoid any conflict of interest, no member of the independent investigation team can be in the employment of the provider or commissioner organisations under investigation, nor should they have had any clinical involvement with the individual(s) to whom the investigation relates.

Investigators must declare any connectivity that might, or might appear to, compromise the integrity of the investigation."

I hope that is explicit and gives the hon. Member for Croydon North some comfort about what we are doing to establish that independence.

I should also mention that we have just completed a consultation on the serious incident framework, and independence of investigations was a key theme, so we will be continuing to review this to make sure we can guarantee that independence. We will be bringing forward our response to the consultation by the end of the year, so we have another opportunity to ensure that we are satisfied that what we have is fit for purpose.

Another complication in the case of Seni Lewis was the interaction with the police investigation. That is where there is still the possibility of delay, and again we need to do everything we can to ensure that families are supported in that context.

Michelle Donelan (Chippenham) (Con): Does my hon. Friend agree that this Bill is vital and it is a testament to the work of Seni Lewis's family? Is she as concerned as I am about jeopardising this Bill, because it is so important, not least to my constituents, that we tackle this important area?

Jackie Doyle-Price: This is an important reform that will considerably alter the balance of the scales of justice in favour of patients and bereaved families. I want it to make rapid progress, and the specific case of how long it took for Seni's family to get a resolution in relation to his death is the inspiration for this Bill.

Sir Christopher Chope: Will my hon. Friend expand a little more on the timescale within which an independent forensic pathologist must reach a conclusion following a death? The husband of a constituent of mine died more than nine months ago, and the coroner ordered a pathology report but that still has not been carried out, causing enormous distress to everybody involved.

1 pm

Jackie Doyle-Price: I am grateful to my hon. Friend for making that point. As he says, the longer the answers take, the more distressing and dehumanising it is for the bereaved. I will come to the timescales later in my remarks, but one of the real achievements of the Bill is that it places clear expectations on the authorities in regard to investigations.

As I was saying, a police investigation could be carried out at the same time, depending on the type of incident involved. That was the case when Seni died. NHS guidance now clearly states that, whenever feasible, serious incident investigations must continue in parallel with police investigations. That is an important point, because what happened in Seni's case was that the police investigation basically put a brake on the NHS investigation. We are clear that these investigations should take place in parallel. That is possible because the terms of reference for the investigations are quite different, and where this eventuality arises, it should be considered in close consultation with the police so that they can be clear about the purpose of the healthcare-led investigation and how it will be managed.

If, following discussions or a formal request by the police, coroner or judge, an application is made to suspend the NHS investigation, it could be put on hold. However, the family must be very much involved in that decision, and the commissioner must ensure that they can agree a date for completion once the investigation can recommence. It is very much down to the commissioner to establish that timeframe. Whether an investigation is put on hold or not, it is absolutely central to our proposals that families should be kept engaged and informed of when the investigation will start up again, and when it will be completed. We also have national guidance on learning from deaths, which was published in March 2017. That now sets out clear expectations of NHS organisations for engaging with carers and families in these circumstances. Dialogue is absolutely central and underpins everything we are doing in this space.

I want to provide some details about what happens if a death follows police contact, when that contact may have caused or contributed to the death, as this is particularly relevant to the events that followed Seni's death. In such circumstances, the police are under a duty to refer the matter as soon as possible to the Independent Office for Police Conduct. Following an investigation, a report is sent to the police force. The report provides the IOPC's opinion about what should happen to those involved in the incident. For example, it might recommend further training, a misconduct meeting or a gross misconduct hearing. The police force will then provide its own view about what should happen. If the IOPC disagrees with the force, it has the power to recommend that it should take appropriate action, such as holding a misconduct meeting or hearing. Ultimately, the IOPC can direct the force to do that.

Under the scheduled reforms, this process will be further streamlined so that the IOPC will make the decision on whether there is a case to answer for misconduct or gross misconduct, and decide what form the disciplinary proceeding should take. The IOPC will provide a copy of the investigation report to the relevant police force, and to the complainants and the family of the person involved, as well as to the coroner and the Crown Prosecution Service, which will consider whether any further action should be undertaken.

I want to return to concerns about the quality of investigations, and to briefly explain the role of the Healthcare Safety Investigation Branch. The Lord Chancellor is looking at how we support people going through an investigation, and the hon. Member for Croydon North has also raised the issue of legal aid. It is important that we ensure that families have appropriate support as they navigate this process. This is not just about the process of walking through the contacts with the NHS investigating bodies, which can be quite formal; they could end up in a situation involving legal action or criminal proceedings, at which point they would need that support.

Much reference has been made this morning to the Dame Elish Angiolini review, in which she was clear that all deaths in custody should be treated on an equivalent basis, and I can confirm to the House that the Lord Chancellor's review into legal aid for deaths in custody will consider deaths in mental health settings on the same basis as deaths in prisons and other forms of custody. I can also advise the House that the ministerial board on deaths in custody constantly reviews what we are doing and how we are implementing the recommendations of the Angiolini review, so the review of legal aid for inquests will consider how it can be applied to deaths in mental health settings, too.

Kevin Foster: The Minister is making some interesting points about the legal aid review. Will she confirm what groups she is considering talking to? I am thinking of third-sector groups, community groups and, potentially, law centres.

Jackie Doyle-Price: I thank my hon. Friend for that intervention. I hope that we will continue to consider everything that we can do to support people, and I welcome those suggestions. Ultimately, such people are facing massive injustice at the hands of the state, and we should never stop looking at what we can do to support people in those circumstances. The simple truth is that those people have put their trust in the institutes of the state, so there is double pain when they are failed by them, and we must ensure that we do everything possible.

I hope that what I have said about legal aid and the investigation process satisfies the hon. Member for Croydon North, so I hope that he will not press his amendments to a Division so that we can get the Bill into the other place and deliver the objectives that he and I both want.

To clarify something that I was saying about the Government amendments, we unwittingly included a loophole that would allow institutions not to provide patients with information, and I might have suggested that that was a matter of discretion. However, it is actually in the Bill that they must provide information unless "the patient refuses" to accept it. I just wanted to make that clear in case there was any misunderstanding. The remaining Government amendments are largely technical, linking the Bill with the Data Protection Act 2018, for example, and providing clearer definitions regarding mental health units. Those are very much drafting changes, and I hope that the House will approve them.

Turning to the amendments tabled by my hon. Friends the Member for Christchurch and for Shipley and the right hon. Member for North Norfolk, I have already discussed the Government's view on such matters, but I will refer first to the right hon. Gentleman's amendments in relation to threats and coercion. The Government's main concern is that putting the use of threats of force and coercion on the face of the Bill might cause confusion for staff working in mental health units when we are trying to encourage them to use de-escalation techniques. We have the same objective as the right hon. Gentleman, which is to minimise restraint, but we are concerned that the amendments might act as an impediment to what we are trying to achieve.

Norman Lamb: Will the Minister look at whether the guidance will be clear about the importance of staff not inappropriately threatening force or coercion, because that all goes down to the culture of the organisation?

Jackie Doyle-Price: The right hon. Gentleman is right about that, so let me go through the provisions we think are in place to protect patients from exactly that circumstance. The care quality regulations—the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014—clearly set out the types of behaviours that are prohibited and create an offence of failing to comply with the requirement to protect service users from those behaviours. We are satisfied that those provisions would be an appropriate tool with which to tackle this issue. Clearly, we will be relying on guidance to implement much of this Bill, and I can give him every assurance that these issues will be very much part of that guidance; this process will be consultative and I am sure he will want to remind me of the undertaking I have just given him as and when that comes through.

My hon. Friend the Member for Shipley has discussed his amendments 44 to 78, providing us with his understanding of the use of the terms "force" and "restraint". The point he made was that he wanted the Bill to be consistent with language used elsewhere in mental health settings. It is important that we make sure the language we use is consistent. The term "force" is a more overarching description of what is happening to a patient, and the individual elements that the definition needs to cover are the types of restraint. In the context of this Bill, those are physical, mechanical and chemical restraint, along with isolation. We have chosen to use the term "force" because it works alongside the Mental Health Act 1983 code of practice, with which practitioners are familiar, and it reduces any risk of confusing the drafting due to the use of similar terms, where that can be avoided. This approach has very much been accepted in our consultation with the sector. I heard my hon. Friend say that he had received representations to suggest the opposite, so I would be pleased to take that up with him offline, in order to satisfy his local care trust that what we are doing is consistent with other law, because it is important that we take everyone with us.

My hon. Friend the Member for Christchurch has tabled amendments that would remove certain types of force from the Bill, particularly chemical restraint and isolation, which covers segregation and seclusion. I am grateful to him for testing our conscience via these amendments, because it is entirely legitimate for him to worry that practitioners might be impeded from administering medication to their patients, as, obviously, that would be harmful if those patients needed it. I can give him the assurance that when we talk about "chemical restraint", we are not considering a patient's normal medication. The type of medication used for chemical

[Jackie Doyle-Price]

restraint would usually be different from that used as part of a patient's normal medication to control or treat their mental health condition. As part of a chemical restraint, patients would not simply be given more of their medication. The types of medication used in chemical restraint are a particular kind of product, lasting for only a short period and not having the effect of over-medicating a patient. It is important that we record and receive national data on the use of those products so that we understand their use and shine a light on areas where they might not be used appropriately. I hope that gives him some comfort.

Sir Christopher Chope: Will the Minister make a statement on which products would be covered by the Bill and which would not? From talking to my constituent, I had the impression that the products used in his case would be covered.

Jackie Doyle-Price: I will commit to writing to my hon. Friend with details of the products licensed by the National Institute for Health and Care Excellence for the purpose of restraint, if that would be helpful.

1.15 pm

Let me come back to the amendments tabled by the right hon. Member for North Norfolk on use-of-force policies. We totally agree with him that force should never be used to inflict pain on, degrade or humiliate patients. We are talking about places where people should always feel safe, and that is very much the intent behind the measures that we want to put into the Bill. The Bill does not say anything about when force can and cannot be used, and it does not prohibit the use of force in any particular circumstances. That is covered by criminal law. It is worth noting that the Health and Social Care Act 2012 created the offence of failing to protect service users from certain types of behaviour, including abuse, degrading treatment and acts that are not proportionate. We therefore do not accept that it is necessary for the Bill to address that issue; it should be part of criminal law. We will, though, look into all these matters when it comes to the guidance.

My hon. Friend the Member for Christchurch has tabled amendments that would make the legislation cover independent hospitals that treat wholly private patients. I understand the intent behind that, but he will be aware that we have been taking the Bill forward very much in the spirit of consensus, and to avoid a big consultation with the sector, we have framed the legislation around services that the NHS commissions. To give my hon. Friend some assurance, the NHS will clearly place patients only where there are the best possible services. We think that that will guarantee that the legislation will apply in all cases. That is very much consistent with how we would apply the law.

Sir Christopher Chope: Would the Bill cover situations in which the NHS is paying for private services in mental health units?

Jackie Doyle-Price: It would; indeed, to be more explicit, any service with which the NHS commissions mental health services would be expected to have procedures that comply with the Bill. That will cover non-NHS patients in those institutions as well.

My hon. Friend the Member for Shipley asked some testing questions about training. I really want to say that from my perspective the detail of what will be covered in training will be taken forward through statutory guidance that will be subject to consultation. He has made it clear that he believes that the training of police forces and training on acute episodes need to be factored into that. That is something that we will take forward as part of that consultation. In all honesty, I do not believe that his amendments will be necessary; in any case, we will take that forward as part of the consultation.

On police roles and responsibilities, my hon. Friend will know now that, as I have mentioned, we have a memorandum of understanding that governs how the police and health services interact in these circumstances. That is owned and taken forward by the College of Policing, and I am sure that he will agree that they are the right people to own that. If a provision affects the police in that way, I cannot make any decision without further consultation with colleagues across the Government.

I hope that I can assure my hon. Friend that I fully take on board his points; indeed, the hon. Member for Croydon North supports the inclusion of those issues in training. We will take forward that proposal as part of the consultation process that will develop the guidance. I hope that that is enough to persuade my hon. Friend to withdraw his amendments.

On enforcement, there have been representations such that the guidance should be published within six months of the Bill being passed. Again, I do not want to prejudge Parliament's decision. We will take forward the consultation as and when the Bill is passed. These are significant issues and a 12-month process would be more appropriate in the context. It is better to get it right than to be guided by speed, however impatient we are to achieve the desired outcomes.

Sir Christopher Chope: My hon. Friend is being very generous. Will she tell us the current state of the guidance? Can it be published for consultation immediately this Bill attains Royal Assent?

Jackie Doyle-Price: We will undertake it speedily and it will be made public, but, as my hon. Friend will appreciate, the whole purpose of consultation is that it consults and we want to ensure that we are taking everybody with us. Personally, I will want to do it in an extremely timely fashion.

There are many amendments to go through, but I hope that I have articulated the Government's overall support for this measure and what we are trying to achieve in terms of supporting the hon. Gentleman's Bill. Central to all this is the need to underline transparency and to strengthen accountability so that patients are protected. Clearly, we desire to minimise the use of force. The best way that we can achieve that is by shining a light on those incidents. We will continue to take this forward in the spirit of openness, and the Secretary of State will be producing reports on how this is being implemented.

Let me turn now to my final point. I have already addressed this in response to the remarks of my hon. Friend the Member for Shipley. On police body cameras, I can give him this assurance: the proposal does not create a criminal offence for not wearing a body camera. We have been very deliberate in our language to say that

it is practicable to make sure that we do not get in the way of the police doing what is right in these situations. The references he makes to the law are consistent with the Police and Criminal Evidence Act 1984, but this would not raise any issue of a police officer being faced with criminal prosecution for not wearing a camera. I hope that that gives him some satisfaction.

Norman Lamb: This is my very final point. Even if this is not in the Bill, does the Minister agree that it would be a good thing if the Secretary of State reported to Parliament annually on the basis of the data that was produced by NHS Digital?

Jackie Doyle-Price: That issue did come up in Committee. Although I appreciate the spirit with which the right hon. Gentleman makes that inquiry, we would not want to make a particular arrangement for one set of NHS data over another. Clearly, we need to explore this issue to make sure that there is some annual return on how this Bill operates when it becomes an Act.

I could say so much more, Mr Deputy Speaker, but I will not. Everybody in this House is very clear that they want this Bill to make progress. I appreciate that I cannot keep all Members happy all the time, but I do hope that I have been able to assure my hon. Friends the Members for Shipley and for Christchurch on how we will take forward their representations and that I can persuade them not to push their amendments to a vote.

Justin Madders (Ellesmere Port and Neston) (Lab): May I start by congratulating my hon. Friend the Member for Croydon North (Mr Reed) on progressing this extremely important Bill to this stage? I had the pleasure of speaking to it on Second Reading back in November. I am sure that the past seven months have felt pretty long to him, particularly as there were delays outside his control with the money resolution, and I am sure that that feeling was present again at times this morning. I hope that his diligence and persistence will pay off. We all know how much it will mean to see this Bill finally enshrined in statute. Nothing can demonstrate better the positive impact that a constituency MP can have in such circumstances, where there are clearly shortcomings in the current law, which we hope to put right.

I congratulate all hon. Members who have contributed so positively to the progress of the Bill, and the Minister on her constructive approach. I also echo the tributes paid to the Lewis family for the dignified and helpful way in which they have assisted in shaping this legislation. It has been evident from contributions that hon. Members have made during the passage of the Bill just how united we all are in our determination to do something to ensure that the tragic case of Seni is not repeated.

It is shocking to hear that, according to the Independent Advisory Panel on Deaths in Custody, 46 mental health patients died following restraint between 2000 and 2014. Victims of restraint in these circumstances have said that face-down restraint by groups of men adds to the trauma that in many cases led to their mental illness in the first place. As well as bias towards women, there is evidence to suggest that members of the BAME community are disproportionately more likely to experience restraint, so we strongly support the Bill, which we hope will reduce the use of force and address the unconscious bias currently reported in the system, by increasing transparency, evidence, accountability and justice.

In terms of transparency, data is not currently collected consistently, so it can be hard to collate accurate data on how often restraint is used and on how restraint is used disproportionately against certain demographics. We hope that the Bill will create a level of uniformity that is currently missing. Recording how and why restraint is used, who it is used on and what steps were taken to avoid its use will inject much needed transparency and consistently into the system. We will then be in a much stronger position to tackle the issues of unconscious bias or overuse of restraint to which hon. Members have referred throughout the passage of the Bill.

We need to ensure that if tragedies of this nature occur again, they are independently investigated and that justice is not only done, but seen to be done. As my hon. Friend the Member for Croydon North has set out, new clause 1 would make it compulsory for an independent investigation to be carried out whenever a death occurs in a mental health unit. He set out the thinking behind the new clause very well. The Minister set out why it is not something that she can take on board, but she did give a clear view of some of the safeguards that will be needed regarding independence, particularly when it comes to potential conflicts of interest or, as she said, appearances of conflicts of interest. She was clear and strong about the need for the ownership and involvement of the families in any investigation. That is of paramount importance. I look forward to hearing whether my hon. Friend considers that a satisfactory response.

In conclusion, the Bill is a step towards a model of care, rather than one of containment. Of course, it does not have everything that we would want, but it is an important step in the right direction that will support patients, their families and emergency service workers. I commend my hon. Friend the Member for Croydon North on his hard work in reaching this stage and look forward to Seni's Bill becoming Seni's law.

Richard Benyon (Newbury) (Con): On a point of order, Mr Deputy Speaker. I seek your advice, because I have heard conflicting views. It is quite clear that we are not going to get to my Armed Forces (Statute of Limitations) Bill today. Would I be right that, if I were to not move it today and were to go to the Public Bill Office to seek another date, we would then have a better chance of having a debate? Many Members on both sides of the House want to debate the Bill, and there are 250 veterans in Parliament Square who particularly want the matter aired on the Floor of the House. I seek your advice on the best way to make that happen.

Mr Deputy Speaker (Sir Lindsay Hoyle): If it goes wrong, it is obviously going to come back on me. In the end the right hon. Gentleman must make the decision, but overall I would say yes; my view is that the actions he mentioned would lead to more time for a better debate.

If there are no further points of order, I call Sir Christopher Chope to speak—briefly, I presume, because I know that he wants to get on with the amendments.

Sir Christopher Chope: There is only a bare hour left, Mr Deputy Speaker.

Mr Deputy Speaker: Twenty-five minutes will do you, then. Come on, Sir Christopher!

1.30 pm

Sir Christopher Chope: It is a pleasure to follow the Opposition spokesman. He was right to pay tribute to the work of the hon. Member for Croydon North (Mr Reed), because this is a really good example of how somebody who is successful in the private Members' ballot can bring forward a Bill that is to the benefit of their constituents and arises from a constituency case. The right hon. Member for North Norfolk (Norman Lamb) put the issue in context by saying that in the last year for which figures are available, more than 3,500 patients and more than 2,500 staff were injured in mental health units. It is therefore an issue of quite considerable significance.

I intervened on the Minister when she was dealing with new clause 1, and I want to say a little more about timescales for the independent investigation of deaths. As I said, I have a constituency case in which the coroner ordered an investigation that went out to an independent forensic person, who then became ill and has not been able to complete her work. It has not been possible, for all sorts of reasons that I cannot really fathom, to get anybody else to take over the responsibility for that work, with the result that my constituents—and, indeed, other families in Dorset—are waiting for results of post-mortems in respect of loved ones' deaths many, many months ago. That is intolerable.

I therefore tabled some questions to the Ministry of Justice. In fact, they were among the last questions answered there by my hon. Friend the Member for Bracknell (Dr Lee). He said that there was a provision in the Coroners (Investigations) Regulations 2013 that reports must be made as soon as practicable after the examination, but there is no absolute time limit. He also said that he would raise the question of timeliness with the Department of Health and Social Care and write to me. I hope that that question of timeliness will be on the Minister's desk soon and that she will then also be able to write to me to explain what could be done to ensure that there is a finite period for these very sensitive post-mortems, and the investigations that flow from them, to be carried out. It would be very useful if we can achieve some progress on that.

The hon. Member for Croydon North says at paragraph (5) of his new clause:

> "A person appointed under this section must provide a report within three months of that appointment."

That is a clear time limit. If the Minister thinks that that is reasonable, then there is no reason why it should not be applied more widely. That could certainly address the problem that I have identified.

I now turn to my amendments. I am grateful to my hon. Friend the Minister for responding, in anticipation, to some of them. Amendment 86 is designed to extend the operation of the Bill to all mental health units in England and Wales, not just to those that in national health service hospitals or those where treatment is provided, or is intended to be provided, for the purposes of the NHS. I still do not understand this: my hon. Friend seems to be saying that she would like to extend these provisions to the independent sector—to all mental health units—but is inhibited in being able to do so because of the constraints of the need to consult on the legislation. Is that correct?

Jackie Doyle-Price: My hon. Friend, as a good small state Conservative, will appreciate my desire not to put burden on business. When we bring forward regulations that will introduce additional burdens, we go through a consultation process to take business with us. I am satisfied that the Bill will affect all patients, because the NHS commissions services from independent mental health care providers, and any institution where the NHS is commissioning services will be captured under the Bill. It will benefit private patients in private settings where those institutions provide services to the NHS.

Sir Christopher Chope: Will it apply to private patients in private institutions as well?

Jackie Doyle-Price: Where that institution provides services to the NHS, it will, because we will only commission services in places that are compliant with the Bill.

Sir Christopher Chope: Okay. That is very helpful. As my hon. Friend says, I am keen to avoid unnecessary burdens and regulation, so it is good to have clarification on that and to know that imposing fresh regulations purely on the private sector would trigger several regulations having to be repealed. Perhaps her Department's list of regulations to repeal is running a bit short. I am grateful for her response.

Amendment 87 is consequential to amendment 86. I am grateful to the Minister for dealing with my amendment 88, which relates to chemical restraint, and for her offer to write to me with a list of the chemicals that satisfy the definition of "chemical restraint". The Bill defines chemical restraint as

> "the use of medication which is intended to prevent, restrict or subdue movement of any part of the patient's body".

However, that does not provide as much clarity as I would wish. My concern is that medication should not be given because it will result in less violence from a patient—for example, if a patient normally takes their medication but becomes more violent if they do not. That seems to be a regular pattern, and I would not want there to be any perverse incentive or disincentive to give people their medication.

Amendment 89 deals with isolation, which the Bill defines as

> "any seclusion or segregation that is imposed on a patient".

I still cannot get my head around why the isolation of a patient is deemed a use of force. Quite often, isolation can prevent a patient from causing physical harm to other patients or indeed staff. Can the Minister expand on that?

Jackie Doyle-Price: My hon. Friend is right, it can, but that should be a clinical judgment. We are trying to tackle the use of seclusion as a method of control where it can do harm, because there are clearly cases where it can, but that will be very much a clinical judgment.

Sir Christopher Chope: I am grateful to my hon. Friend for that clarification.

I tabled amendments 92 to 95 because I was concerned about the term "relevant" health organisations and felt that we should be referring to all health organisations, but the Minister dealt with that point in response to an earlier amendment, so I will not press it. As my

hon. Friend said, some of the issues relating to the unintended consequences of the amendments made in Committee have also been addressed.

I turn now to clause 5, and particularly my amendment 98. Clause 5 has turned out to be the weakest part of the Bill. My hon. Friend the Member for Shipley (Philip Davies) made a stunning and really illuminating speech in support of his amendments 11 and 12, which I most heartily endorse. I do not see how anybody who listened to him could do anything other than reach the same conclusion, which I am glad to say is the conclusion reached by the promoter of the Bill. A lot of my hon. Friends were sitting in the Chamber and listening to my hon. Friend the Member for Shipley, and I think they were also in strong agreement with the sentiments he expressed.

The Minister's response has very much been to say that such amendments are not needed. I do not know whether she will respond in the same way to my amendment 98, but that amendment makes it clear that the training provided under subsection (1) must include how to involve not just patients but their families in the planning, development and delivery of care and treatment in mental health units. The involvement and engagement of families is of absolutely fundamental importance. If the Government have chosen to set out a whole list of what they consider to be very important ingredients in any training course, I cannot understand why they have omitted any reference to the involvement of families in the planning, development and delivery of care and treatment.

In one of the constituency cases I mentioned earlier, the parents have had an incredibly distressing time not just because of their personal circumstances, but because of their son's circumstances. They have experienced great frustration in trying to get proper contact with the people in the mental health unit where their son is a patient. It seems to me that families, who often care for 20 years or more for mentally ill children, are in a really strong position to know and understand their children's needs. It is also very important that they should be informed about what is happening. For example, in this case, the young person concerned is sometimes suddenly discharged from the mental health unit at the weekend, and he then goes and makes a nuisance of himself and the police have to bring him back to his parents' house many miles away. On one recent occasion, he proceeded to trash the whole place. We cannot allow such situations to arise, and it seems to me that there is a really important role for involving and engaging with the families. I hope that my hon. Friend will confirm that the Government really take seriously the involvement of the families.

Jackie Doyle-Price: The Government most certainly do. I mentioned earlier that we are currently undertaking a review of the Mental Health Acts. The involvement of families is a key part of what is coming out of that, and there will be recommendations on that when the report is completed in the autumn. There are also issues regarding mental capacity, so the review of the deprivation of liberty law raises issues about the role of families, and we need to provide greater clarity. However, this is very much part of what we need to get right. My hon. Friend is absolutely right to say that families not only have an interest in, but can do much to support their loved ones. There are also occasions when that can cause harm and families ought not to be involved, but, again, that is part of the clinical judgment. I come back to the fact that all of this will be addressed in the guidance, which we will take forward in consultation with the sector.

Sir Christopher Chope: I am grateful to the Minister, and to you for your indulgence, Mr Deputy Speaker. It shows your flexibility that you allowed one long response, rather than having more interventions flowing on from that. *[Interruption.]* Well, it was very welcome for its content, and I am grateful to the Minister for putting that on the record.

My final point concerns clause 5(2)(k) and what we mean by

"principal legal or ethical issues".

It seems to me that "principal" is redundant. Why do we need to talk about "principal" legal issues unless we specify more clearly what we mean by that? Do we mean that some laws or legal issues are more important than others? What does it mean? We have not yet had an answer on that—I do not know whether the Minister has one readily to hand.

1.45 pm

We then get on to guidance and the timescale within which it should be published. The Minister said that she expects guidance to be in place within 12 months, and that she would take personal responsibility for delivering that. That is a helpful undertaking, but I hope that the Government will be able to produce draft guidance before the Bill is considered in the other place. There are a lot of precedents for the Government bringing forward draft guidance while legislation is still under consideration, and it is a pity that we do not have it at this stage. If my hon. Friend wants to put pressure on her officials, as I know she does, I urge her to demand that they produce draft guidance before the Bill reaches the other place. That draft guidance will then have the benefit of being commented on in the other place by groups of people who are not lacking in expertise in this area. That will make for a better public consultation, which will formally follow once the Bill is enacted. I hope my hon. Friend will push that forward as hard as she can, and use the encouragement that we are giving her today to put pressure on her officials and show that she is in charge of the whole process.

I have already said that clause 7 does not make sufficient reference to family and relatives, and other amendments to the Bill are of less significance than those tabled by my hon. Friend the Member for Shipley. I hope that when responding to the debate, the hon. Member for Croydon North will reinforce the view that amendments 11 and 12 go to the heart of this matter. The issues that were dealt with in extenso by my hon. Friend were highly informative and persuasive. It may be that there is just a technical problem as far as the Government are concerned, but that they buy into the idea. Indeed, I am sure there is every possibility that they might buy into it a bit more if, when he responds to the debate, the hon. Member for Croydon North makes clear that he strongly supports amendments 11 and 12, as do I.

Mr Reed: I am grateful to right hon. and hon. Members across the Chamber for the constructive way in which they have engaged with this debate, and for the kind

[Mr Reed]

comments thrown my way. It is important to say, however, that this Bill is the work of many people who have contributed to its development and to getting it to its current stage. I hope that this debate is a further contribution to strengthening the Bill and the shape that we have it in now. That includes the many campaign groups and advocacy groups outside the Chamber that have been working with me and with the Government, as well as the Government's officials, who have been extremely helpful all the way through.

The driving force behind this Bill is something that the coroner said when we held the inquest into the death of Seni Lewis. Seni died in 2010 but we only got the coroner's verdict in June 2017, while the general election was under way. She said that if things did not change to address the failings that led to Seni's death, there would be more deaths of that kind. Seni was one of many people who died unnecessarily because of failings in the system and many, many others have been injured because of those failings. Report after report coming out of inquiry after inquiry, and inquest after inquest, pointed to what the problems were, but they were not being picked up by the system, nor lessons learned to keep people safe in future. The coroner said clearly that change must come. That change is this Bill, and I am grateful to everybody who has brought us to this point today.

I have a couple of specific thank yous. I pay particular tribute to the Minister, who has been robust and clear in her support for the Bill right from the start. She has been absolutely clear about the commitments that she could make as a Minister and has delivered on those, so I am immensely grateful to her. In my opinion, we are very lucky to have her as the Minister.

Above all, I pay tribute to the family—to Seni's parents, Aji and Conrad Lewis, who are with us today, because the real reason we are here is the profound depth of love that they have for their son, who was lost in such tragic circumstances. That love has driven them to campaign for justice, not just for their son, but for everybody using mental health services. Their profound wish is that Seni did not die in vain, so this Bill is dedicated to them and to Seni. It his legacy and his testament, and because of this Bill no one else will need to suffer in the way that Seni did.

On the basis of the Minister's assurances at the Dispatch Box, I am happy to withdraw my new clause 1 and not to press new clause 2, and I look forward to the further progress of the Bill. I beg to ask leave to withdraw the motion.

Clause, by leave, withdrawn.

Clause 4

INFORMATION ABOUT USE OF FORCE

Amendments made: 1, page 3, line 16, at end insert—

"unless the patient (where paragraph (a) applies) or the other person (where paragraph (b) applies) refuses the information."

This allows for cases where a person refuses the information provided, and supersedes subsections (9)(a) and (10)(a).

Amendment 2, page 3, line 22, leave out subsection (5) and insert—

"(5) The responsible person must take whatever steps are reasonably practicable to ensure that the patient is aware of the information and understands it."

This expands the duty to provide information accessibly so that it requires the responsible person to take whatever steps are reasonably practicable to ensure the patient understands.

Amendment 3, page 3, line 33, leave out subsections (9) and (10).—*(Jackie Doyle-Price.)*

Subsections (9)(a) and (10)(a) are superseded by Amendment 1. Subsections (9)(b) and (10)(b) are unnecessary as the information will not be of a nature that would cause distress.

Clause 5

TRAINING IN APPROPRIATE USE OF FORCE

Amendment proposed: 11, page 4, line 18, at end insert—

"(l) the roles, responsibilities and procedure in the event of police involvement,".—*(Philip Davies.)*

Question put, That the amendment be made.

The House divided: Ayes 8, Noes 47.

Division No. 186] **[1.52 pm**

AYES

Campbell, rh Mr Alan
Hollobone, Mr Philip
Madders, Justin
Martin, Sandy
Onasanya, Fiona
Reed, Mr Steve
Slaughter, Andy
Sobel, Alex

Tellers for the Ayes:
Philip Davies and
Sir Christopher Chope

NOES

Adams, Nigel
Argar, Edward
Atkins, Victoria
Benyon, rh Richard
Bradley, rh Karen
Brown, rh Mr Nicholas
Campbell, rh Mr Alan
Cartlidge, James
Churchill, Jo
Courts, Robert
Doyle-Price, Jackie
Ellis, Michael
Evans, Mr Nigel
Foster, Kevin
Frazer, Lucy
Hands, rh Greg
Harris, Rebecca
Heaton-Harris, Chris
Hobhouse, Wera
Hollingbery, George
Lamb, rh Norman
Lopresti, Jack
Madders, Justin
Mann, Scott
Martin, Sandy
Milling, Amanda
Moore, Damien
Morton, Wendy
O'Brien, Neil
Onasanya, Fiona
Pincher, Christopher
Pound, Stephen
Pursglove, Tom
Quin, Jeremy
Quince, Will
Reed, Mr Steve
Robinson, Mary
Ruane, Chris
Slaughter, Andy
Smith, Chloe
Sobel, Alex
Throup, Maggie
Tomlinson, Michael
Tracey, Craig
Trevelyan, Mrs Anne-Marie
Warman, Matt
Wright, rh Jeremy

Tellers for the Noes:
Julian Knight and
Michelle Donelan

Question accordingly negatived.

Amendment proposed: 12, page 4, line 18, at end insert—

"(m) awareness of acute behavioural disturbance."—*(Philip Davies.)*

Question put, That the amendment be made.

The House proceeded to a Division.

Mr Deputy Speaker (Sir Lindsay Hoyle): I ask the Serjeant at Arms to investigate the delay in the Aye Lobby.

The House having divided: Ayes 3, Noes 49.

Division No. 187] **[2.4 pm**

AYES

Campbell, rh Mr Alan
Hollobone, Mr Philip
Reed, Mr Steve

Tellers for the Ayes:
Philip Davies and
Sir Christopher Chope

NOES

Adams, Nigel
Argar, Edward
Atkins, Victoria
Benyon, rh Richard
Bradley, rh Karen
Brown, rh Mr Nicholas
Campbell, rh Mr Alan
Cartlidge, James
Churchill, Jo
Courts, Robert
Doyle-Price, Jackie
Ellis, Michael
Evans, Mr Nigel
Foster, Kevin
Frazer, Lucy
Hands, rh Greg
Harris, Rebecca
Heaton-Harris, Chris
Hobhouse, Wera
Hollingbery, George
Lamb, rh Norman
Lopresti, Jack
Madders, Justin
Mann, Scott
Martin, Sandy
Milling, Amanda
Moore, Damien
Morris, David
Morton, Wendy
O'Brien, Neil
O'Mara, Jared
Onasanya, Fiona
Pincher, Christopher
Pound, Stephen
Pursglove, Tom
Quin, Jeremy
Quince, Will
Reed, Mr Steve
Robinson, Mary
Ruane, Chris
Slaughter, Andy
Smith, Chloe
Sobel, Alex
Throup, Maggie
Tomlinson, Michael
Tracey, Craig
Trevelyan, Mrs Anne-Marie
Warman, Matt
Wright, rh Jeremy

Tellers for the Noes:
Michelle Donelan and
Julian Knight

Question accordingly negatived.

Amendment made: 4, page 4, line 30, leave out "meets the standards of" and insert

"is of an equivalent standard to".—*(Jackie Doyle-Price.)*

This is a small drafting change that clarifies that training does not need to be provided under Clause 5 if training that was recently provided was of an equivalent standard to the training provided under that Clause.

Ordered,

That Clause 6 be transferred to the end of line 34 on page 7. —*(Jackie Doyle-Price.)*

Clause 7

RECORDING OF USE OF FORCE

Amendments made: 5, page 6, line 5, leave out

"made by or under the Data Protection Act 1998"

and insert

"of the data protection legislation".

Amendments 5 and 6 are consequential on the Data Protection Act 2018.

Amendment 6, page 6, line 6, at end insert—

'( ) In subsection (8) "the data protection legislation" has the same meaning as in the Data Protection Act 2018 (see section 3 of that Act)."—*(Jackie Doyle-Price.)*

Amendments 5 and 6 are consequential on the Data Protection Act 2018.

Clause 13

INTERPRETATION

Amendment made: 7, page 8, line 32, leave out

"has the meaning given by section 2"

and insert

"means a person appointed under section 2(1)".—*(Jackie Doyle-Price.)*

This improves the drafting of the definition of "responsible person.

Ordered,

That Clause 15 be transferred to the end of line 15 on page 9. —*(Jackie Doyle-Price.)*

Title

Amendment made: 8, line 2, leave out "and similar institutions".—*(Jackie Doyle-Price.)*

This removes from the long title a reference to "similar institutions" as these are not covered by the Bill.

Third Reading

2.21 pm

Mr Reed: I beg to move, That the Bill be now read the Third time.

Given that we have only nine minutes, I shall be extremely brief. I am grateful to Members from all parties for their support for the Bill's intentions and ambitions. Having spoken to many advocacy and professional groups outside the House, I know that the Bill in its current state will, if passed, give the United Kingdom some of the best legislation in the world to protect mental health patients from abusive or excessive restraint. That is exactly as it should be.

The Bill will make a difference in four broad areas. First, on accountability, by requiring the appointment of a named senior manager in each mental health unit to be accountable for the existence and implementation of a policy governing the use of restraint and its reduction, the Bill will ensure clear and direct accountability for how restraint is used.

By standardising the reporting of incidents of restraint throughout the country so that they are recorded in exactly the same way against the same demographics, we will be able to see for the first time where the best practice really is, so that it can be spread. That will also allow us to scrutinise the data so that if particular groups—for example, women, BME people, young men and people with disabilities—are subject to more frequent or more severe forms of restraint than other groups, that can be corrected.

According to academic research, the requirement on the police, when operationally practicable, to wear body cameras in and of itself reduces the likelihood of restraint being used by the police by 50%. That alone makes it worth doing, but it also protects the police against vexatious complaints and provides evidence when things do go wrong so that lessons can be properly learned to prevent any repetition.

I am grateful for the Minister's comments on Report about the investigation of deaths. It is important that those investigations happen immediately following a death or serious incident, and it is critical that they are sufficiently independent to allow people to learn what has gone wrong to prevent any repetition and deliver justice to the family of any victim. It is important, too, that there is consistency among all forms of state custody and that mental health custody is not treated

[Mr Reed]

disadvantageously compared with police or prison custody, so I welcome the Minister's commitment to achieve that through the deaths in custody panel that she co-chairs.

I said that I would be brief, and I will to stick to my word. The Bill is an important step away from the containment of people who are mentally ill towards treating them with the care and compassion that their circumstances deserve. It will give this country mental health services that are fair and equal for everybody.

2.24 pm

Jackie Doyle-Price: I cannot pay tribute enough to the hon. Member for Croydon North (Mr Reed) for his incredible leadership in getting us to this point. He has made it extremely easy for me to work with him and to engage with the sector. I cannot overstate the signal that this reform will send both in terms of how we treat mental health and how we treat patients and enhance their rights; it will be extremely significant indeed. When, as I hope, the Bill gets on to the statute book, he can really be proud of a very significant achievement. I am very pleased that he was able to use his place in the ballot to bring forward such a progressive and important measure.

I could not disagree with a word the hon. Gentleman said as he introduced the Bill's Third Reading. He was absolutely right. For too long, restrictive interventions have been accepted as the norm in health and in mental healthcare settings, as the right hon. Member for North Norfolk (Norman Lamb) said.

It has been great to have the right hon. Gentleman's input into today's proceedings. He is the one who blazed the trail that I am trying to follow, which is quite a tough act it has to be said, but we are all extremely grateful for the real efforts that he made while he was a Minister, and I hope to build on the change that he started to embed.

We must expect that restrictive interventions and the use of force must never be used for the purpose of punishment, or to degrade or to humiliate patients. Mental health settings are places where people should feel safe, and it is clear that the existing guidance is not having the impact that the Government expected, and that we must do more. This Bill will be a very important tool to achieve that.

I come back to why we are here today: the death of Seni Lewis. The measure of the Bill's success will be in the strength of the independence of the investigations and in the support that bereaved families get should, unfortunately, any other family find themselves in this situation. That is the yardstick against which the Bill should be measured. We should be very sensitive to ensure that we all continue to do our best so that, when people are let down by organisations of the state, we in this House are at the front of the queue to see that they get justice—and justice promptly, because justice delayed is justice denied.

2.27 pm

Sir Christopher Chope: I, too, pay tribute to the hon. Member for Croydon North (Mr Reed) for bringing forward this Bill. He has done a masterly job. I was also impressed by much of what the Minister said in response to concerns that have been expressed. None the less, there are still some unanswered questions, particularly around the implementation of the Bill.

The Minister has said that she will bring forward guidance as a substitute for some of the provisions that we think should have been included in the Bill. She said that we did not need other aspects that we thought should be included in the Bill because they were already in law. I hope that we will be able to keep up the pressure on the Minister to come forward with more precise answers regarding when she will publish the draft guidance.

On Report, I asked the Minister what state the draft guidance was in at the moment and if it was in a form in which it could be produced. I did not get an answer to that question. I also did not get an answer to the question of whether draft guidance would be published before the Bill goes to the other place. There is a lot to be said for the Government publishing the draft guidance tomorrow, say, or next week. One merit of doing that would be that if the Bill's Third Reading debate does not conclude today, we would have the chance to look at that draft guidance before commenting on it during the remainder of the debate.

As the hon. Member for Croydon North said, the Bill is important because it introduces means by which we can measure lots of things that are happening in our mental health units about which we are not aware at the moment. As we know, what we cannot measure, we cannot control.

I remain concerned that some of the information that will be produced as a result of the Bill could lead to unintended consequences, as my hon. Friend the Member for Shipley (Philip Davies) also mentioned. We heard a reference to the fact that women in mental health units suffer more force against them than men, but that might be because only the most serious cases of women in mental units are brought before the—

2.30 pm

The debate stood adjourned (Standing Order No. 11(2)).

Ordered, That the debate be resumed on Friday 6 July.

Business without Debate

FREEDOM OF INFORMATION (EXTENSION) BILL

Motion made, That the Bill be now read a Second time.

Hon. Members: Object.

Bill to be read a Second time on Friday 6 July.

ARMED FORCES (STATUTE OF LIMITATIONS) BILL

Motion made, That the Bill be now read a Second time.

Hon. Members: Object.

Bill to be read a Second time on Friday 23 November.

POSTAL VOTING BILL

Motion made, That the Bill be now read a Second time.

Hon. Members: Object.

Bill to be read a Second time on Friday 6 July.

TYRES (BUSES AND COACHES) BILL

Motion made, That the Bill be now read a Second time.

Hon. Members: Object.

Bill to be read a Second time on Friday 6 July.

VOYEURISM (OFFENCES) BILL

Motion made, That the Bill be now read a Second time.

Hon. Members: Object.

Bill to be read a Second time on Friday 6 July.

NATIONAL HEALTH SERVICE (CO-FUNDING AND CO-PAYMENT) BILL

Motion made, That the Bill be now read a Second time.

Hon. Members: Object.

Bill to be read a Second time on Friday 6 July.

LOCAL AUTHORITIES (BORROWING AND INVESTMENT) BILL

Motion made, That the Bill be now read a Second time.

Hon. Members: Object.

Bill to be read a Second time on Friday 6 July.

PRINCIPAL LOCAL AUTHORITIES (GROUNDS FOR ABOLITION) BILL

Motion made, That the Bill be now read a Second time.

Hon. Members: Object.

Bill to be read a Second time on Friday 6 July.

COASTAL PATH (DEFINITION) BILL

Motion made, That the Bill be now read a Second time.

Hon. Members: Object.

Bill to be read a Second time on Friday 6 July.

JUDICIAL APPOINTMENTS AND RETIREMENTS (AGE LIMITS) BILL

Motion made, That the Bill be now read a Second time.

Hon. Members: Object.

Bill to be read a Second time on Friday 6 July.

BBC LICENCE FEE (CIVIL PENALTY) BILL

Motion made, That the Bill be now read a Second time.

Hon. Members: Object.

Bill to be read a Second time on Friday 6 July.

INTERNATIONAL DEVELOPMENT ASSISTANCE (DEFINITION) BILL

Motion made, That the Bill be now read a Second time.

Hon. Members: Object.

Bill to be read a Second time on Friday 6 July.

BENEFITS AND PUBLIC SERVICES (RESTRICTION) BILL

Motion made, That the Bill be now read a Second time.

Hon. Members: Object.

Bill to be read a Second time on Friday 6 July.

ELECTRONIC CIGARETTES (REGULATION) BILL

Motion made, That the Bill be now read a Second time.

Hon. Members: Object.

Bill to be read a Second time on Friday 6 July.

PEDICABS (LONDON) BILL

Motion made, That the Bill be now read a Second time.

Hon. Members: Object.

Bill to be read a Second time on Friday 26 October.

KEW GARDENS (LEASES) (NO.2) BILL

Motion made, That the Bill be now read a Second time.

Hon. Members: Object.

Bill to be read a Second time on Friday 6 July.

RIVERS AUTHORITIES AND LAND DRAINAGE BILL

Motion made, That the Bill be now read a Second time.

Hon. Members: Object.

Bill to be read a Second time on Friday 6 July.

WILD ANIMALS IN CIRCUSES BILL

Motion made, That the Bill be now read a Second time.

Hon. Members: Object.

Bill to be read a Second time on Friday 6 July.

FORENSIC SCIENCE REGULATOR BILL

Motion made, That the Bill be now read a Second time.

Hon. Members: Object.

Bill to be read a Second time on Friday 6 July.

PARENTAL LEAVE AND PAY ARRANGEMENTS (PUBLICATION) BILL

Motion made, That the Bill be now read a Second time.

Hon. Members: Object.

Bill to be read a Second time on Friday 23 November.

ANIMAL WELFARE (SERVICE ANIMALS) BILL

Motion made, That the Bill be now read a Second time.

Hon. Members: Object.

Bill to be read a Second time on Friday 6 July.

Stage Lighting: Efficiency Regulations

Motion made, and Question proposed, That this House do now adjourn.—*(Amanda Milling.)*

2.34 pm

Will Quince (Colchester) (Con): I thank my hon. Friend the Minister for being here to respond to this debate and apologise for making his Friday longer than it might otherwise have been.

Britain has a world-class arts and culture scene that generates a huge amount of tourism, growth and economic activity. In no sector is this more true than our theatre scene, which is not only beloved by millions of theatregoers up and down the country but engages with people from all ages and backgrounds, from the pantomime at Christmas in our local theatre to the big-name productions at the National theatre and everything in between. Theatre gives everyone an opportunity to take part, whether children at school, amateur dramatics in the local village hall, or world-class theatrical schools up and down the country. Some people even say that this very Chamber is the greatest theatre of them all. I guess that it is true for many MPs that our time in Parliament ends either as a comedy or a tragedy. I live in hope of neither.

We have many fantastic local theatres and performance venues in Colchester: the Mercury and Headgate theatres and Colchester arts centre. These theatres are proof that cuts to the arts are a false economy. Every £1 of grant aid that the Mercury theatre receives generates £3 for the local economy. The total economic impact of this theatre for my local area is £3.6 million—hardly an insignificant sum.

Robert Courts (Witney) (Con): My hon. Friend is leading a fascinating debate, and I congratulate him on having secured it. He has talked about the impact of some of his local theatres. In my constituency, in west Oxfordshire, we have Chipping Norton theatre. It belies the description of a local theatre, because people come from all over the country—not just west Oxfordshire—to attend this outstanding venue. I am sure that it is the same with his theatres.

Will Quince: I thank my hon. Friend—he is absolutely right. The reputation that precedes so many of our theatres up and down the country means that they attract a wider audience than just the local population. With that comes additional spend from people going to restaurants and staying in hotels. Theatres play a huge role in the local economy. That is one of the reasons—not the only one—why they are so important. Investing in the arts provides a strong cultural boost in our regional towns and cities. These theatres are also where the careers of some of our best British actors and actresses begin and where some of the most innovative plays and productions start their lives.

I have secured this debate because I have real concerns about the impact that potential changes in regulations on stage lighting could have for our local theatres and performance venues. The European Union is currently reviewing legislation on eco-design, which includes lighting. The new regulations, which have been proposed for September 2020, will require a minimum efficiency of 85 lumens per watt and a maximum standby power of 0.5 watts on all light sources, lamps or self-contained

fixtures sold within the European Union. As part of the review, an existing exemption was removed. Without this exemption, the majority of tungsten, arc and LED stage lighting fixtures would no longer be available on the market, and venues could be forced to go dark.

Michael Tomlinson (Mid Dorset and North Poole) (Con): My hon. Friend gives me the opportunity to mention two establishments in my constituency—the Rex in Wareham and the Tivoli in Wimborne. He mentions EU regulations. I am sure that he will come on to this, but how does Brexit impact on that now that we are of course leaving the European Union?

Will Quince: I thank my hon. Friend for his question. Being as observant as he is, as a non-practising barrister, he will know that I mentioned that the regulations come into effect in 2020. Nevertheless, the Government are talking about frictionless trade, and given that this trade regulation will apply across the European Union, it is really important to have an exemption that applies across the EU. We are requesting this exemption for theatres and performance venues in not just the United Kingdom but across the EU, and I will come on to that. I am glad he had the opportunity to mention two of his local theatres, both of which I have heard of, so their reputation precedes them.

Some people may say that this is fine. They will ask, "Why shouldn't theatres and other performance venues play their part in saving the environment?" The theatre and entertainment industry do want to play their part. They fully support the sustainability agenda and are taking steps day by day to improve their environmental standards. However, introducing these regulations without an exemption will have a considerable negative impact across European entertainment industries that would far outweigh the positive intentions behind the proposals.

With such a steep climb, there would be a tremendous financial burden on theatres, community halls, churches, schools and every single performance venue that uses theatrical lighting instruments as part of its shows. It is true that nothing in the new regulations requires venues to stop using their existing fittings, yet what good is a lamp without a bulb? Once the bulbs can no longer be sold, the existing fixtures will become worthless. That does not exactly support the principles of a more circular economy.

It is not possible to simply buy a compliant LED replacement bulb for a stage light. That is not how it works. In the entertainment industry, LED lights come as one whole unit, and the current cost for one of these high-quality lights is approximately £2,500. If someone runs a venue with, say, 300 tungsten sources and they need to be replaced overnight, along with the infrastructure that runs them, the total cost quickly escalates. Likewise, for those who run a community hall and own 10 lights, put on two shows a year and are used to spending only £20 on a bulb every now and then, the financial demand would be crippling.

If these regulations are introduced as they currently stand, there will only be a limited supply of existing bulbs. Once they are gone, they are gone, leaving behind an enormous amount of otherwise perfectly functioning scrap metal and glass. If theatres and venues were to refit their tungsten and arc rigs with the high-quality LED lights required—provided, of course, that they are available on the market—they would need to do so before September 2020.

The estimated cost of this transition to the UK theatre industry alone is £1.2 billion. This is considerable disruption and cost for limited power savings, given how entertainment lighting is typically used, notwithstanding the enormous amount of waste generated and electricity and energy used to manufacture and ship the new fixtures. Surely, there is a better way to achieve such energy savings. Even if venues could afford an overhaul of this magnitude, no high-quality LED lighting units currently on the market are compliant with these proposals. Venues will be left with no adequate tools with which to light productions.

Just as important an issue is how these regulations will affect the technical elements behind the productions we witness. Research and technical development over the past decade have enabled significant progress in LED spotlights to make them suitable for use in stage lighting for theatrical productions. However, it is still not possible to replace all professional entertainment lighting products with LEDs. The currently used tungsten lightbulbs allow for a wide spectrum of colour choice that can reliably fade and mix with the rest of a rig, so that all elements of a show can be precisely controlled to the needs of a production. LEDs are now approaching a similar standard, but these developments have all come about organically.

The introduction of these proposals would stifle such innovation, and as a result, we would be left with little more than harsh, unflattering floodlights with which to light our productions. It should be noted that it is extremely difficult to get LED lights perfectly to dim all the way off in the same manner as traditional lighting, and that for the lighting of live events very small halogen lamps, with a diameter of 0.5 cm, are used to produce a high-power output. Again, there are currently no available replacements for those special lamps with LED technology.

Finally, and probably most importantly, there is the issue of how all those individual issues join together to affect the artistic vision of a production. Change can be important, and perhaps these new conditions will result in visionary directors who take advantage of cold—always on, but not very bright—lighting, but it may lead to some very bleak plays. The reality, however, is that the technical problems with LED lighting will severely affect the artistic quality of performances. The richness of lighting for a live event lies in the diversity of light sources' colours and intensity; without that, our world-famous productions would be left flat.

The impact of these regulations on local theatres and performance venues will be both financial and artistic, so we need the exemption to remain in place. I therefore turn to my hon. Friend the Minister and say that we should all be concerned about these proposals. Although I am reassured to hear that representatives have been in active, and I understand positive, dialogue with the European Commission about introducing a narrow technical exemption, we need the Government to play their part.

I understand that my right hon. Friend the Secretary of State for Digital, Culture, Media and Sport, who is himself a fan of the theatre, has written to the Secretary of State for Business, Energy and Industrial Strategy expressing his Department's support for an exemption

[Will Quince]

for professional stage lighting for theatres and other venues. I think there is support for that across the sector and across the Government, so I ask the Minister to take forward our concerns to his friends and counterparts at the European Commission. I hope that he can reassure me that this is a priority, and that he will do everything he can to support the industry in securing this important exemption.

We should be very proud of the creative arts sector in our country. It does so much to improve our culture and our communities, yet it is at risk from these regulations, both financially and artistically. That was previously recognised—hence the exemption—so I hope the Government will do all they can to ensure that the exemption continues and that performances up and down this country are not compromised by poor or inadequate lighting, or indeed no lighting at all.

2.47 pm

The Minister for Universities, Science, Research and Innovation (Mr Sam Gyimah): I congratulate my hon. Friend the Member for Colchester (Will Quince) on securing a debate on this important subject. I am very much aware of this issue, which has already been raised by many in the sector, and I understand the potential impact of the draft legislation on theatres and other live entertainment venues up and down the country. By way of reassurance, let me say that the Government take this issue very seriously. Indeed, the Arts Minister, the Under-Secretary of State for Digital, Culture, Media and Sport, my hon. Friend the Member for Northampton North (Michael Ellis), is sitting next to me. We need to look at this issue on a cross-departmental basis.

We all recognise that the theatre is a hugely important part of the creative industries and of our country's cultural history. British theatre is respected across the world for its high-quality productions and its skilled professionals both on and off the stage. I am sure that the Mercury theatre in the constituency of my hon. Friend the Member for Colchester—I gather that it has raised concerns about this issue—is a shining example of that quality and professionalism. Let me make it clear that the Government recognise the value of theatre. We already support it in a number of ways, including through Arts Council funding, our theatre tax relief and a number of capital investments in recent years, such as the £78 million provided towards the creation of the Factory in Manchester.

Before I talk specifically about the draft EU lighting proposal, I will highlight for hon. Members the purpose of the policy and why it benefits both UK consumers and businesses. EU eco-design and energy labelling measures are about minimising the costs and environmental impact of products used in both homes and businesses by setting minimum performance requirements and empowering consumers to make informed purchasing decisions through the use of energy labels.

The EU measures have been around for several years, and we estimate that those agreed to date will be saving household consumers about £100 on their annual energy bills in 2020, and will be leading to greenhouse gas emissions savings of 8 million tonnes of carbon dioxide. Minimum standards for lighting alone are estimated to contribute more than 1 million tonnes of CO_2 savings. This policy therefore constitutes one of the most cost-effective ways to meet our carbon budgets and reduce energy consumption.

As well as bolstering our commitment to reduce carbon emissions, the policy also serves a purpose for industry. Setting minimum performance standards and promoting better environmental performance of products through labelling can help to drive innovation and increase the competitiveness of businesses, in line with our industrial strategy. Minimum performance standards and labelling schemes exist in various forms throughout the world, including in America, Canada, Australia and New Zealand. It can therefore be a challenge for businesses placing products in those markets to meet the various requirements.

Setting the standards at EU level means that manufacturers have to meet only one standard before placing their products on the market, without the burden of navigating multiple national regulations. However, when standards are set for the entire single market, it is important that they are proportionate and achieve what they are supposed to achieve, without unintended consequences. That is why the European Commission consults member states and relevant stakeholders when developing a policy proposal. At the same time, we engage extensively with UK stakeholders and listen to the concerns raised before we come to a position and vote on legislation.

That brings me to the matter raised by my hon. Friend the Member for Colchester, which is the potential impact of an EU draft lighting regulation on theatres in the UK. The Commission held a consultation forum in December to discuss the first draft of the proposal—here I wish to stress the importance of the word "draft". Following that forum, stakeholders were able to submit comments in writing to the Commission, which were considered as part of the review process of the draft regulation. It is therefore still a proposal at this stage and remains open for discussion. I understand that a final decision will not be made on the proposed legislation until later in the year, so my hon. Friend is right to bring the matter before the House at this point. Until then, my officials will continue to listen to the concerns and views of all interested parties—indeed, the issue has already been brought to the Department's attention by many in the sector, and as I said, the Arts Minister also takes a keen interest in the matter.

To put it in context, the draft proposal is a revision of the current lighting regulation that came into force in 2012. The purpose of that regulation was gradually to improve the performance of lighting products and push the market towards more energy-efficient and longer-lasting technologies such as ultra-efficient LED lighting. However, due to the special purpose of certain lighting, the existing regulation contains an exemption for various types of lighting equipment, such as that used in theatres and other live entertainment venues.

The intention, as stated in the regulation, was to look again at special purpose lamps when the measure came to be reviewed. It is therefore important that hon. Members are aware that the draft regulation builds on previous experience of the issue. Theatre and stage lighting has had an exemption for six years and, although I understand that tungsten is still commonly used in theatres, in that time some venues have begun to adopt LED alternatives. I believe that most large-scale theatres

make at least partial use of LEDs, and have done so for years. LED lighting may, however, not always be a suitable option, and it may not be cost-effective for some venues, particularly smaller venues, to transition to newer, more efficient technologies. I also understand that even some LED lights may struggle to meet the proposed performance requirements in 2020.

I reassure hon. Members that my Department's officials have already met representatives of the Association of Lighting Designers and the National Theatre and are aware of the impact that the proposal could have on the availability of theatre lighting equipment. Following that meeting, my officials made representations to the European Commission in writing and in person to discuss this issue and potential solutions. I gather that since meeting Department for Business, Energy and Industrial Strategy officials, the Association of Lighting Designers, as well as other sector representatives, have had a productive meeting with the Commission and have now submitted an alternative proposal for its consideration.

As I mentioned, this is still a draft regulation and member states will not vote on it until the Commission calls a regulatory committee, which we expect to take place at the end of this year. Until then, officials and, of course, the Arts Minister will continue to consult on further iterations of the regulation and consider concerns raised by interested parties. As we have seen only an early draft of the regulation, we will not be carrying out a cost-benefit analysis at this stage. Once we see the final draft version of the regulation prior to the regulatory committee, we will carry out a cost-benefit analysis of the lighting proposal for the whole UK. Both we and the European Commission have listened to the sector and are aware of the potential impacts on the theatre and the live entertainment industry, and support finding a solution that works for everyone.

Question put and agreed to.

2.55 pm

House adjourned.

Written Statements

Friday 15 June 2018

HOME DEPARTMENT

Immigration Rules

The Minister for Immigration (Caroline Nokes): My right hon. Friend the Home Secretary is today laying before the House a statement of changes in immigration rules.

The changes include exempting doctors and nurses from the tier 2 (general) limit, recognising the important contribution that overseas health professionals make to our NHS. This is in response to the particular shortages and pressures facing the NHS at the current time, as well as the fact that the limit has been oversubscribed in each month since December 2017. The change will mean that health sector employers will be able to sponsor doctors and nurses without putting pressure on the limit, freeing up places within the limit for other key roles which contribute to the UK economy and other public services. The changes will be kept under review.

The Government will also ask the independent Migration Advisory Committee to review the composition of the shortage occupation list.

Building on the changes announced by the Chancellor in the autumn, which were implemented in January of this year, further improvements are being made to the tier 1 exceptional talent route. These changes include widening the scope of the creative element of the route to include leading fashion designers, and improved provisions for applicants in film and television.

Appendix H is being updated to include a number of visa national countries, which will allow a greater number of students to benefit from a streamlined application process by reducing documentary requirements. This change demonstrates the continued focus on improving the UK's offer to international students.

Today also sees the introduction of a new rule for those transferred to the UK under section 67 of the Immigration Act 2016 (section 67 leave), who do not qualify for refugee or humanitarian protection leave under the existing rules. In keeping with our commitments in the legislation, and in line with those granted refugee or humanitarian protection leave, individuals who qualify for section 67 leave will have the right to study, work, access public funds and healthcare and apply for indefinite leave to remain without paying a fee after five years.

New settlement provisions are being created to put beyond doubt that Afghan nationals who worked with our armed forces in Afghanistan, and subsequently relocated to the UK with their families, will be able to apply for permanent residence here. As announced on 4 May, these applications will also be free of charge. Afghan locally engaged staff worked in dangerous and challenging situations, regularly putting their lives at risk and we would not have been able to carry out our work there without them. The new dedicated settlement rules make clear our commitment to honour their service and ensure they can continue to build their lives here. The changes also implement plans to extend the ex gratia redundancy scheme by six years to recognise and honour the service of those made redundant before 19 December 2012, as announced by the Defence Secretary on 11 June.

As announced in March, a new route to settlement for Turkish business people and their families who are in the UK under the European communities association agreement is also being created. Eligibility is being extended for this route to Turkish workers and their families who are also here under the association agreement.

Changes are being made to provisions to allow holders of an electronic visa waiver (EVW) to present their EVW in a digital format. The changes will also establish a wider set of permissible errors that will overlook specific, minor discrepancies in the biographic details of an EVW, without compromising on the security of the EVW system.

[HCWS768]

WORK AND PENSIONS

Personal Independence Payments

The Secretary of State for Work and Pensions (Ms Esther McVey): Last week I came to the House to answer an urgent question regarding two PIP appeals to the upper tribunal (known as AN and JM) that I had withdrawn. I was unable to comment on a related case that was pending an appeal to the Court of Appeal (known as LB) as it concerned ongoing litigation, and I committed to updating the House at the earliest opportunity on this case when I was able to do so.

I carefully considered this appeal and have decided to not continue with it in order to provide certainty to the claimant involved. The March 2017 amending regulations (regulations 2(2) and (3) of the Social Security (Personal Independence Payment) (Amendment) Regulations 2017) clarified the Department's position on PIP daily living activity 3 (managing a therapy or monitoring a health condition) and therefore further litigation is unnecessary.

On Wednesday 13 June I received confirmation that the Court of Appeal had consented to my Department's application to withdraw the appeal in the LB case, and I am pleased to confirm the claimant will be receiving arrears of benefit as soon as possible.

My Department has now begun work to apply the law as stated by the upper tribunal in LB and will take all steps necessary to implement it in the best interests of all affected claimants for the period 28 November 2016 (the date of the upper tribunal decision in LB) to 16 March 2017 (when the amendment to activity 3 came into force). This work will include a review exercise later in the year. We expect that around 1,000 claimants will be affected.

I am absolutely committed to ensuring that disabled people and people with health conditions get the right support they need. PIP is a modern, personalised benefit that assesses claimants on needs, not conditions. It continues to be a better benefit than its predecessor DLA for claimants with chronic conditions. This Government are spending over £50 billion a year supporting people with disabilities and health conditions—this is higher than ever before.

[HCWS767]

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