South East Coast Ambulance Service NHS
NHS Foundation Trust

# Violence Prevention and Reduction Procedure

**Contents**

# 1 Scope

1.1. This procedural document, the Violence Reduction Strategy and the Security Management Policy / Procedures it relates to, exists to set out protocols for the management and reduction of violence and aggression South East Coast Ambulance Service NHS Foundation Trust (the Trust) staff, contractors and volunteers may experience from patients, relatives, general public and other third parties. It considers current NHS England Violence Reduction Standards Guidance.

1.2. By ensuring a robust process combined with effective monitoring, the Trust will be able to assure itself internally and externally that appropriate arrangements are in place, as far as practically possible, for the safety and security of staff as a paramount responsibility for the Trust.

1.3. This document will define the correct processes in relation to the aspects of training, risk assessments, verbal de-escalation, conflict management and prosecutions, sanction, and redress.

# 2 Management and reduction of violence and aggression

2.1 Due to the nature of the work Trust staff undertakes it is recognised that there is a level of risk of violence and aggression towards staff from external sources, including but not limited to patients, relatives, and the general public.

This may manifest itself from various underlying factors including, but not limited to, character, intoxication, medical condition, mental health condition, language barriers, patient condition concerns, pain, response delays, previous poor experience etc.

Most commonly, violence and aggression is experienced by operational responders face to face on scene or by advisors and clinicians in the Emergency Operations Centre (EOC) or Trust 111 Centres over the phone. However it is possible non-operational staff may also experience violence and aggression if they are identified as working for the Trust e.g. by having their ID card on display in the public domain or again where in telephone contact, such as a complaint or Serious Incident.

2.2 Risk Assessments

2.2.1 Effective full risk assessments with suitable controls must be established for each group i.e. staff responders, volunteer responders, control room staff etc. as the primary mechanism for working safely and securely.

2.2.2 There must be an overarching risk assessment developed covering each staff group when determining roles considering the level of risk for the role with suitable and proportionate controls put in place.

2.2.3 Using the above overarching risk assessment as a basis, local risk assessments must be completed by area for operational responders to cover their Operating Unit (OU) covering staff dynamics, the geography of the OU, attendance types, any specific or local risks etc. relating to violence and aggression that may be experienced face to face and again with suitable and proportionate controls put in place. Other areas, such as EOC and 111 must also have a risk assessment covering similar perspectives in consideration of call types, e.g. intoxication, clinically led challenging behaviour, general aggression etc. Non-Operational staff based at an office must also have a risk assessment covering face-to-face and/or telephone contact.

2.2.4 In some cases, there may be a requirement for a specific risk, small group of people or an individual within a local area which requires suitable and proportionate controls to allow safe working. In such cases local management for the area must ensure the risk assessment is suitable and sufficient and made available to all staff who may need to view it. For regionally operating staff travelling and lone working refer to the Lone Worker Policy.

2.2.5 Staff, whilst performing their duties, must complete the ongoing process of dynamic risk assessments and consider personal safety and security for themselves and their colleagues. These assessments should incorporate the risks and controls of the full risk assessments, as above. Additionally, the assessment should include all information available that directly applies to the activity to balance credible risk and personal safety.

2.3 Training

2.3.1 All staff must receive training in conflict management.

2.3.2 Accredited Conflict Resolution Training will be delivered to Trust staff by accredited trainers. All frontline staff including community first responders are required to attend this training every three years.

The training aims are to resolve potentially confrontational situations, develop skills and knowledge to make a dynamic risk assessment to be able to recognise potentially violent situations and give an understanding of how to de-escalate and respond accordingly.

Clinical restraint and breakaway techniques are included within the training.

2.3.3 Body Worn Cameras are available to staff as a tool in preventing violence and aggression across the trust, wearing, and carrying of the equipment is voluntary. A training package is available.

2.3.4 Individuals who may have verbal contact with patients, e.g. EOC and 111 operatives, will attend Challenging Behaviour and Verbal De-escalation training.

2.4 Information Sharing

2.4.1 Identified information from internal or external sources must be recorded officially through the appropriate processes (as below) and held securely but available to appropriate individuals or groups who may require the information to complete a risk assessment on personal safety and security.

2.4.2 A History Marker may have been applied due to an incident of violence and/or aggression. Where this information is recorded it must be made available in sufficient time for the responder to consider and use with other information to support their dynamic risk assessment. The information must be present through the Computer Aided Dispatch (CAD) system and records kept for meetings where markers were discussed. The information may be made available through e.g. the Mobile Data Terminal (MDT) however to support Single Responders, who may be unable to operate the MDT whilst driving, information must be available via radio or through a hands-free phone system. It is equally important that EOC make responders aware of risks as well as responders contacting EOC for information on risks.

2.4.3 In some instances, there may be high level security information available identifying significant risk to the security of staff, determined at national, regional or Trust level. In such cases an alert may be determined and disseminated through the Trust lead for security only. Disseminated alerts must be treated with the strictest confidence, held securely with information shared appropriately and made available to relevant staff. See the guidance document within the appendices.

2.4.4 Where there is an official record or information available from another NHS service or e.g. Police, for staff safety and security this information may be shared with or received from that organisation and distributed in line with security alert processes as described in 2.4.3 and Appendix F. To ensure governance, information must be kept to the minimum to address the risk and communications, where written and include protected information, must be transferred or received through an nhs.net account.

2.4.5 In some instances, individuals may be identified as falling within the frequent caller process as well as demonstrating aggressive tendencies. Each case must be determined on its own merits and in some cases, the frequent caller process may take precedence and in some cases the security processes for sanction and redress may take precedence. There may also be instances of joint or overlapped work and so advice should be sought from the Frequent Caller Lead and/or Security Team where the matter is unclear.

2.4.6 Certain general information which is not considered protected information may be shared with or received from other organisations where this supports joint working and staff safety and security. Management involved with such organisations as Community Safety Partnerships may discuss trends, themes or aspects of concerns during meetings or written

communications to establish links and support working to mitigate identified local risks.

2.4.7 In working to reduce incidents of violence and abuse towards staff, a quarterly report will be completed, seeking to identify where staff with protected characteristics have been victims. The report will be managed by HR through GRS and data will be produced in an anonymised format.

2.5 Police Attendance

2.5.1 To ensure responders receive support/back-up on appropriate attendances it is vital to establish and communicate the '*credible threat*' that exists. This is determined by the likelihood and severity of harm based on the information available and relating to the attendance on the day, not simply the possibility of future risk.

2.5.2 Where local or regional agreements exist for joint working or for specific individuals, attendance types or addresses etc. staff should consult the associated agreement for protocols.

2.5.3 Where Police are in attendance and an assault has occurred which should be pursued (i.e. is not medical related) staff and management must ensure the Police are aware of the assault and reviewing the incident in addition to any scene management and/or conveyance.

2.5.4 Responders should allow Police in attendance to manage any matter of restraint, as Trust staff should consider personal safety and only be in physical contact for disengagement or breakaway due to violence and aggression. For matters relating to medical treatment where there is a lack of mental capacity, staff should refer to the appropriate clinical policy.

# 3 Incidents, Support and Interventions

3.1 Datix Report Forms

3.1.1 Incidents of violence and aggression must be reported on Datix ensuring the category is listed as violence and aggression and the sub-category cites the appropriate offence type. (See the guidance document in the appendices for details of categorisation).

3.1.2 All physical assaults not attributed to medical factors and where offender details/address are known must in addition to having a Datix have a history marker applied for. This must be completed irrespective of whether the matter is progressing through the Police and/or Courts to ensure colleagues have information available to support their risk assessments.

3.1.3 In all circumstances of violence and aggression Datix the staff member(s) who was the victim of the offence must be recorded under the contact section with a role of victim of violence or aggression only, to ensure

accurate recording of information. Any other staff cited as witnesses or in attendance can be recorded under an associated role.

3.1.4 Datix must include detail to support any internal, local and/or police/court action regarding the circumstances of the violence and/or aggression and any *operative* aggravating factors as listed on Datix.

3.1.5 The details of the Police Crime Reference Number (CRN) or where not available, their attendance number, the officer in charge and any contact details should also be included in the report to allow follow up communications where appropriate to progress action.

3.1.6 Local Management should have systems and/or processes in place to ensure that security related incidents are investigated in a timely and proportionate manner.

3.1.7 Each Datix relating to a physical assault should have an automated system notification sent to security management by the Datix system for awareness and where required, to provide guidance and/or support (see support section later in the procedure).

3.1.8 Data recorded on Datix will support submissions by security management of reported physical assaults to the national database, the Security Incident Reporting System (SIRS).

3.2 Support

3.2.1 Acts of violence or aggression by such individuals as service users, relatives, general public etc. against individuals who operate for the Trust are not acceptable and the Trust supports any individual who may seek to progress a prosecution against an alleged offender where the incident was not as a direct result of a medical factor.

3.2.2 Recognising a diverse workforce who may react to violence and aggression or the severity of the act individually, support must be available at the appropriate level(s) and time(s) for those who are the victim of violence and/or aggression.

3.2.3 Immediate duty management must be available to support the health and wellbeing of staff following an incident, ensuring internal and external services that are available are made aware to the individual, that include;

3.2.4 Line Management
3.2.5 Health and Wellbeing Hub
3.2.6 Chaplaincy Services
3.2.7 Counselling Services
3.2.8 Security Management Services
3.2.9 Police Service
3.2.10 Victim Support Services (through the Police if reporting a crime)
3.2.11 Witness Care Services (through the Court where there is a hearing/trial)

3.2.12 Communication is vital and is in two-way operation between the victim and any of the above support mechanisms and each case is to be taken on its own merits. However, where action is progressing internally or externally, as in the interventions section later in the procedure, communication should continue to ensure.

3.2.13 Victims receive continued supported.

3.2.14 The support mechanism is provided with any necessary information to support action.

3.2.15 Feedback and outcomes are provided to the victim, as well as documented on the Datix.

3.2.16 Any Trust wide learning can be identified for review or inclusion in such work as risk assessments, policy, and training.

3.3 Interventions

3.3.1 Following an incident being reported and support provided it is essential for the incident investigator to identify an appropriate route for redress wherever possible with particular emphasis on the most serious offences such as physical assaults and/or any aggravated offences.

3.3.2 Voluntary intoxication of dangerous drugs or alcohol should not be considered suitable mitigation for a criminal act and can still be pursued via internal or external redress.

3.3.3 Similarly, individuals who may have a form of mental health issue, however, was not the operative factor in the act, as capacity was present, again can still be pursued via internal or external redress.

3.3.4 It is recognised in some instances an act of e.g. physical assault, may occur due to a medical factor of the patient, such as those who may be in a post ictal stage. In these instances, it is accepted that potentially no redress would be sought as it would be considered inappropriate.

3.3.5 Where victims may not wish to pursue individual action against the offender and whilst support mechanisms should encourage victims to pursue, advising of support available, the victims' rights should be respected. However, where the incident investigation identifies an overarching risk if there was re-attendance by the victim or colleagues, Investigating Managers still have a duty to identify a general internal redress mechanism, such as history marking. This is to ensure any risk can be appropriately managed in line with local full risk assessments and staff dynamic risk assessments.

3.3.6 Wherever possible, both internal and external routes should be pursued for redress, see the IWR1 Security Incidents - Guidance Document in the appendices.

3.4 Internal Interventions

3.4.1 Dependent on the act committed and the situation and/or severity around the individual in all cases an internal redress route should be considered, and these include, but are not limited to.

- Local Management inappropriate behaviour letters
- Local Management meeting with alleged offender
- History Markers applied.
- Security Management warning letters
- Frequent Caller letters
- Frequent Caller / Multi-Disciplinary Task meetings with alleged offender

3.5 External Interventions

3.5.1 Again, dependent on the act committed and the situation and/or severity around the individual where possible and appropriate an external redress route should be sought through the relevant law enforcement body and may result in, but not limited to.

- Formal letters of apology from offender
- Offender agreed Community Resolution Orders
- Police imposed Community Resolution Orders
- Police formal Caution
- Criminal Behaviour Orders, Youth Orders, Rehabilitation Orders
- Fines
- Compensation
- Community Service
- Suspended Sentence
- Custodial Sentences

3.5.2 Where Police are in attendance the presumption should always be to encourage staff to communicate to the Police that they as the victim seek to pursue action for the act of e.g. physical assault with the exception of such cases where a medical factor was operative in the act. The Trust encourages all staff where appropriate to pursue criminal sanctions.

3.5.3 Where the incident is prosecuted and is taken on by the Crown Prosecution Service (CPS) line management support will be available to the victim for attendance at the hearing and/or trial.

3.5.4 Security Management should be notified of any case going to Court to provide any required support to the victim and to supply a Victim Impact Statement on behalf of the Trust.

3.6 Level of Aggression, Violence and Aggravated Offences

3.6.1 Incident investigators, with support where required, from Security Management, should look to identify a proportionate response as it is recognised not every incident may be accepted by the CPS for prosecution or indeed be appropriate to approach this route.

3.6.2 Generic outward aggression or swearing by an individual may not be sufficient to result in formal redress and should be handled in line with training and risk assessments.

3.6.3 There are however certain acts as below that, with the exception of medical factors, should always be reviewed by Investigating Managers as serious to ensure a form of redress is determined as an outcome to the Datix and in all cases to seek both an internal and external route.

3.7 Physical Assaults

3.7.1 Regardless of whether the victim wishes to pursue other sanctions, a history marker application should be completed as a matter of course in order to protect others. Externally, victims should be offered the necessary support and encouraged to pursue a prosecution ensuring where necessary Security Management is informed of Police CRNs and Officer in Charge (OIC) details.

3.7.2 Investigating Managers and victims should be aware that an assault to an NHS staff member which may impede their ability to carry out their duties is noted as formal guidance to Magistrates when considering sanctions.

3.8 Aggravated Offences

3.8.1 An offence, whether a physical assault or verbal abuse, or other may be considered aggravated when immediately before, during or immediately after the act, specific aspects, such as race/religious (i.e. hate crimes), homophobic, transphobic, etc., and sexually inappropriate comments or touching. In all cases these incidents should be treated seriously by the Investigating Manager, Police, and the CPS, through to the Courts.

3.9 Other Serious Offences

3.9.1 There are also far rarer, but equally as critical incidents which may not be physical assaults but should be treated extremely seriously. Again, in all cases these incidents should be treated seriously by the Investigating Manager, Police, and the CPS, through to the Courts. These incidents include but may not be limited to;

- Personal credible threats to an individual over the phone or face-to-face.
- False Imprisonment such as physically blocking a responders' exit.

- Direct credible threats made to personal safety with the use of a weapon.

3.9.2 Where this is not an offence as above there may still be other offences where action internally or externally may be appropriate. Where the victim is outside of a dwelling and by another's act causes distress or discomfort, this may also have scope to pursue action.

3.9.3 Similarly, where an offensive message has been communicated, such as over the phone, and causes the victim distress or anxiety, there may also be the scope to pursue action.

# 4 Responsibilities

4.1 Chief Executive Officer

4.1.1 Ultimately responsible for all policies and procedures within the Trust, including those pertaining to the reduction of violence and aggression to Trust staff and ensuring suitable redress is pursued.

4.2 The Trust Board

4.1.2 Trust Board is responsible for ensuring that the strategy is implemented and tracking progress of its delivery.

4.3 Executive Director of Nursing and Quality

4.1.3 Responsible for ensuring processes, procedures and systems are in place to support the reduction of violence and aggression, through risk assessing, training, support, and suitable redress being pursued.

4.4 Trust Security Team

4.1.4 Responsible for planning and, following Exec/SMD approval, implementing the strategic direction for the reduction of violence and aggression and pursuit of suitable redress.

4.1.5 Responsible for the management of the processes, support and guidance available to victims and investigating managers to reduce violence and aggression and pursue suitable redress.

4.1.6 Where required directly supporting victims of serious offences and assisting or guiding on redress and sanction routes.

4.1.7 Where required supporting Investigating Managers on incidents involving serious offences and assisting or guiding on redress and sanction routes.

4.1.8 Responsible for administration of the support for such incidents as physical assault, aggravated or other serious offences.

4.1.9 Promoting publicised results, sanctions support and approved guidance to assist victims and Investigating Managers.

4.1.10 Production of data and reports to various dashboards, groups etc.

4.1.11 Escalation of identified trends and themes from monthly, quarterly, or annual data.

4.1.12 Administration of the internal security sections on the Datix forms.

4.1.13 Coordination on behalf of the Trust for national reporting of physical assaults data.

4.1.14 Coordination of meetings with partner agencies such as the police under the Op Cavell banner.

4.2 Risk Coordinators

4.2.1 Administration of incidents on Datix which relate to violence and aggression incidents ensuring risk management processes are completed for Datix requirements.

4.2.2 Managers (Senior / Head Of / Lead / Operating Unit)

4.2.3 Ensuring risk assessments are in place with suitable and sufficient controls to manage and reduce violence and aggression for those who respond operationally and those in control in direct phone contact with patients/scene.

4.2.4 Ensuring they continually familiarise themselves with the principles of security to complete or brief a deputy for risk assessment completion.

4.2.5 Strategic level ownership for their Operating Unit's security culture and ensuring suitable Managers are tasked with providing support to victims of violence and aggression and management of IWR1 incidents determining a suitable redress/sanction route.

4.2.6 Ensure all applicable staff under their management receive an appropriate level of Conflict Resolution Training.

4.3 Managers (Local / General / Operating / Team Leader)

4.3.1 Providing line management support to the victim and raising awareness of support services both to cover health and wellbeing and to work with the victim to pursue a route of internal and external sanction/redress, where identified, as detailed earlier in the procedure.

4.3.2 Responsible for ensuring Datix incidents relating to violence and aggression are handled in a timely and proportionate manner and are completed with

all necessary feedback, sanction route identified and being pursued with the outcome notified to security management.

4.3.3 Managing the controls from full risk assessments completed for their local area for staff with regards to violence and aggression.

4.3.4 Ensuring staff are aware of full risk assessments and the mechanisms of dynamic risk assessments, guiding Operational Responders seeking information through the EOC or guiding EOC Operatives identifying history markers or other risk information on calls to communicate to Operational Responders.

4.3.5 Ensuring staff training in conflict resolution is up to date and identifying any gaps in training needs.

4.3.6 Seeking guidance where required, from security management, for advice or input on serious and sensitive incidents, including physical assaults.

4.3.7 Where a duty Manager, ensuring Police on scene address any assault and not just scene management, with the presumption (unless medical in nature) to support staff and encourage pursuit of prosecution.

4.3.8 Understanding the requirements for history marking applications and identifying incidents of violence and aggression where markers must be applied, such as for physical assaults (where offender details are known and the assault is not as a result of medical factors).

4.3.9 Identifying local controls to support staff where violence and aggression (including false allegations) may exist, such as pre-arranged ambient listening, with staff involvement.

4.4 All Employees

4.4.1 Responsible for their own and where applicable colleague's safety and security when completing dynamic risk assessments taking into account all necessary information to make an informed decision.

4.4.2 Compliance with controls from full risk assessments.

4.4.3 Compliance with training related to conflict management.

4.4.4 Ensuring incidents of violence and aggression are reported via a Datix Incident Reporting form.

4.4.5 Awareness and where meets the criteria, a history marker is applied for, provided an Datix has also been completed.

4.4.6 Operational responders to be aware of the mechanisms to operate the man down button on their radios.

4.4.7 EOC operatives to identify risk information to be communicated to responders and where applicable to probe on a call to establish or allay risk considerations.

4.4.8 When discussing and/or reporting an incident, providing specific information on the nature of the act, e.g. if physical, was it a push, punch etc. Where words used, what type of words, what tone etc.

4.5 Audit and Review

4.5.1 The Security Team will continuously monitor the content through its use, to ensure it meets the security needs of the Trust, whilst remaining relevant and appropriate prior to its scheduled review.

4.5.2 The procedure will be reviewed every three years or sooner if new legislation, codes of practice or national standards are introduced.

## 5 Associated Documentation

5.1 Violence Prevention and Reduction Strategy
5.2 Security Management Policy
5.3 Security Management Procedure
5.4 ID & Access Procedure
5.5 Site Security Procedure
5.6 Lone Worker Policy
5.7 Incident Reporting and Investigation Manual
5.8 Risk Management Policy
5.9 History Marking Policy
5.10 History Marking Procedure
5.11 Frequent Caller Policy
5.12 Frequent Caller Identification and Management Procedure
5.13 Information Governance Policy
5.14 Body Worn Camera Policy
5.15 Body Worn Camera Procedure

## 6 References

6.1 The Department of Health and Counter Fraud Security Management Service – A professional approach to managing security in the NHS
6.2 Criminal Justice Act (1988)
6.3 The Emergency Workers (Obstruction) Act 2006
6.4 Offences Against a Person Act (1861)
6.5 Protection from Harassment Act (1997)
6.6 Malicious Communications Act (1988)
6.7 Public Order Act (1986)
6.8 Health and Safety at Work Act (1974)
6.9 Assault on Emergency Worker Act (2018)

# 7 Equality Analysis

7.1 The Trust believes in fairness and equality, and values diversity in its role as both a provider of services and as an employer. The Trust aims to provide accessible services that respect the needs of each individual and exclude no-one. It is committed to comply with the Human Rights Act and to meeting the Equality Act 2010, which identifies the following nine protected characteristics: Age, Disability, Race, Religion and Belief, Gender Reassignment, Sexual Orientation, Sex, Marriage and Civil Partnership and Pregnancy and Maternity.

7.2 Compliance with the Public Sector Equality Duty: If a contractor carries out functions of a public nature, then for the duration of the contract, the contractor or supplier would itself be considered a public authority and have the duty to comply with the equalities duties when carrying out those functions.

## Appendix A: Datix Violence & Aggression Incidents Guidance

# Datix Violence & Aggression Incidents: Investigations Guidance Document

This document is designed to guide Team Leaders and Managers etc. investigating security related Datix and providing the specialist information over and above standard requirements for completion of Datix investigations.

A general principle
Incidents are based on evidence, never assume information, if it is not cited and/or confirmed, it needs to be questioned or cannot be considered a point of fact.

Focus Security Datix : Violence and Aggression

The 4 elements you need to review are:

1. The level the staff member has been affected.
   - Welfare check staff, with particular time spent for those significantly affected physically or psychologically by the event. Support services internally / externally should be offered as well as Security if can assist (Internal support – Line manager, counselling, Security / External support – Victim support, witness care).

2. What information is required in investigating:
   - Check the sub-category to ensure it is appropriate **(see Appendix part 1 for grading)**
   - What risk assessments were in place, are the controls sufficient and what dynamic risk assessment did the staff member complete? Are there any training needs to support the staff member?
   - What does it appear was the trigger for the aggression / assault, a generally aggressive individual. The fact they were intoxicated. A mental health crisis? Breakdown in communication between patient and staff member? Was this medical, e.g. a patient coming out of a seizure etc?
   - Were the Police called? Did they attend? Was any aggression/assault dealt with as an offence or was the attendance only for scene management? Does an offence need to be reported via 101?
   - Were there any aggravating factors that were operative to the offence, i.e. did the aggravating factor occur immediately before, during or after the assault/aggression not merely present?
   - What other evidence is available? E.g. witnesses, CCTV, notes on CAD, the phone call etc?

3. Points to consider.
   - Voluntary intoxication by alcohol or dangerous drugs is NO defence, even if the perpetrator may have no memory of their actions. A route for sanction should still be determined.

- Physical assaults, unless caused by a medical factor (again e.g. coming out of a seizure) or no details available to mark must always be applying for a history marker in addition to any other ongoing action.
- If the staff member as a result of injury is going to be or has been off sick for more than 7 days this is a RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations).
- Staff members should be encouraged to pursue a prosecution, especially in instances of physical assault considering the impact on them, future colleague attendances and/or the general public.
- Where assaults were not considered by Police on scene, offences can still be reported retrospectively via 101. If the perpetrator was de-arrested at any point the matter for that incident cannot be pursued.
- It is in the notes for sentencing guidelines that physical assaults on NHS staff should be taken more seriously in persecutions and in sanctions. This may need to be reminded to the Police/Prosecution/Court.
- Where a history marker exists, always re-apply as a new marker or even extending the date may be required.
- Can always pursue action locally as well as police / prosecution action.
- Advice, guidance or support is available to investigators and staff from the lead on security to provide specialist expert advice on the complexity of individual cases.

4. Correct route to take to consider the Datix complete **(See Appendix part 2 for more information)**;
   - Where a physical assault and staff are pursuing a prosecution, you have the crime reference number on the Datix, support / input from the lead on security to the investigator and / or staff member.
   - Where a matter is being pursued for an offence other than physical assault, consider supporting evidence to assist external buy in for getting prosecution e.g. previous local warnings, frequent calling / directed aggression, previous IWR1s etc.
   - Determine a local route in addition to any criminal action, e.g. frequent caller process, history marking and / or associated warning letters etc.
   - Was the perpetrator or any other person on scene actually at risk themselves and that a vulnerable person report is the appropriate course of action.

**Appendix Part 1:**

| Violence and Aggression sub-categories | Explanation |
|---|---|
| • Witnessed Aggression (Not directed at SECAmb Staff) | E.g. witnessing domestic abuse / intoxicated or aggressive individual hitting a wall or breaking an item / acting out into the air swearing or motion. In all cases the crew being in attendance is inconsequential. |
| • Anti-social Behaviour/Aggression Experienced (Causing Distress/Discomfort) | Would tend to be a category more used by Field Ops than EOC/111, may be any of the examples in witnessed aggression and / or generally directed at the crew because they are an Ambulance representative. In all cases the individuals' actions are directed towards the crew or designed to intimidate crew. Violence may not be directly intimated but the crew may feel distress or discomfort. |
| • Directed Verbal Abuse (General)<br>• Directed Verbal Abuse (Sexually Aggravated)<br>• Direct Verbal Abuse (Homophobic Aggravated)<br>• Directed Verbal Abuse (Racially/Religiously Aggravated) | More used by EOC/111 than Field Ops but can occur for Field Ops as well (more EOC/111 as more of a form of abuse over the phone). The intention is to personally insult and degrade the individual and cause discomfort or distress, be grossly offensive, threatening, or false. Any of the 3 aggravating factors apply if made immediately before, during or immediately after the comment. |
| • Non-Physical Assault (Words/Behaviour - Physical Violence Anticipated) | This may occur where a credible threat can be established that the words or mannerisms may constitute a fear or imminent violence, irrespective of the 'true' intention of the perpetrator. There must be a credible threat, not an individual conceiving a threat where one does not exist. Similarly, if a threat is made however the staff member is not concerned or believes imminent violence, there is no assault. Therefore, you need a credible threat and the belief of imminent harm. |
| • Attempted Physical Assault (Attempted but failed) | This is a case of swing and miss, whether a punch or throwing an article, spitting etc. It is aimed at a staff member but misses them or they move out of the way. |
| • Physical Assault (General)<br>• Physical Assault (Sexually Aggravated)<br>• Physical Assault (Homophobic Aggravated)<br>• Physical Assault (Racially/Religiously Aggravated) | There is a physical application of touching, hit, punch or force that is intentional or reckless. Inappropriate touching to e.g. intimate areas even without violence would be classed as sexual assault. (Additional: Whilst medical factors are an assault - e.g. coming out of a seizure - they would only be reported for records purposes).<br>As with abuse any of the 3 aggravating factors applies if made immediately before, during or immediately after the comment. |

**Appendix Part 2:**

| Violence and Aggression sub-categories | Possible Offences (non-exhaustive list) | Possible routes of action and information required |
|---|---|---|
| Witnessed Aggression (Not directed at SECAmb Staff) | • None to SECAmb staff but possibly elsewhere | • A referral to an HCP for their action<br>• A vulnerable person referral if anyone was witnessed as at risk<br>• No further action |
| Anti-social Behaviour/Aggression Experienced (Causing Distress/Discomfort) | • Public Order – Causing distress or discomfort in a public area<br>• Harassment – 2 or more unwanted acts by the same person to the same victim (warning after first given) | • History marking / associated warning letter / frequent caller process / MDT etc. as appropriate if derogatory, offensive, or aggressive directly to staff member(s)<br>• Where strong evidence and/or previous local warnings exist, pursue prosecution |
| Directed Verbal Abuse (General)<br>Directed Verbal Abuse (Sexually Aggravated)<br>Direct Verbal Abuse (Homophobic Aggravated)<br>Directed Verbal Abuse (Racially/Religiously Aggravated) | • Malicious communications – written or verbal communication, which is grossly offensive, threatening, or false.<br>• Harassment – 2 or more unwanted acts by the same person to the same victim (warning after first given)<br>• Any aggravating factor must be immediately before, during or after act | • History Marking if the verbal element used derogatory, offensive, or aggressive words directly to staff member(s)<br>• Where strong evidence and/or previous local warnings exist, pursue prosecution.<br>• Any case which is aggravated is automatically a strong case |
| Non-Physical Assault (Words/Behaviour - Physical Violence Anticipated) | • Public Order – Causing distress or discomfort.<br>• Assault – A credible threat which the victim believes intimates imminent physical harm | • History marking and / or associated warning letter / frequent caller process etc. even if only credible threat.<br>• Where strong evidence and/or previous local warnings exist, pursue prosecution |
| Attempted Physical Assault (Attempted but failed) | • Attempted battery – intended or reckless attempt at physical harm | • Always consider history marking and /or associated warning letter as a minimum |
| Physical Assault (General)<br>Physical Assault (Sexually Aggravated) | • Battery (Common Assault) ABH, GBH, GBH with intent – depending | • History marker must be completed unless |

| | | |
|---|---|---|
| Physical Assault (Homophobic Aggravated)<br>Physical Assault (Racially/Religiously Aggravated) | on the level of injury / physical harm.<br>• Any aggravating factor must be immediately before, during or after act | medical or cannot trace individual.<br>• Staff to be encouraged and supported to pursue prosecution |

## Appendix B: Field Ops on scene safety guidance

### *What to do if the scene may potentially be violent/aggressive:*

A. Utilise all available information to support and be clear about the ***rationale*** *for* your risk assessment. Unless explicit, do not base an assessment on any one piece of information and where required, request clarification or further information to complete an assessment.

B. Always continually assess the risk at each stage of the attendance, from receiving a job, en-route, as approaching, when exiting vehicle, as approaching the scene, first contact generally, first contact with patient, environment, other individuals present and where applicable, exiting, supporting patient to vehicle, conveyance to hospital, to handover.

C. Rely on any training and skills provided by the Trust with regards to conflict management, where there is such a presentation.

### *What to do if faced with violence/aggression:*

A. Utilise training and techniques with regards to verbal communication and de-escalation.

B. Where there is still direct violence or aggression, where you determine by your dynamic risk assessment your do not consider the scene safe and/or where violence is present at any point immediately withdraw from the area of violence – the priority is your own safety and that of your crewmate / colleague(s).

C. Where there is violence and/or aggression present and the perpetrator is the patient and is communicating they wish you to leave, consider your safety and security by staying on scene when not sought by a patient with capacity.

D. Where necessary utilise breakaway techniques but not restraint, though or ***reasonable*** force is acceptable as required so as to enable you to withdraw from the area of violence.

E. When withdrawing, identify a safe location to retreat to, be this another area of the scene, your vehicle, or even withdrawing in your vehicle to stand off scene.

F. Where a ***credible*** threat is present inform Control as soon as possible, so they can request police presence and other assistance.

G. Seek support where required from a Duty Manager for welfare and support where violence is present.

### *What to following stand off for violence/aggression:*

A. Where standing off, ensure you consider your safety and security first before re-entering the area where violence and aggression was present. If this is away from the scene, ensure Control is aware of your position and safety and any required information before returning to the scene, if it is safe to return at all.

B. Where the Police are backing up to scene ensure any action to manage violence and/or restraint relating to violence and you consider your safety and security at all times.

C. Only support in clinical holding where you have such clinical training relating to Mental Capacity or Mental Health and to be aware this is distinctive from Security and any conflict management or resolution training.

## Appendix C: Description Aid

It is often difficult to give an accurate description following an incident. This aid can be used either on its own or to assist you in writing a statement. If you are not sure what to write, the following prompts may help:

**Name (if known)**
**Age (actual if known otherwise an estimation of age / age range)**
**Male/Female**
**Ethnic appearance:** European, Afro Caribbean, Asian, Oriental, Arab, Other:
**Skin tone:** Light, Dark
**Height:** Tall, Short, Medium
**Build:** Fat Heavy, Stocky, Broad, Thin, Slim, Medium, Proportionate
**Eye colour(s): (glasses?)** Blue, Brown, Green, Grey, Hazel, Pink
**Facial hair:** Moustache, Beard (long/short), Goatee, Shaped, Stubble, Sideburns, Clean-shaven
**Hair colour:** Grey/greying, Blond, Brown, Black, Red, Ginger, Dark, Light, Hat, Head Covering
**Hair length:** Bald, Collar-length, Cropped, Receding, Short, Shaved, Shoulder-length, Very Long
**Hairstyle:** Straight, Curly, Untidy, Bob, Thinning, Wig, Dyed, Streaked, Highlights, Afro, Mohican, Spiky, Dreadlocks, Ponytail, Skinhead
**Accent:** Strong or slight, English: Northern, North East, North West, Liverpool, Yorkshire, Southern, South East, South West, London, Midlands, Birmingham, West Country, East Anglia, Welsh, Scottish: Glaswegian Irish: Northern Irish European: French, German, Spanish, Italian, East European African Asian American Australian Caribbean Oriental Other
**Marks/scars/abnormalities:** Tattoos/piercings/jewellery
**Describe and state body position**
**Clothing:** Colour / style / logos / slogans / numbers, Jacket/coat, Top/t-shirt, etc, Trousers/skirt,
Shoes

## Appendix D: Security Alert Guidance

On receipt of a Security Alert cascaded by the Security Manager the Senior Managers in receipt should make themselves aware of the content of the alert and where applicable, any additional information in the dissemination email.

Staff who should be made aware of the alert should be sent the alert electronically.

Do not:

- Print or put a copy on any notice board on station or display in any accessible area.
- Take appropriate steps to avoid the alert to being misused, internally publicised or leaked externally due to inappropriate cascading or access allowance (much of which can be achieved by following this guidance email)
- (Staff or management) socially discuss the subject of the alert either by email, grape vine or social media etc – only the security aspects of the alert relating to staff safety/security should be discussed and in an appropriate forum.

Do:

- Observe general data protection, information governance and security obligations regarding these alerts.
- Keep communications to the minimum requirements to still cascade the information.
- Allow staff to have sight of the alert as and when needed via e mail.
- Report an Datix and inform your security team directly for any incident which involves the subject of the alert, whether this is a safety/security incident for staff or even if the alert is unsecured/information governance issue involving the alert.
- Seek guidance from your security team for any concerns/queries you have on security alerts.

Failure to observe this may lead to complaints, claims, and fines for our Trust. Additionally, if the information in the Alert is not handled appropriately, we are putting staff (and potentially patients) at risk.

South East Coast Ambulance Service NHS
NHS Foundation Trust

## Appendix E: General Violence and Aggression Risk Assessment Template – For Guidance Purposes Only

Assessment No.

**General Risk Assessment Form**

| | |
|---|---|
| Completed by and role: | Initial assessment date: |
| Location of the risk: Trust Wide | |
| Task / Hazard being Assessed: Violence and Aggression | |

| STEP 1 | | | STEP 2 | STEP 3 | STEP 4 | | |
|---|---|---|---|---|---|---|---|
| **REF NO** | **ACTIVITY** | **HAZARD** | **PERSON (S) AFFECTED AND HOW** | **CURRENT CONTROL MEASURES** | **RISK RATING L x C = R** | | |
| 1 | Responding | Attendance to Aggressive patient / bystanders leading to abuse, threats and/or physical assault | Staff, contractors, and volunteers' risk to personal security both psychologically and physically | 1. Body Worn Camera (24 locations)<br>2. CCTV<br>3. Mandated conflict resolution training.<br>4. Radio activated crew down button.<br>5. Incident reporting systems - Datix<br>6. History marker scheme<br>7. Frequent caller team<br>8. Violence Reduction Support Officer to assist staff with reporting and tracking incidents.<br>9. Welfare support through line management<br>10. Violence Reduction Working Group meeting monthly to assess trends and themes, review compliance with NHS Violence Reduction Standards | 3 | 3 | 9 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | | | 11. Local knowledge<br>12. Potential Police back up<br>13. Potential additional resource back up<br>14. Warning Letters<br>15. Prosecution<br>16. Dynamic Risk Assessments<br>17. Trim process<br>18. Welfare and Wellbeing Hub<br>19. Line management support.<br>- | | | |
| 2 | | Attendance to intoxicated patient / bystanders leading to abuse, threats and/or physical assault | Staff, contractors, and volunteers' risk to personal security both psychologically and physically | 1. Body Worn Camera (24 locations)<br>2. CCTV<br>3. Mandated conflict resolution training.<br>4. Radio activated crew down button.<br>5. Incident reporting systems - Datix<br>6. History marker scheme<br>7. Frequent caller team<br>8. Violence Reduction Support Officer to assist staff with reporting and tracking incidents.<br>9. Welfare support through line management<br>10. Violence Reduction Working Group meeting monthly to assess trends and themes, review compliance with NHS Violence Reduction Standards<br>11. Local knowledge | 3 | 3 | 9 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | | | 12. Potential Police back up<br>13. Potential additional resource back up<br>14. Warning Letters<br>15. Prosecution<br>16. Dynamic Risk Assessments<br>17. Trim process<br>18. Welfare and Wellbeing Hub<br>19. Line management support.<br>- | | | |
| 3 | | Attendance to clinically led challenging behaviour of patient / bystanders leading to abuse, threats and/or physical assault | Staff, contractors, and volunteers' risk to personal security both psychologically and physically | 1. Local operational controls.<br>2. Conflict Resolution Training<br>3. Local knowledge<br>4. 'Crew Down' button on radio<br>5. Potential Police back up<br>6. Potential additional resource back up – OTL / Bronze Commander<br>7. CCTV<br>8. Body Worn Cameras<br>9. Warning Letters<br>10. Prosecutions<br>11. Dynamic Risk Assessments<br>12. Incident reporting systems – Datix<br>13. Trim process<br>14. Warning Letters<br>15. Dynamic Risk Assessments<br>16. Welfare Hub<br>- | 2 | 4 | 8 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 4 | Responding | Staff transferring patients in ambulances | Staff injured from being physically or verbally assaulted | 1. CCTV Fitted internal and external.<br>2. Central locking<br>3. Communication system between front and rear cabs<br>4. Mandated conflict resolution training.<br>5. Body Worn Camera (24 locations)<br>6. Incident reporting systems – Datix<br>7. Radio activated crew down button.<br>8. History marker scheme<br>9. Frequent caller team<br>10. Violence reduction support to assist in reporting and tracking incidents.<br>11. Welfare support through line management<br>12. Violence Reduction Working Group monthly meetings to assess trends and themes, review compliance with NHS Violence Reduction Standards.<br>13. Local knowledge<br>14. Potential Police back up<br>15. Potential additional resource back up<br>16. Warning Letters<br>17. Prosecution<br>18. Dynamic Risk Assessments<br>19. Trim process<br>20. Welfare Hub<br>- | | | |
| 5 | | Delayed conveyance back up | Staff, contractors, and volunteers' risk to personal security both | - Dispatch communication.<br>- Dynamic risk assessments<br>- Conflict Resolution Training | 2 | 3 | 6 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | leading to aggression | psychologically and physically | | | | |
| 6 | | Attending as non-optimal service out of hours to manage mental health patient's leading to aggression due to lack of suitable pathways for needs | Staff, contractors, and volunteers' risk to personal security both psychologically and physically<br>Additional risk to patient safety | - None<br>- | | | |
| 7 | Call taking in EOC or 111 | Call from Aggressive patient / bystanders leading to abuse and/or threats | Risk of psychological harm to call taker. | 1. Violence reduction support to assist in reporting and tracking incident.<br>2. Welfare support from line management<br>3. Policy to enable termination of calls.<br>4. Incident Reporting System - Datix<br>5. Frequent caller team<br>6. History marker team<br>7. Mandatory CRT training<br>8. Violence Reduction Working Group monthly meetings to assess trends and themes, review compliance with NHS Violence Reduction Standards.<br>9. Bespoke course delivered to 999 call handlers - Improving the patient experience for call centre staff / EMA 999<br>10. Trim process | 3 | 3 | 9 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | | | 11. Warning Letters<br>12. Prosecution<br>13. Dynamic Risk Assessments<br>14. Welfare Hub<br>15. Internal abusive caller log. | | | |
| | | Call from intoxicated patient / bystanders leading to abuse and/or threats | Risk of psychological harm to call taker. | 1. Violence reduction support to assist in reporting and tracking incident.<br>2. Welfare support from line management<br>3. Policy to enable termination of calls.<br>4. Incident Reporting System - Datix<br>5. Frequent caller team<br>6. History marker team<br>7. Mandatory CRT training<br>8. Violence Reduction Working Group monthly meetings to assess trends and themes, review compliance with NHS Violence Reduction Standards.<br>9. Bespoke course delivered to 999 call handlers - Improving the patient experience for call centre staff / EMA 999<br>10. Trim process<br>11. Warning Letters<br>12. Prosecution<br>13. Dynamic Risk Assessments<br>14. Welfare Hub<br>15. Internal abusive caller log. | 3 | 3 | 9 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 8 | | Call from clinically led challenging behaviour of patient / bystanders leading to abuse and/or threats | Risk of psychological harm to call taker. | 1. Violence reduction support to assist in reporting and tracking incident.<br>2. Welfare support from line management<br>3. Policy to enable termination of calls.<br>4. Incident Reporting System - Datix<br>5. Frequent caller team<br>6. History marker team<br>7. Mandatory CRT training<br>8. Violence Reduction Working Group monthly meetings to assess trends and themes, review compliance with NHS Violence Reduction Standards.<br>9. Bespoke course delivered to 999 call handlers - Improving the patient experience for call centre staff / EMA 999<br>10. Trim process<br>11. Warning Letters<br>12. Prosecution<br>13. Dynamic Risk Assessments<br>14. Welfare Hub<br>15. Internal abusive caller log. | 3 | 3 | 9 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 9 | People on site | In rare circumstances staff, visitors, volunteers, and contractors may be exposed to aggressive individuals attending a Make Ready Centre | Staff, contractors and volunteers' risk to personal security, intimidation, both psychologically and physically | - <br>1. Site security arrangements, e.g., barriers, fencing, swipe carded doors, CCTV.<br>2. Body Worn Cameras<br>3. Make Ready Operatives available 24/7.<br>4. Duty OTL on call<br>5. Prosecutions<br>6. Dynamic Risk Assessments<br>7. Potential Police back up<br>8. Incident reporting systems – Datix<br>9. Trim process<br>10. Warning Letters<br>11. Dynamic Risk Assessments<br>12. Welfare Hub<br>13. Conflict Resolution Training | 1 | 3 | 3 |
| 10 | | In rare circumstances staff, visitors, volunteers, and contractors may be exposed to aggressive individuals attending a Station | Staff, contractors and volunteers' risk to personal security, intimidation, both psychologically and physically | 1. Site security arrangements, e.g., barriers, fencing, swipe carded doors, CCTV.<br>2. Body Worn Cameras<br>3. Make Ready Operatives available 24/7.<br>4. Duty OTL on call<br>5. Prosecutions<br>6. Dynamic Risk Assessments<br>7. Potential Police back up<br>8. Incident reporting systems – Datix<br>9. Trim process<br>10. Warning Letters | 1 | 3 | 3 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | | | 11. Dynamic Risk Assessments<br>12. Welfare Hub<br>13. Conflict Resolution Training | | | |
| 11 | | In rare circumstances staff, visitors, volunteers, and contractors may be exposed to aggressive individuals attending an HQ, EOC, 111 Fleet or Training building etc. | Staff, contractors and volunteers' risk to personal security, intimidation, both psychologically and physically | -<br>1. Site security arrangements, e.g., barriers, fencing, swipe carded doors, CCTV.<br>2. Body Worn Cameras<br>3. Make Ready Operatives available 24/7.<br>4. Duty OTL on call<br>5. Prosecutions<br>6. Dynamic Risk Assessments<br>7. Potential Police back up<br>8. Incident reporting systems – Datix<br>9. Trim process<br>10. Warning Letters<br>11. Dynamic Risk Assessments<br>12. Welfare Hub<br>13. Conflict Resolution Training | 1 | 3 | 3 |
| 12 | Responding | Attendance at local prisons | Ambulance Staff, volunteers | 1. Prison escort whilst on premises<br>2. Local prison lockdown procedures<br>3. Dynamic Risk Assessments<br>4. Body Worn Cameras<br>5. Conflict Resolution Training<br>6. Local knowledge<br>7. Incident reporting systems – Datix<br>8. Trim process<br>9. Warning Letters<br>10. Prosecutions<br>11. Dynamic Risk Assessments | 3 | 3 | 9 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | | | 12. Welfare Hub | | | |
| 13 | Responding | Attendance at sporting stadiums. Exposure to bystanders, members of public and large crowd and potential disruptive behaviours. | Ambulance Staff, volunteers | 1. Local operational controls.<br>2. Conflict Resolution Training<br>3. Local knowledge<br>4. 'Crew Down' button on radio<br>5. Potential Police back up<br>6. Potential additional resource back up – OTL / Bronze Commander<br>7. CCTV<br>8. Body Worn Cameras<br>9. Warning Letters<br>10. Prosecutions<br>11. Dynamic Risk Assessments<br>12. Incident reporting systems – Datix<br>13. Trim process<br>14. Warning Letters<br>15. Dynamic Risk Assessments<br>16. Welfare Hub | 3 | 3 | 9 |
| 14 | Responding | Attendance to Immigration Detention Centres | Ambulance Staff, volunteers | 1. On site security / border force escorts<br>2. Body Worn Cameras<br>3. Operational Commander activation to incidents of disorder<br>4. Mandated conflict resolution training.<br>5. Radio activated crew down button.<br>6. Incident reporting systems – Datix<br>7. Potential additional resource back up – OTL / Bronze Commander<br>8. Local management welfare support | 2 | 3 | 6 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | | | 9. Trim process<br>10. Warning Letters<br>11. Prosecutions<br>12. Dynamic Risk Assessments<br>13. Welfare Hub | | | |
| 15 | Responding | Attendance at Ambulance Community Response Point (ACRP)<br>Exposure to other members of public, aggressive patient / bystanders leading to abuse, threats and/or physical assault potential disruptive | Ambulance Staff, volunteers | 1. Body Worn Camera (24 locations)<br>2. Conflict Resolution Training<br>3. Radio activated crew down button.<br>4. Incident reporting systems - Datix<br>5. History marker scheme<br>6. Frequent caller team<br>7. Violence Reduction Support Officer to assist staff with reporting and tracking incidents.<br>8. Welfare support through line management<br>9. Violence Reduction Working Group meeting monthly to assess trends and themes, review compliance with NHS Violence Reduction Standards<br>10. Local knowledge<br>11. Potential Police back up<br>12. Potential additional resource back up<br>13. Warning Letters<br>14. Prosecution<br>15. Dynamic Risk Assessments<br>16. Trim process<br>17. Welfare Hub<br>18. Line management support.<br>19. Local Violence Risk Assessments of ACRP. | 1 | 3 | 3 |

## Appendix F: Guidance Reminder

1. The safety and security of staff is a critical responsibility of the Trust and Senior / Line Managers for staff ensuring controls are in place to meet legislative and governance requirements to mitigate, as far as practicably possible, violence and aggression to staff.

2. Risk assessments are a fundamental first step to ensure activities can be completed safely and securely and must be in place to cover risks of violence and aggression towards staff. Also consult the Security Audit Procedure for individuals on site, Lone Worker Policy for general lone working, the appropriate HR Policy for job role and the associated Operational Policy for Single Responders.

3. Certain staff, such as responders must receive a suitable level of Conflict Resolution Training. In addition to induction there should be refresher training every three years to ensure skills are up to date. Other areas may be identified as requiring a level of training where in contact with the public or exposure to the public.

4. Responders should utilise all available information to continually assess personal safety, including information from the call, history marking, risk assessments etc. and unless explicitly stated, should not use any one aspect as a basis for a decision but to support a decision. In turn however where risk has been identified and appropriately assessed which indicates standing off from scene or leaving scene should be supported.

5. Where Police assistance may be sought as back up, it is a requirement to communicate effectively the '*credible threat*' to demonstrate the need for support and receive an appropriate response.

6. Ensure where an assault has occurred on scene and Police are in attendance that it has been communicated so that the assault and not just scene management are addressed by the Police. The presumption is to seek action unless there is a specific reason or medical factor to deem this inappropriate.

7. Incidents of violence and aggression should be reported via the Trust's Datix Incident Reporting System and line management offering appropriate support services where required (see Appendix A on Datix guidance).

8. Only the *operative* factor is of concern if e.g. an assault is committed, i.e. A perpetrator who may happen to have mental health concerns but had capacity to complete the assault may still be pursed for action.

9. Intoxication voluntarily of alcohol and or dangerous drugs may still be prosecuted as the offence is deemed reckless, which can be pursued as if intended.

10. Assaults against NHS staff should be treated more seriously as is in the public interest and is in e.g. Magistrates sentencing guidance that e.g. a Paramedics evidence would carry weight and outcomes more serious for the perpetrator.

11. History marking amongst others is a tool to highlight incidents to provide information for any future attendance and risk assessment by the staff member or their colleagues. **All** incidents of physical assault not of a medical nature must have a history marker applied for.

12. A general point of contact in the first instance to raise matters, discuss Datix etc. and request support is through Security.Management@Secamb.NHS.UK.