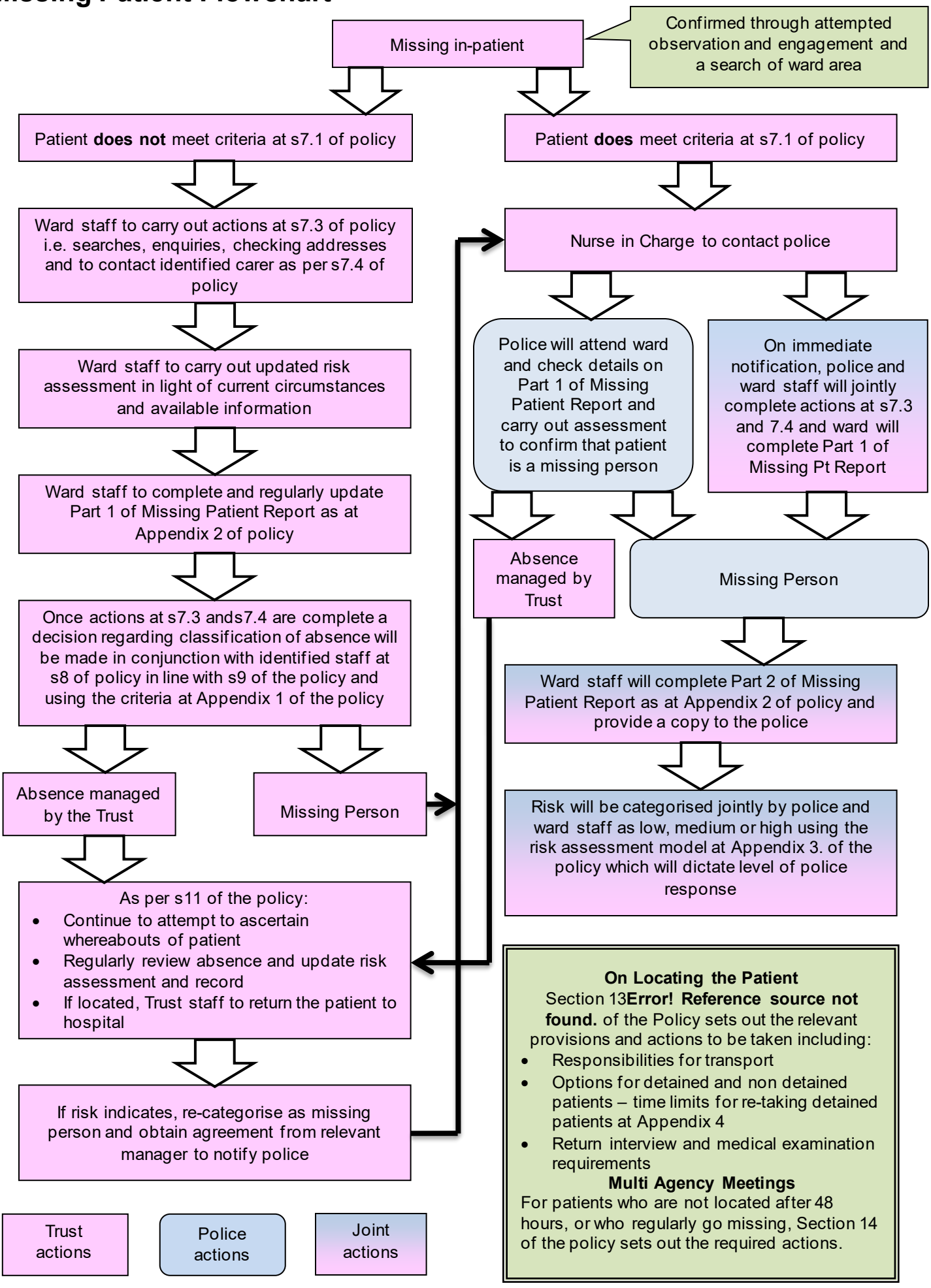
Tees, Esk and Wear Valleys NHS Foundation Trust

Missing patients procedure Ref CLIN-0006-v5

Status: Approved

Document type: Procedure

Missing Patient Flowchart



1. Purpose

This is a joint procedure between the police forces of Durham and Darlington, Cleveland and North Yorkshire and Tees, Esk and Wear Valleys NHS Foundation Trust.

This joint procedure applies to all patients of Tees, Esk and Wear Valleys NHS Foundation Trust (The Trust), irrespective of which part of the mental health service they are using.

This document:

- gives guidance to assist staff when to report a person who is absent as a missing person
- defines the roles and responsibilities of the police and Trust staff.

This document cannot anticipate every situation. Police and Trust staff should use their professional judgement to take any action that is deemed necessary to protect the safety of the patient and the public based on an assessment of risk for each patient.

Channels of communication between the Trust and the relevant Police Division must be established and maintained in order to facilitate the partnership approach.

2. Related documents

- Code of Practice Mental Health Act 1983, TSO, 2015
- Reference Guide to the Mental Health Act 1983, TSO, 2015
- TEWV Leave Policy
- TEWV Incident reporting and investigation policy
- TEWV Clinical risk assessment and management policy

3. Terminology

Term	Definition
Missing patient	• patient cannot be found on a ward, unit, department or other provision, and has not informed staff of their intention to leave; or • patient has failed to return from agreed time away from the ward, or it becomes apparent that they are not where expected to be whilst away from the ward and their whereabouts are unknown – see Leave Policy

Absent without leave	A patient is defined as absent without leave (AWOL) if they are liable to be detained and: • are absent from hospital without authorised leave; or • fail to return to hospital at the end of a period of authorised leave; or • fail to return to hospital following revocation of authorised leave; or • are not residing at the address at which required to, as a condition of authorised leave. A patient is defined as AWOL if they are subject to a Community Treatment Order (CTO) and: • have failed to attend hospital when recalled; or • have absconded from hospital after being recalled there.

4. Roles and responsibilities

Role	Responsibility
Chief Executive	The Chief Executive is ultimately responsible for ensuring the Trust complies with this procedure
Trust	The Trust is responsible to make sure that services are there to provide the processes associated with the MHA and to ensure that clinical staff understand and comply with agreed policies and procedures.
Manager	Each manager is responsible for ensuring that policies and procedures are followed within their area of responsibility
Your responsibilities	You are responsible for your own actions and must follow this procedure with regard to patients who are absent without leave or missing

5. Scope

This procedure relates to:

- Missing patients (not detained);
- AWOL patients (liable to be detained); and
- CTO patients who have been recalled to hospital.

6. Key principles

Under Paragraph 28.15 MHA Code of Practice, the police should always be notified immediately if a patient is missing who is:

- **Considered particularly vulnerable, including aged 16 years of age or under**
- **Considered to be dangerous,**
- **Subject to restrictions under Part III of the MHA**

There is no requirement to notify the police immediately unless there is an obvious immediate serious risk to the patient or the public or the patient is subject to restrictions under Part III of the MHA.

All patients who escape from medium secure services or abscond during escorted leave from medium secure services, regardless of status under Part III of the Act, should be immediately notified to the police.

The Trust is responsible for the welfare of patients in its care, and has primary responsibility for locating and returning patients unless the risk is so serious and immediate that police resources are immediately required to organise a co-ordinated search.

Where the risk is not serious and immediate, the Trust should make its own enquiries with relatives, friends, A and E Departments and at the home address.

The police should not be used as a means of making these enquiries due to a shortage of mental health trust resources.

The Police will use the THRIVE model (see Appendix 3) to determine their response.

7. On discovering that a patient is missing

7.1. From an inpatient area

Engagement and observation of patients in inpatient and residential settings will be carried out in line with the protocol at appendix 1 of the Clinical Risk Assessment and Management Policy.

When it is apparent through attempted observation and engagement that a patient is absent, and this has been confirmed through an initial search of the ward, the person in charge of the ward/department/unit will be informed and initial actions at 7.3 and 7.4 must be followed *before* contacting the police.

The police must be contacted immediately that the initial ward search has confirmed the absence of the patient if the patient:

- is aged 16 years or under;

- is considered particularly vulnerable leading to an obvious serious risk to the patient; or
- is considered to be dangerous leading to an obvious serious risk to the patient or the public; or
- is subject to restrictions under Part III MHA; or
- has escaped or absconded from medium secure services.

The initial actions at 7.3 and 7.4 must still be followed whilst awaiting arrival of the police, following which responsibility for coordinating further actions can be jointly agreed.

The person contacting the police must make clear to the call handler the reasons for reporting the absence to the police e.g. the specific concerns that lead to the person being considered particularly vulnerable or dangerous.

7.2. Failure to return from agreed leave or respond to recall

When it is apparent that a patient has:

- **failed to return from an agreed period of leave, or**
- **has been recalled from s17 leave, or**
- **recalled under the powers within s17E (community treatment order) and failed to return**

and this has been confirmed, the person in charge of the ward / department / unit will be informed and, other than searches and CCTV checks, the initial actions at 7.3 and 7.4 will be followed *before* contacting the police

7.3. Initial actions

The person in charge of the ward / department / unit must identify themselves or a named individual to coordinate and act as a single point of contact.

All actions and conversations must be recorded in the patient's record on Paris.

Staff must follow local protocols / standard procedures and conduct reasonable inquiries and searches, including:

- searches of rooms/wards/departments/units including all locked areas;
- initiating a ground search of the site/surrounding area and alerting any existing reception and security services if working at the time;
- enquiries with other staff/service users/visitors to see if they have seen or heard anything or know the current whereabouts of the patient (see section 7.5 below);

- enquiries with relatives/friends, associates and other relevant agencies (see sections 7.4 and 7.5 below);
- telephoning or sending a SMS text message to the absent patient's home or mobile phone;
- contact security staff to check CCTV systems where available;
- arranging for the home address of the patient to be checked by ward staff, the crisis team, the community mental health team, or a relative;

Staff will take all reasonable steps to:

- identify the nature and reason for the absence;
- identify the likely intentions of the absent patient, taking into account:
  - their clinical presentation
  - recent events
  - precipitating factors
- establish the likely whereabouts and wellbeing of the absent patient
- use the information gained above to formulate an updated risk assessment.

7.4. Contacting the identified carer

The identified carer must be informed by telephone as soon as it is clear that the patient is absent unless:

- there is evidence that the patient will be returning shortly;
- informing the identified carer is judged by the clinical team to be counter-productive for example, by causing excessive alarm;
- it is thought more appropriate to contact them by another means e.g. CPN,Social Worker;
- there has been a prior agreement with the identified carer that they do not need to be contacted immediately.

Regular contact with the identified carer must be maintained throughout the patient's absence.

7.5. Confidentiality

The overriding concern is the safety of the patient, their carer/relatives and the public.

Although every case must be considered on its merits, patient confidentiality will not usually be a barrier to providing basic information about a patient's absence to people who may be able to help find them

	(Paragraph 28.19 MHA Code of Practice).

Basic information about a patient's absence can be provided to those the patient normally lives with and those the patient is likely to contact if they may be able to help with finding the patient.

Enquiries should be made with other service users/patients and visitors to find out if they have seen an absent patient or know their current whereabouts

	**This will not breach confidentiality providing the minimum information is given for the purpose of determining whether the person can help with finding the patient.**

8. Further actions

If the patient is not from one of the groups that must be immediately notified to the police as above, a decision as to whether or not the police will be informed will not be made until the actions at 7.3 and 7.4 above to establish the whereabouts of the patient have been taken.

1. If the patient is not detained, the person in charge of the ward/department/unit will contact the responsible psychiatrist during working hours or the relevant duty doctor out of hours.
2. If the patient is detained, the person in charge of the ward/department/unit will contact the Responsible Clinician or nominated deputy at all times
3. During working hours, the relevant Manager will be contacted.
4. Out of hours, the on-call manager will be contacted.

Contact will be made in order to:

- discuss the level of concern;
- review and update the risk assessment taking into account the current circumstances of absence; and
- agree the appropriate response.

9. Risk assessment and classification of absence

With the medical and management representatives identified in 8 above, the person in charge of the ward / department or unit will:

- confirm that the initial actions described at 7.3 and 7.4 above have been completed;
- consider the circumstances of absence;
- review and update the risk assessment; and
- categorise the absence.

	**Although there may be an element of risk with many mental health patients (whether detained or not) if they are not located, it is not always the case that the risk is so immediate and so serious that urgent police assistance is necessary.**

All absences will be classified as either:

- an absence that will be managed by the Trust; or
- an absence that will be notified to the Police as a missing person

See **Appendix 1 Classifying absence** for the criteria for the different types of absence.

There may be unknown risks that are not apparent at the time of the initial incident despite due diligence. But mental health care staff, police officers and police staff should not be risk averse. They should have the confidence to make decisions according to considered risk assessments in light of the information available at the time.

	**Decisions will not be judged with hindsight. They will be judged against the information that was reasonably available at the time. There will also be many occasions when more than one decision lies within the reasonable band of decision making.**

The relevant Manager in consultation with the Responsible Clinician or Psychiatrist has ultimate responsibility for the risk assessment and categorisation of absence conducted by the Mental Health Trust.

The Duty Inspector has ultimate responsibility for the risk assessment and categorisation of absence conducted by the police.

10. Record keeping

Throughout the period that the patient is absent, Trust staff must keep a full contemporaneous record on Paris of all circumstances, decisions, actions taken and messages received and given within the patient's health record. The missing patient report at **Appendix 2** should be completed and used as a checklist to ensure that all necessary actions have been taken and once the incident has resolved, it should be filed within the patient's paper care record.

All telephone calls made to the police are recorded by the police.

	**Staff must inform the MHA Department using notify in Paris if a service user detained under the Mental Health Act 1983 is absent without leave. The MHA Department will check each episode of absence and inform the Care Quality Commission where there is an obligation to do so.**

An incident report must be submitted on Datix regardless of whether the patient is detained or not.

Where the incident may be classified as a possible SUI, the Patient Safety Team must be informed.

An incident will be a possible SUI if the patient is an absconding (missing) client who is deemed to be potentially violent, vulnerable or suicidal, a detained patient who is a serious risk to themselves or others, or where media interest is likely.

Please refer to the Trust Incident Reporting Procedure

11. Absences that will be managed by the Trust

The police will not be informed of these cases.

The Trust is responsible for:

- managing the absence;
- making enquiries to locate the patient; and
- returning the patient to hospital.

The person in charge of the ward / department / unit must:

- regularly review the absence and the risk assessment;
- make a record of the review; and
- decide whether to seek a clinical review to consider the next steps.

A patient who is initially classified as 'An absence that will be managed by the Trust' can be subsequently re-classified as 'a missing person' if the risk increases due to a change of circumstances or because the patient does not return and is not located as expected.

If the category of absence is upgraded to 'missing person', the person in charge of the ward/department/unit will contact the relevant Manager who should then authorise the police to be contacted if they agree that the missing criteria apply.

12. Missing Person

12.1. Informing the police

If the patient meets the criteria for classification as 'Missing', the person in charge of the ward/department or unit must notify the relevant Manager.

	**If the relevant Manager agrees that the missing criteria apply and authorises the incident to be reported to the police, the police must be contacted.**

	**The police call handler will make an initial assessment as to whether this should be classed as a missing person, in which case an officer will be deployed or an absent person, in which case the Trust will retain responsibility.**

12.2. Police attendance

The officer who attends to take the initial report will check the details on the Missing Patient Report in consultation with the person in charge.

The officer will conduct a risk assessment and consider whether the absence falls within the definition of:

- an absence that should be managed by the Trust; or
- an absence notified to the Police as a missing person.

12.3. If classified as a missing person

The officer in consultation with the person in charge of the ward/department or unit and using the risk assessment model at appendix 2 will categorise the risk as:

- High
- Medium
- Low

12.4. Disputes over category of absence

Any dispute between the Police Officer and Trust staff over the categorisation of absence or risk will be referred to the Duty Inspector and the appropriate relevant Manager see **Appendix 5 Disputes about classification and risk**.

12.5. Responsibilities during absence

The police will investigate all cases falling within the definition of missing person and conduct appropriate enquiries in accordance with the National Guidance on the Management, Recording and Investigation of Missing Persons.

Trust staff will be expected to help the police to find the person and to work co-operatively with the police during any enquiry.

The Trust remains responsible for people in its care.
This does not change when a patient is reported as missing to the police.

12.6. Informing the media

The police have responsibility for considering whether to inform the media about missing patients to assist in locating that individual and to warn the public should that individual pose a significant threat.

Decisions to publicise will always be made in consultation with the clinical team and the responsible person from the Communications Department of the Mental Health Trust who will consult the relevant family members.

12.7. Planning for return

The appropriate Trust staff will start contingency planning for when the patient is found.

Consideration must be given to:

- what arrangements need to be made to escort and return the patient;
- appropriate arrangements to support their return e.g. transport;
- whether the risk assessment indicates that police assistance is likely to be required;
- who is the most appropriate person to conduct the return interview;
- whether the patient can be effectively managed on their existing ward.

Where it has been identified that the patient poses a significant risk to other individuals who may be required to detain or transport that individual, this should be communicated to the police.

For example

- although it would not normally be disclosed that a patient has a disease that can only be passed via bodily fluids, this information should be passed if that patient is known to be violent or prone to spitting or self-harming;
- it should be disclosed if a patient is known to carry weapons;
- it should be disclosed if it is known that a patient has a partner who is likely to be violent if attempts are made to recover that patient.

13. When the patient is located

13.1. Detained patients

The time limits for retaking patients detained under the MHA are in Appendix 4 Time limits for retaking AWOL patients.

13.2. Notification of return

When the patient returns or is located, the person in charge of the ward/department/unit will inform all those who have been contacted previously without delay.

	**If the returning patient is detained under the MHA, the MHA department must be informed using notification on Paris.**

13.3. Power of entry to recover

If entry to the premises where the patient is believed to be located is refused, the police only have powers of entry:

- if it is necessary to save life or limb - S17 (1)(e) Police and Criminal Evidence Act 1984; or
- to recapture a patient who is unlawfully at large and whom the police are **immediately pursuing** - S17 (1)(d) Police and Criminal Evidence Act 1984; or
- to prevent a breach of the peace; or
- if a warrant is obtained under S135 Mental Health Act 1983 to retake a mental health patient who is unlawfully at large back into custody or because there is reasonable cause to suspect that a person is suffering from mental disorder and is either being ill-treated, neglected or is living alone and is unable to care for him/herself.

	**The police are not able to obtain a warrant under S135 of the MHA. See TEWV interagency policy for the operation of sections 135 and 136 MHA 1983.**

13.4. Responsibility for transport

"Where a patient who is absent without leave from a hospital is taken into custody by someone working for another organisation, the managers of the hospital from which the patient is absent are responsible for making sure that any necessary transport arrangements are put in place for the patient's return"

(Paragraph 17.30 MHA Code of Practice).

	This means that the hospital that detained a patient is responsible for transporting the patient back to the hospital they went missing from.

13.5. Unsuitability of police transport

	Patients should always be conveyed in a manner which is most likely to preserve their dignity and privacy consistent with managing any risk to their health and safety or to other people' (Paragraph 17.3 MHA Code of Practice).

	When making arrangements for the return of patients temporarily held in police custody, hospital managers should bear in mind that police transport to return them to hospital will not normally be appropriate (Paragraph 17.32 MHA Code of Practice).

	Where long distances are involved, patients should always be transported in ambulances rather than police vehicles. Where practicable, given the risk involved, an ambulance service (or similar vehicle) should be used even where the police are assisting (Paragraph 11.18 Code of Practice Mental Health Act 1983).

13.6. When the police will transport

If a patient is unlawfully at large and is taken into custody by the police then the police will, wherever possible, transport the patient back to the hospital that detained them providing this is not inappropriate due to:

- the excessive distances involved (police transport is not considered to be suitable to transport a mental health patient long distances); or
- the patient's current condition (e.g. if they are violent or under the influence of drugs or alcohol).

	If the patient is taken directly back to the ward/department or unit, the police should ensure the patient is calm and stable before leaving the patient with the Mental Health staff, particularly if the patient is violent or aggressive.

13.7. If police transport is not appropriate

Where it is inappropriate to use police vehicles to transport the patient back to the hospital that detained them, which may be due to the distance involved, the police will transfer the patient to a locally agreed suitable place of safety which will usually be a local hospital.

If the patient has been initially taken to police cells, the patient should be temporarily transferred to a suitable local hospital pending collection. The hospital who originally detained the patient should provide that hospital with written authorisation to hold the patient temporarily pending collection.

Where a patient requires transport between hospitals, it is for the managers of the hospitals concerned to make sure that appropriate arrangements are put in place

(Paragraph 17.29 MHA Code of Practice)

	**The hospital that originally detained the patient is responsible for making those arrangements.**

When returning a detained patient to hospital Trust staff will use the most appropriate and practical form of transport.

Choices include using a Trust vehicle, a taxi or ambulance.

- a taxi may be used to return a patient located in the local area back to the hospital,
- a Trust vehicle where available may be used to collect and return an AWOL patient who has been located out of the area, for example has been picked up by police and is in Leeds.
- ambulances would be used where the specific circumstances require this

The return will be facilitated by the most appropriate staff, for example:

- ward staff,
- Crisis Team staff or
- Community Mental Health Team staff

The choice will depend on availability and numbers required as indicated by a risk assessment and the assessed needs of the patient.

	**The police should only be asked to assist in returning a patient to hospital if necessary: for example where the patient is violent and police assistance is required to prevent a breach of the peace.**

13.8. When the location of the patient is known

If a Mental Health Trust is informed that a patient who is unlawfully at large is staying at a particular address, it is the responsibility of the Mental Health Trust to attend and collect the patient.

If the patient's location is known, the role of the police should, wherever possible, be only to assist a suitably qualified and experienced mental health professional in returning the patient to hospital

(Paragraph 28.14 MHA Code of Practice)

13.9. Returning patients who are not liable to be detained

	**If a patient who is not liable to be detained is located, the Mental Health Trust is responsible for transporting the patient back to the original hospital, ensuring that they have the legal authority to do so.**

When returning an informal patient who is willing to return to hospital Trust staff will use the most appropriate and practical form of transport as described at 13.7 above

The return will be facilitated by the most appropriate staff.

In some situations an escort may not be necessary for an informal patient, for example if a patient has been contacted by phone and agreed to return it may be appropriate to send a taxi to collect the patient.

On some occasions, it will be appropriate for the police to leave the patient at the location that they have been found whilst the Mental Health Trust make the necessary arrangements to collect the patient.

	**However the police should not leave the patient at a location where they are likely to suffer harm, cause harm to another person, or go missing again prior to being collected**

In these circumstances, if there is likely to be significant delay in collecting the patient, the police may need to consider returning the patient **with their consent** direct to the hospital ward, department or unit or consider taking the patient, **with their consent**, to a local police station until the ward, department or unit can arrange collection.

	**In arranging for the return of mental health patient who is not liable to be detained, the welfare of the patient and the public are the paramount considerations.** **The patient and the public must not be put at risk as a result of disputes between agencies over responsibilities.**

13.10. If a patient who is not liable to be detained refuses to return

	**If a patient who is not liable to be detained refuses to return there is no power to use reasonable force to return them unless there are sufficient grounds to detain them under S135 or S136 Mental Health Act 1983.**

If a patient who is not liable to be detained refuses to return to the ward/department/unit:

- the mental health staff will attempt to speak to the patient, or the responsible person at the scene, either in person or on the telephone;
- attempts will be made to establish the patient's intentions and the level of concern at the time;
- discussions will take place between the clinical team, relatives and the police to establish the next steps (this may include discharge, arranging a visit by the Crisis Team or Community Mental Health Team, or assessment under the Mental Health Act).

All actions and decisions will be fully documented in the patient's Paris record in accordance with professional guidelines on record keeping

13.11. Return interview

When the patient is found or located, it is important that a return interview is conducted to establish:

- why the individual went missing;
- what they did;
- where they went; and
- what action now needs to be taken to prevent a reccurrence?

If the person was categorised as 'missing' any required information must be provided to the police who will then record details on the Police Missing Person Computer System.

It is usually more appropriate for a trained mental health professional to conduct the return interview of a mental health patient unless there are allegations that the patient has been the victim of a crime or they have made allegations against staff.

Therefore if the mental health patient has **returned to the hospital** either of their own accord or by another person, there is no requirement for a police officer or Police Community Support Officer to attend **providing** a mental health professional conducts the return interview.

If the mental health patient is located **elsewhere**, a police officer or Police Community Support Officer must attend to ensure the patient is safe and well, but there is no requirement to conduct a return interview providing a mental health professional conducts the return interview on the patient's return to hospital.

If there are concerns that the patient went absent as a result of circumstances relating to their placement, consideration should be given to whether it is appropriate to return the patient to their previous environment, initiate an investigation, or activate Safeguarding Adult procedures.

13.12. Medical examination and investigation

The patient's physical and mental health must be assessed by a doctor on return.

The patient's observation and leave status must be reviewed.

If there is any concern that the patient has been the victim of, or responsible for a crime, it may be necessary to secure evidence for forensic examination.
This may include securing clothing and / or delaying washing or bathing where appropriate.

The police will investigate allegations of physical or sexual abuse and take whatever steps are necessary to protect the patient from further abuse.

Adult / Child Protection Procedures must be followed.

14. Multi-agency meetings

14.1. Patient who is still missing

If a patient is not found within 48 hours or there are particular high risk factors, the person in charge of the ward / department / unit will arrange an urgent multi-agency meeting to:

- Review the action taken to date;
- Ensure that all possible steps are being taken to find the patient;
- Develop a strategy to find the patient; and
- Agree a combined response.

These meetings will be attended by:

- Relevant clinical staff;
- Family members / carers where appropriate;
- The Police Duty Inspector or representative;
- A representative from the Patient Safety Team must be invited.

14.2. Where a patient regularly goes missing

Staff in all organisations concerned should avoid dismissing the potential significance of repeated absconding. Often such individuals are immediately labelled as a problem and insufficient consideration given as to why they persistently abscond. Persistent absconding needs to be explored with the patient and preventative action considered.

If a patient repeatedly absconds or causes specific concern due to risk factors, a meeting will be held to discuss preventative action and the appropriate combined response to future incidents. This will include:

- agreeing a risk assessment that considers the likelihood of the patient absconding again and the risks the patient may be exposed to whilst absent;
- agreeing a reporting strategy;
- recommending the minimum enquiries to be conducted by the Trust and by the police should the patient go missing again;
- agreeing an appropriate return strategy;

- agreeing a return interview strategy; and
- considering appropriate interventions to address the long-term issues.

These meetings will be attended by:

- relevant clinical staff;
- family members/carers if appropriate;
- the Police Divisional Missing Person Co-ordinator or representative;
- a representative from the Patient Safety team if appropriate;
- the patient if appropriate.

15. Audit

The patient safety team will audit compliance with this policy. This will include

- Monitoring of the process when a patient absents themselves from an inpatient setting;
- Monitoring of the process when a patient fails to return from a period of leave of absence.

The results and any subsequent actions will be considered by the Mental Health Legislation Committee on an annual basis.

16. Organisational learning

Incidents of AWOL will be recorded as incidents following TEWV Incident reporting and investigation policy.

17. Document Control

Date of approval:	10 January 2017	
Next review date:	31 January 2022	
This document replaces:	CLIN-0006-v4 Missing Persons Procedure	
Lead:	Name	Title
	Mel Wilkinson	Head of Mental Health Legislation
Members of working party:	Name	Title
	Simon Marriott Mel Wilkinson Lorraine Joyce Mark Hall Bill Scott Jane Wilson Ian Kelly	Training and Policy Manager Head of Mental Health Legislation Durham Constabulary Cleveland Police North Yorkshire Police Cleveland Police Durham Constabulary
This document has been agreed and accepted by: (Director)	Name	Title
	Elizabeth Moody	Director of Nursing and Governance
This document was approved by:	Name of committee/group	Date
	Mental Health Act Committee	21 October 2016
This document was ratified by:	Name of committee/group	Date
	Executive Management Team	10 January 2017
An equality analysis was completed on this document on:	10 January 2017	

Change record

Version	Date	Amendment details	Status
5	10-Jan-17		Published
5	01 Apr 2020	Review date extended to 30 Sept 2020	Published
5	29 Sep 2020	Review date extended by six months	Published
5	07 Jan 2021	Review date extended by six months	Published
5	July 2021	Review date extended to 31 January 2022	Published

Appendix 1 Classifying absence

The absence is likely to be short term and will be managed by the Trust

It is the Trust's responsibility to locate the person, and the risks do not justify police intervention at this time.

Either:
• the behaviour is not out of character; or
• there is a good explanation for the absence;
And the person is:
• expected to return; or
• is likely to be staying with a relative, friend or associate; or
• is likely to be at one of several known locations;
And
• the person is not expected to suffer or cause harm whilst absent.

Examples:

"A patient has left the ward. He usually goes for a cigarette and a walk and then returns of his own accord. There is no immediate risk providing he returns within the next few hours."

A detained patient was granted leave last Friday and was due to return at 10am today. It is now 12pm and she has failed to return. She is likely to be at her home address or her mother's."

Other absences managed by the Trust

Other absences will initially be managed by the Trust and should not be automatically notified to the police if all of the following are true:

• the person is over 16 years or age, is capable of independent living or has gone missing with a parent, relative or carer who is capable of looking after them; and
• the circumstances indicate that the patient has intentionally gone absent; and
• there are no suspicious circumstances; and
• it is not difficult to explain why the patient has gone absent; and

- there are no grounds to believe the person has suffered harm; and
- there is no apparent risk that the patient will suffer harm; and
- there is no apparent risk that the patient will cause harm to another person; and
- the reporting person, family and friends have no significant concerns for the patient's welfare; and
- the reporting person, family and friends have no significant concerns for the welfare of the public.

Examples:

"An informal patient who has left the ward. She informed staff that she was not returning. She is due to see the psychiatrist this afternoon. There are insufficient grounds to detain her under the MHA at this time, but it is in her interests that she is assessed and receives support. The clinical team have reviewed her case and decided that the Crisis Team will visit her."

"An informal patient has declined treatment and left the hospital. We believe he has gone home. He was seen by a neighbour, but he refuses to answer the door. We have made contact by mobile telephone and he states that he has no intention of returning to hospital. The clinical team have reviewed the case and decided to discharge him."

There will nearly always be some level of risk. Consideration must be given as to whether there is sufficient concern to warrant formally assessing the patient under the MHA if they refuse to return to hospital when located

If the intention is to attempt to persuade the patient to return to hospital when located, but to discharge them if they refuse to cooperate, they should **not** be reported as missing to the police.

Missing patients

A patient will be categorised as a **missing person** if:

- They have gone absent or failed to return; and
- the above criteria do not apply; and
- their whereabouts are unknown; and
- there are reasons to believe one or more of the following:
    - there are suspicious circumstances
    - the behaviour is out of character and there is no good explanation for the

absence
○ there is concern that the patient may have suffered harm;
○ the patient is vulnerable and there is significant risk they will suffer harm whilst absent;
○ the patient is dangerous and there is a significant risk they will harm another person whilst absent;
○ the patient has gone absent from conditions of medium security.

Examples:

'A patient has just walked off the ward after assaulting a member of staff. He is currently unstable and poses an immediate risk to the public.'

'A patient has gone missing from the ward. She has never done this before and this is completely out of character. The patient is suffering from severe depression and there is serious possibility that she left with the intention of committing suicide or self-harming.'

'An informal patient is missing. Other patients say that he received a letter this morning telling him that his wife has taken out an injunction preventing him entering the family home. He was angry, and was heard to shout "we'll see about that" before leaving the ward.'

'A patient who is subject to restrictions under Part III of the MHA has gone missing from the ward. Initial searches of the ward and hospital have not located the patient.'

Appendix 2 Missing patient report

Missing Patient Report: Part 1 Patient Details					
Name:		**DoB:**		**NHS No:**	
Maiden Name:			**Marital Status:**		
Address:			**Religion:**		
			Consultant/RC:		
			Contact No:		
Tel. No:			**GP & Contact Details:**		
Relative/Carer:					
Address:			**Ward/Service:**		
			MHA Status:		
			Diagnosis:		
Tel. No:			**Date of Admission:**		

Please tick **one** of the following:

• Patient is missing from an inpatient service	
• Patient failed to return from agreed leave	
• Patient is not residing where required as a condition of leave	

When it is noticed that a patient is absent, the following actions must be taken **before** contacting the police unless the patient is:

- Considered particularly vulnerable, including aged 16 years or under
- Considered to be dangerous,
- Subject to restrictions under Part III of the Act.
- Missing from medium security

Action (initial, and give details below)	**Initial**
Make enquiries with other staff/patients/visitors to see if they have seen or heard anything.	
Make enquiries with relatives/friends/associates and other relevant agencies.	
Telephone and send a SMS text message to the patient's mobile phone.	
Alert any reception/security services if working at the time and provide a description and photograph if available.	
Search rooms/wards/departments/units including all locked areas.	
Initiate a ground search of the site and surrounding area	
Request security to check CCTV systems	
Check the home address of the patient	

Time and Date of action	Full details of enquiries (Time, Date and Sign all entries)

Missing Patient Report: Part 2 Brief Description of Patient					
Height		**Weight**		**Build**	
Eye Colour		**Hair colour and length**			
Beard/Moustache		**Complexion**			
Distinguishing Marks (tattoos, scars etc.)					
Clothing when last seen					
Evidence of risk of harm to self or suicidal behaviour					
Evidence of risk of harm or violence to others					
Additional information (medical information e.g. medication necessary to sustain life, name of anyone who patient may be in the company of, name and address of people the patient may visit etc.)					
Date and time reported missing					
Name of person completing					
Signature					
Designation			**Date**		

Appendix 3 The Police National Decision Making Model

THRIVE is a risk management tool which considers six elements to assist in identifying the appropriate response grade based on the needs of the caller and the circumstances of the incident.

The practice of response grading being dictated by incident classification (e.g. serious acquisitive crime) no longer takes place.

All incidents are subject to the application of professional discretion.

T	**Threat** This would include identification of whom or what is subject to any threat and what threat has been made: • Person(s) • Property • Force reputation • Public safety • Community cohesion
H	**Harm** If any threat identified were realised or the circumstances of an incident were to deteriorate what would the harm caused be?
R	**Risk** The likelihood of something occurring based on: • Intelligence • Information • Comments • S.O.P.s • Previous calls
I	**Investigation** Is there a need for an investigation, and if so, in what form and by whom: • Crime in progress / recently discovered? • Suspect seen? • Known offender? • Forensic evidence? • CCTV? • Property value? • Injury level • S.O.P. / Response Plan in use
V	**Vulnerability**

	Is someone connected to the incident 'vulnerable'? Taking into account: • Repeat victimisation • Family circumstances (e.g. Child at Risk in premises) • Personal circumstances (drugs / alcohol) • Health and disability • Equality and diversity factors • Economic circumstances
E	**Engagement** The needs of the caller or circumstances of the incident may represent an opportunity for engagement, particularly if the caller is from a hard to reach group or would benefit from a reassurance visit. This factor should be considered when identifying: • The appropriate response grading • The need for a neighbourhood policing team referral.

Appendix 4 Time limits for retaking AWOL patients

Section 5(4)	Not after expiry of 6 hour period beginning from the time and date of the section implementation
Section 5(2)	Not after expiry of 72 hour period beginning from the time and date of the section implementation
Section 4	Not after expiry of 72 hour period beginning from the time and date of the section implementation
Section 135	Not after expiry of 72 hour period beginning from the time and date of the section implementation
Section 136	Not after expiry of 72 hour period beginning from the time and date of the section implementation
Section 2	Not after expiry of 28 day period beginning from the date of section implementation
Section 3	Not after expiry of current period of detention or 6 months from the date of absconding – **whichever is the later**
Section 37	Not after expiry of current period of detention or 6 months from the date of absconding – **whichever is the later**
Section 47	Not after expiry of current period of detention or 6 months from the date of absconding – **whichever is the later**
CTO	Not after expiry of current period of the Community Treatment Order or 6 months from the date of absconding – **whichever is the later**
Restricted patients	No time limits whilst the Restriction Order is in force
Please contact the MHA Department for clarification if necessary	

Appendix 5 Disputes about classification and risk

- Any dispute over the categorisation of risk or how an absence should be recorded will be referred to the Duty Police Inspector and the relevant manager.
- The Police and Mental Health Trust are seeking to develop a partnership approach to dealing with individuals who go missing so the Duty Inspector and the relevant manager must make every effort to find agreement on the appropriate categorisation of absence.
- However, where agreement cannot be reached, it will ultimately be the Police Duty Inspector that decides whether the police will take a "missing person report" and accept responsibility for searching for the absent patient. The Duty Inspector must take into account the concerns expressed by the relevant manager and all decisions must be recorded as they are subject to independent scrutiny.
- Where there has been a disagreement between the duty Inspector and the relevant manager that has not been satisfactorily resolved locally, this should be referred to the Police Chief Inspector for that area and the mental health Trust Clinical Service Manager/Area manager for discussion, review and future development.