Birmingham and Solihull Mental Health NHS Foundation Trust

Missing Patient Policy

Policy number and category	**C37**	**Clinical**
Version number and date	**3.1**	**August 2021 – Updated May 2024**
Ratifying committee or executive director	**Clinical Governance Committee**	
Date ratified	**April 2022**	
Next anticipated review	**April 2025**	
Executive director	**Executive Director of Quality & Safety (Chief Nurse)**	
Policy lead	**Associate Medical director for Mental health legislation**	
Policy author *(if different from above)*		
Exec Sign off Signature (electronic)		
Disclosable under Freedom of Information Act 2000	**Yes**	

Policy context

This document lists the actions to be taken when a patient is missing from a community or inpatient setting or absent without leave (AWOL). This policy applies to all patients open to Birmingham and Solihull Mental Health NHS Foundation Trust (BSMHFT).

The Policy needs to be implemented in the context of Right Care Right Person National Framework, National Police Chief's Framework Guidance and The National Multi-agency Response for Adults Missing from Health and Care Settings Guidance for England.

Policy requirement (see Section 2)

This policy replaces all previous Trust and Locality policies and procedures relating to patients who are Missing / Absent Without Leave (AWOL).

The policy describes the actions to be taken when a patient is missing or AWOL

The actions required are described as they relate to Informal inpatients, Detained patients who are AWOL and patients in the community.

The Policy needs to be read in line National Partnership Agreement: Right Care, Right Person (RCRP)

1. Introduction

1.1 Rationale

Birmingham & Solihull Mental Health NHS Foundation Trust (the Trust) has a duty to provide safe and effective services for those who are receiving a service from the Trust. This document lists the actions to be taken when a patient is missing from a community or inpatient setting or absent without leave (AWOL).

1.2 Scope

This policy applies to all patients open to Birmingham and Solihull Mental Health NHS Foundation Trust (BSMHFT). Patients open to the Trust who are detained under the mental health act, or liable to be detained under the act, when missing are to be treated as being absent without leave (AWOL)

All employees of BSMHFT and those working with the Trust as students or other training roles, secondments or under contract, including agency workers.

A missing person is anyone whose whereabouts can't be established and:

- The context suggests the person may be a victim of crime; or
- The person is at risk of harm to themselves or another; or
- Where there is particular concern because the circumstances are out of character, or there are ongoing concerns for their safety because of a previous pattern of going missing.

1.3 Principles

- The safety of BSMHFT patients is of paramount concern.
- The Trust recognises the need to make clear the difference between AWOL and Missing Patients and the differences in approaches to be taken between the two groups.
- The Trust has a legal obligation to correctly apply the MHA when a patient is AWOL.
- When a patient is missing or AWOL it is likely BSMHFT will need to involve our partners. We will only ask for assistance from partners when it is necessary to do so.
- The patient will be immediately categorised as a missing person where there is critical concern for the patient's or public's safety that justifies an immediate police response (i.e., an Article 2 or Article 3 duty, or there are suspicious circumstances that suggest the patient may have been a victim of a serious crime);
- The patient will not be categorised as a missing person where there is no critical concern for the patient's or the public's safety unless the BSMHFT has conducted reasonable actions to locate the patient, including checking the patient's home address, and the patient is now considered to be missing from home, as well as missing from the medical facility.
- If there is critical concern that justifies an immediate police response, the police would normally record the patient as a missing person and conduct enquiries to locate the missing patient.
- If there is no critical concern that justifies an immediate police response as per the police. BSMHFT has to conduct reasonable actions to locate the patient, including checking the home address where possible and safe to do so (with police assistance where appropriate), lack of action of one agency does not absolve another agency of its responsibilities to protect life and prevent degrading treatment (suffering).

- Where there is disagreement as to whether there is critical concern regarding the missing patient between the reporting nurse and the Police.
- The Police should provide their reasoning for the decision in writing via email to the nurse. The Nurse should seek the reasoning in writing via email if not readily provided.
- **BSMHFT clinicians are the experts on mental health diagnosis, including identifying those conditions that carry an increased risk of suicide, and assessing the risk of suicide generally and their assessment of critical concern in this area should be accepted by the Police. Should this not be accepted.**
- **This will be escalated to the senior most nurse in the Hospital (CNM, Duty senior nurse) at that time and the RC (responsible clinician)/consultant psychiatrist . Who will then follow the escalation procedure as set out in Appendix K.**
- Predicting low frequency events such as suicide is not possible with Any degree of accuracy based on a risk assessment tool. Events such as serious harm or death even in the most severely mentally ill are low frequency events.
- Current NICE guidance (National Institute of Clinical Excellence)[1] recommends that the NHS.
- Do not use risk assessment tools and scales to predict future suicide or repetition of self-harm.
- Do not use risk assessment tools and scales to determine who should and should not be offered treatment or who should be discharged.
- Do not use global risk stratification into low, medium or high risk to predict future suicide or repetition of self-harm.
- Do not use global risk stratification into low, medium or high risk to determine who should be offered treatment or who should be discharged.
- Given the above Global Risk stratification as High, medium and Low should not be made to make decisions.

If there are any significant doubts or disagreements over which category the patient should be allocated, then the critical concern category should be used.

2. The Policy

- This policy replaces all previous Trust and Locality policies and procedures relating to patients who are Missing / Absent Without Leave (AWOL).

- The policy describes the actions to be taken when a patient is missing or AWOL.

- The actions required are described as they relate to Informal inpatients, Detained patients who are AWOL and patients in the community.

[1] **https://www.nice.org.uk/guidance/ng225**

3 The procedure

3.1 Inpatients who are missing

3.1.1 Stage 1 – Detained or Informal Patient Missing or Unaccounted For

Any member of staff, who becomes aware that a patient has gone absent without leave or is otherwise unaccounted for, should immediately inform the nurse-in-charge of the patient's ward. Not all patients who leave a health facility without being formally discharged are missing people. Many patients go home and consequently their whereabouts can be easily established. A missing patient is not a missing person if they are at home and they are not considered high risk / of critical concern.

The nurse-in-charge will ensure that the following procedures are undertaken whilst completion of the first part of the Trust's 'Missing Patient Form 1' is completed (Appendix A).

If it is certain that the missing patient is NOT on the ward, for example they have left the hospital grounds or have not returned from leave, the nurse-in-charge will go directly to Stage 3 of this procedure. Otherwise the nurse in-charge must implement Stage 2.

The nurse-in-charge should inform the patient's Responsible Clinician (RC) immediately if they are on duty or at the earliest opportunity when the RC returns to duty.

MHL office doesn't need Missing Patient Form as they get the eclipse of AWOLS.
Patients who are detained in a Low, Medium or High secure hospital, must have their absence reported to the Care Quality Commission (CQC)

Restricted patients must have their absence reported to the Ministry of Justice. When they return from absence that too must be reported to MoJ. Reporting forms are in appendix G.

There is no automatic requirement to notify the victim when a restricted patient (see section 8 for definition of restricted patient) or a Section 37 patient absconds, but the risk to any identified victim should be considered and care planned in a section 17 leave process and via the MAPPA process. In all events of a restricted patient being absence there should be an immediate consideration of any victims. A discussion with the Responsible clinician or on-call Consultant must inform part of that discussion.

3.1.2 Stage 2 – Initial Search

The objective of an initial search of the ward is to confirm that the patient is not within the confines of the building in which the ward or unit is situated.

The nurse-in-charge must organise a thorough search of the ward and other areas within the building, including any adjacent rooms, corridors, cupboards, pathways or roadways.

If the patient is not located, the nurse-in-charge must then contact any other wards, departments or services on the same campus or site and request that a similar, thorough search is undertaken within those buildings.

If the patient is located outside of the ward and in the hospital grounds, staff should attempt to persuade the patient to return.

In the case of a detained patient, if all attempts at persuasion fail to achieve a detained patient's return and there is enough staff present to safely affect a forced return, then force may be used providing that it is 'reasonable'. In these circumstances, 'reasonable' means the minimum force to achieve the required outcome.

Where an informal patient leaves the ward and is located within the hospital grounds, or in close proximity to the hospital the patient, if willing, should be persuaded to return.

If a voluntary patient has left the ward, and is found in the hospital grounds, but is unwilling to return to the ward, then a nurse of the prescribed class (RMN / LD Nurse) should consider whether there are grounds for the implementation of the nurse's holding power under section 5(4) of the Act. Section 5 (4) can only be used by a qualified mental health or learning disability nurse, who cannot be instructed to use the power but must make a personal decision. It can only be used when the patient is still on the Trust premises. The nurse using the power must be satisfied that the patient is suffering from a mental disorder to a degree that it is necessary for their health or safety, or the protection of others, that they are not allowed to leave the hospital.

If an informal patient is located outside of the hospital grounds and refuses to return, the return of an informal patient to hospital against their will would require the police to use a Section 136 and take them to a place of safety for a Mental Health Act. Police may only use this power while a patient is outside of a domestic residence.

If the patient is not located after Stage 2 is completed, then the nurse-in-charge will proceed to Stage 3 below.

3.1.3 Stage 3 – Determining the Category of Risk

For the purpose of determining whether to notify the police service within these procedures the current Trust approved Risk Assessment document should be completed and documented within the patient's clinical record. The Decision-Making Tool in Appendix C should also be completed. The following definitions may aid decision making:

Critical concern is the wording for the purpose of communicating with the police.

The missing patient presents a risk to themselves or others. The patient may be subject to a detention order under the Act, or they may be informal or voluntary.

Other factors that need to be considered include any potential victims or child protection issues. Such a decision must be made jointly involving the nursing team on duty and the Clinical

Service/Nurse Manager (CS/NM) or Lead Nurse (or on-call manager if out of hours) and a member of the RC's medical team or the on-call junior doctor, who may wish to consult the consultant on-call.

The patient must be located and returned directly to hospital or taken to a place of safety from where s/he can be returned to hospital as soon as possible. The police may, at their discretion, undertake a full search of the hospital grounds on larger hospital sites when patients who are assessed as 'critical concern' are reported as missing.

Any patient subject to a restriction order (section 41 or 49) under Part III of the Act is automatically in the critical ***concern category*** *if they are absent without leave and the Ministry of Justice must be informed.*

Examples of critical concern

- where a patient is suicidal and there is concern that they have no intention of going home but are likely to go to a remote location to complete suicide,
- where a patient who has left a health facility is suffering serious mental health issues, is dangerous, and poses an immediate serious risk to the public's safety,
- where a patient is suffering from dementia, a learning difficulty, or is lacking capacity, and there is concern that they will be unable to find their way home safely,
- where a patient is suffering from a serious physical illness or injury and there is concern that before they arrive home, they may collapse, suffer serious bleeding, or exacerbate an injury that may result in a permanent disability or long-term medical complications. For example, a serious head injury, deep wound, compound or complicated fracture, or overdose.
- The above is not an exhaustive list but are examples of the threshold that would justify immediately reporting a patient who has left a health setting as a missing person to the Police with critical concern.

Where there is no critical concern

The patient is detained or liable to be detained under the Act but is considered not to present any danger to themselves or others. The decision must be made jointly between the ward nursing team, the CS/NM (or on-call manager if out of hours) and a member of the RC's medical team or the on-call junior doctor who may seek advice from the consultant on-call. This category will apply to detained patients who have received a full assessment and whose mental state, behaviour and symptoms have improved since admission or are considered to present little or no risk.

The missing patient is not subject to a detention order and does not present any danger to themselves or others. This decision must be made jointly between the nursing team on duty and / or the on-call junior doctor or RC (if available).

If there are any significant doubts or disagreements over which category the patient should be allocated, then the critical concern category should be used.

3.1.4 Stage 4 – Notification

If, at the completion of stage 2, the patient is not located, the nurse-in charge will notify the following people and agencies:

The patient's **nearest relative** (if detained or liable to be detained) must be informed immediately that the patient is known to be absent without leave. A telephone call may be the most appropriate method of contact, but alternatives should be recorded if preferred by the nearest relative. There may be times when it is impractical to notify the nearest relative immediately, but all efforts must be made to inform them within one hour after the patient's absence is known and documented.

Sharing information with the nearest relative should only happen where we have a record that the AWOL patient has consented to them being kept informed of any care changes etc. The exception to this is where there is a risk to the nearest relative. See code of practice 4.31 to 4.36 CoP.

For *informal patients*, the **next of kin** and / or a friend / carer / relative previously identified by the patient should be notified immediately unless there are sound reasons for not doing so. An example where it may not be appropriate to notify the next of kin or others is where a voluntary patient has expressly stated that they do not want their relatives to know their whereabouts and there are no assessed risks.

If there are child protection / victim protection issues, then the appropriate agencies need to be informed.

Other persons or agencies that may need to be informed of the patient's absence are detailed in Table 1 below:

Remember that a missing patient's Risk Category can alter whilst the patient is absent without leave or missing and that all agencies must be informed of any decision to alter their Risk Category.

3.2 Detained Patient Absconding from Escorted Leave

If a detained patient absconds while on escorted leave, the nurse in charge of the ward must be immediately informed. Subject to the risk assessment in section 3.3.1, if there is critical concern the West Midlands police must also be informed.

The patient's S17 leave must be immediately revoked on RIO /in writing. This will give any approved social worker, by any officer on the staff of the hospital, by any constable, or by any person authorised in writing by the managers of the hospital powers to detain the patient under section 18 MHA.

Staff should make efforts to maintain observations and track the patient's location.

It should be decided before leave commences if police will be notified in the event of the patient absconding.

In order to contact the nurse in charge, the escort must take with them a means of mobile communication.

TABLE 1: WHEN TO INFORM AGENCIES / INDIVIDUALS

AGENCY	For ALL categories of risk, the following people should be informed within the given timescale
SDM(service manager)	Immediately
POLICE	Immediately, if there is critical concern i.e. a need to inform police
MHA ADMINISTRATOR	Immediately
Medical Staff	**Office Hours**: RC or Consultant ASAP **Out of Hours**: On-call Junior Doctor Immediately
Switchboard Operator	Immediately (0121 301 0000)
Out of Hours: CNMs/CSMs(nurse manager /service manager) (via Senior Duty Nurse)	CNMs/CSMs discretion as to when on-call Duty Manager is informed
Nearest Relative / Next of Kin	Within 1 Hour of patient missing, if permission exist to inform them
Local Authority	If involved, inform by 09:00hrs the following day working day
Care Co-ordinator	Within 24 hours
Care Quality Commission	As soon as a **detained** patient is AWOL from a Low, Medium or High Secure hospital.
Ministry of Justice	When restricted patients go AWOL and when they return

3.3 Returning an AWOL Patient

Section 18 of the Mental Health Act provides powers for the return of patients who are absent without leave and liable to be detained in hospital. The patient may be taken into custody and returned to hospital by an Approved Mental Health Professional (AMHP); any officer on the staff of the hospital; any police officer; or any person authorised in writing by the hospital managers. More

than one agency may be involved in returning the patient, so cooperation between agencies is vital.

If the police locate an AWOL patient, they may either return the patient to hospital or inform the appropriate Trust manager of the patient's whereabouts. Section 6 of this policy details the procedures for returning missing patients when they are located.

The National Police Chief's Council. Advice to Police Forces on the Interpretation of the Multi-agency Response for Adults Missing from Health and Care Settings Framework id found in appendix D.

When a patient who is liable to be detained, is located outside of the West Midlands, the CNM or on-call manager if out of hours, is delegated to act on behalf of the Hospital Managers to authorise the detention of the patient at a local hospital in writing. Such authority can be provided by fax. The manager should also ensure that the relevant clinical details are provided to the host hospital.

3.4 Return of AWOL Patients

The detaining hospital has primary responsibility for returning AWOL patients to their place of detention.

Where healthcare staff seek police support in their attendance to return an AWOL patient, this can be offered by police where a patient is likely to be 'violent or dangerous' in order that officers can prevent a breach of the peace. Agreeing to joint attendance against this threshold is perfectly permissible and often necessary to prevent serious risks to healthcare staff.

When the missing patient is located, the CNM or on-call manager, as appropriate, is responsible for taking the decisions as to what staff and resources are to be utilised in organising the return of the patient. See Box 2 below.

Example

A missing patient is located after normal hours and a member of the ward nursing team has a positive relationship with the patient. The only community team available to assist may be the Home Treatment Team. It would be appropriate in these circumstances for the manager to deploy a member of the HTT to the ward to cover the duties of the ward-based nurse to facilitate the involvement of the ward-based nurse as part of the team sent to persuade the patient to return.

The manager responsible may request police assistance only if they think this is necessary.

The manager responsible for organising the return of the patient will make a decision as to the mode of transport used as well as the number and skill mix of staff required to ensure the patient's

safe return. In circumstance where police assist, it will be highly unlikely that they would return a patient in a police vehicle.

Where a detained patient is taken to another hospital, the CS/NM (clinical service manager , nurse manager) may make arrangements for the return of the patient or delegate responsibility for organising the patient's return to the nurse in charge of the ward. The person organising the return should ensure that the appropriate transport and escorts are organised to collect the patient, usually within 36 hours of receiving notification of their whereabouts.

Where a patient who is liable to be detained is believed to be on premises to which access has been refused, then an officer of the hospital can be authorised by the CNM to apply to a magistrate for a warrant under section 135(2). The warrant will authorise any police constable to enter the premises, if need be by force, and remove the patient. West Midlands Police will expect NHS staff who can take ownership of the detainee's care to be present when executing a warrant under s135(2).

The Clerk to the Magistrates Court has agreed a "fast-track" procedure for the application of a warrant under section 135(2), and this is attached as Appendix E of this policy. Section 135(2) warrant would be normally secured by NHS staff (Social worker in secure care, and social worker/ care coordinator / CS/NM in other settings.

Where a patient who is AWOL is taken into custody or returns after 28 days, within the first week, the RC must examine the patient and if the relevant conditions are satisfied complete; Form H6, renewal of authority to detain or CTO8 for CTO patients or form G10 for guardianship patients. If this authority to detain isn't completed within one week, the detention / guardianship will lapse, and the patient will automatically become informal.

If the patient remains AWOL past midnight on the first day of AWOL and is detained / or liable to be detained, the Nurse in Charge must inform the Care Quality Commission using the reporting form found on the Trust Intranet on the MHA page. This practice ensures the most up to date version of the form is being used.

3.5 Time Limits

Patients who are absent without leave and on Section 3, 7, 37 (both hospital order and guardianship order) 47 or a recalled community treatment order can be returned:

Up to six months after going absent without leave.
Or
Until the expiry date of the section they are under

Patients on restricted Sections 37/41, 47/49 and 48/49 are not subject to time limits and can be retaken for as long as their section is in force.

Should a patient remain absent for a prolonged period, regular clinical reviews of the patient's absence and risk must be completed and documented.

For patients identified as High Risk/critical concern, a daily appraisal of the information and circumstances must be undertaken.

For those patients who are assessed as a Medium Risk, reviews should be arranged twice each week for the period of the patient's absence.

For Low-Risk patients, such reviews should occur as agreed by the team involved, but should be undertaken at least every two weeks.

The reviews indicated above should involve, as a minimum:

- The RC for the patient
- The nurse in charge of the ward or community team responsible for the patient's care whilst on leave.
- A CS/NM.
- A representative from the police should be invited if there is sufficient concern over the patient's absence.
- In the event a police representative is unable to attend, CSM to make contact with relevant lead in WMP for update and ensure risk status of missing patient is agreed between mental health services and police. If there is a change in risk status by police, which is not agreed by the mental health team, this can be challenged via the escalation route with WMP (annex K)

These reviews will be to consider the current risk status of the patient, review all actions taken to locate the patient and to agree any further actions that may be appropriate. This may include press involvement for which detailed guidance is found in the Patient safety policy. In general, however, all press contact should be channelled through the Trust's Director of Communication on 0121 301 1296 or in their absence the Media & Communications Manager or member of the Communications team on 0121 301 1298, who will be responsible for liaison with the media and

communication with the Chief Executive Office. No member of staff should speak to the press unless the above channels of communication have been followed.

3.6 Missing Community Patients

When a member of a Community MDT becomes aware that a patient is missing from their normal residence the following actions should be considered and documented accordingly on RIO
An MDT meeting or discussion should be held as soon as reasonably possible and include the Team Manager and Consultant or their deputies.

The risks to the patient or others should be assessed by thorough review of RIO documentation including clinic letters, progress notes, care plans, advance statements and risk assessments with particular attention paid to any recent communication from the missing patient.

Assessment of this risk should take into consideration any recent adverse events, significant anniversaries, community disruption (such as neighbour disputes, gang activity etc.)

For patients considered to be at critical concern the police should be contacted. This needs to be reviewed on an ongoing basis as the risk may increase in line with the duration of being missing.

Where there is a registered carer or a next of kin recorded on RIO contact should be made with them to assist with locating the individual. Where the MDT feel, this may lead to a breach of confidence the decision to do so must be subject to MDT discussion and documented accordingly.

In similar fashion the MDT must consider contacting known friends, associates, ex-partners and wider family members after due consideration of confidentiality issues.

Repeated efforts should be made to visit the patient's normal residence and "calling cards" with a polite and clear message asking the individual to contact his community team should be left on each occasion.

The individual should be telephoned (or video called, or texted, or e-mailed or any combination thereof) asking them to contact the community team. A more formal letter may also be posted or left at the residence.

Contact should be made with other agencies involved in the individual's care – this may include the GP, social care, employment support agencies, advocates etc. When contacting any of these the last known contact should be elicited together with a view (if possible) on the individual's mental state or general demeanour. Last known collection of prescriptions from GPs and dispensation from relevant chemist should be determined.

Discreet enquiries may be made with neighbours without disclosing the nature of the team's involvement.

The community team should consider asking the HT team to visit on an out of hours basis.

In the event of successfully locating the individual then consideration should be made to amending care plans, contact details, risk assessments and alerts on RIO to reflect the possibility of repeated events in future and to guide the MDT response.

3.7 Recording

Every step of the procedure must be fully documented and relevant documents completed within the patient's care record and copies of all forms kept for the records.

All incidents of AWOL must be recorded on ECLIPSE (the Trust electronic Incident Reporting System).

4 Responsibilities

This should summarise defined responsibilities relevant to the policy.

Post(s)	Responsibilities	Ref
All Staff	All staff will ensure Chapter 28 of the MHL Code of Practice (2015) is adhered to in relation to AWOL patients. The Nurse in Charge / Ward Manager will ensure that the Care Quality Commission (CQC) is notified of any **detained** patient AWOL from a secure environment) The Nurse in Charge / Ward Manager will manage the AWOL situation using the checklist in **Appendices**. The Nurse Manager (CNM) or On-Call Manager (out of Hours) will provide support and assistance where appropriate. All AWOL incidents will be recorded on ECLIPSE (the Trust Incident Recording System)	
Nurse in Charge	**Responsibilities** The nurse in charge of the ward is responsible for ensuring that all required agencies and persons are informed within the relevant time scales. This is to be recorded on the AWOL checklist (Appendix F)	
Clinical Service Manager	For High-Risk category patients, the CSM's responsibility is to co-ordinate the attempts to locate the patient immediately. It is the manager's responsibility to notify and determine the level of involvement of the Home Treatment Team. Any delegation of responsibility should occur after the following information has been considered: • The circumstances under which the absence has occurred. • If the patient has failed to return or is recalled from s.17 leave; the length of the authorised leave and any progress reports received during the leave. • The care plan agreed for the leave, and any conditions attached to the leave granted. • If the patient is on CTO, what conditions are attached?	

	• Risk posed by the patient. • Is there an appointed care co-ordinator that knows the patient? • Is there a member of staff with whom the patient has a positive therapeutic relationship? • Any previous episodes of periods of absence without leave? • Any addresses, places or areas where the patient may have been located or has attended previously. • What staff are available, including ward and community-based staff. • Organise appraisal meetings to review the information and circumstances. The frequency of these will depend on the degree of risk. • Ensure all relevant parties are invited to the meetings e.g. police to the appraisal meetings. • Annual audit of	
Policy Lead	• Monitor compliance with the police as set out in section 9. • Review the policy as and when required, but at least every 3 years and when issues relating to missing persons arise in lessons learnt, change of regulations or national policy. • Act as a subject matter expert in relation to missing persons.	
Executive Director	• Ensure the policy is ratified in accordance with trust Procedures. • Ensure the Policy is reviewed at appropriate intervals	
Others…		

5 Development and Consultation process

Consultation summary		
Date policy issued for consultation	may August 2024	
Number of versions produced for consultation	3	
Committees / meetings where policy formally discussed	Date(s)	
Where received	Summary of feedback	Actions / Response
West Midlands Police	Several comments were received regarding clarity of police actions	Comments were incorporated into the policy. The latest police procedures on missing persons has been added to the policy as appendix .

6 Reference documents

- Mental Health Act

- Mental Health Act Code of Practice.
- West Midlands Police Missing Persons Procedures.
- Mental Capacity Act
- Confidentiality Policy
- Right care Right person national partnership agreement **https://www.gov.uk/government/publications/national-partnership-agreement-right-care-right-person/national-partnership-agreement-right-care-right-person-rcrp**
- Right care right person national college of policing tool kit **https://www.bing.com/search?q=right+care+right+person+college+of+policing&cvid=1fa65524cd014126849058eeb9274298&gs_lcrp=EgZjaHJvbWUqBggAEAAYQDIGCAAQABhAMgYIARBFGDkyBggCEAAYQDIGCAMQABhAMgYIBBAAGEAyBggFEAAYQDIGCAYQABhAMgYIBxAAGEAyBggIEAAYQDIICAkQ6QcY_FXSAQkxNzYxMWowajGoAgCwAgE&FORM=ANAB01&PC=U531**
- Right care Right person National police chiefs council advice **https://www.npcc.police.uk/SysSiteAssets/media/downloads/publications/publications-log/national-crime-coordination-committee/2023/npcc-advice-requesting-missing-person-enquiries-in-another-force-and-transfers-of-investigations.pdf**
- Right Care, Right Person position statement - March 2024 | Independent Office for Police Conduct (IOPC)
- The multi-agency response for adults missing from health and care settings (npcc.police.uk)

7 Bibliography:

- Care Records Policy
- Clinical Risk Assessment Policy
- Transporting Patients Policy

8 Glossary

Absence With Out Leave (AWOL)

Patients **detained under Part 2** of the Act and **Sections 37, 47** or **48** are absent without leave if they:

- Are absent from the ward without authority granted under section 17; or
- Fail to return from leave at the specified date and time; or
- Are absent without permission from the address where they are required to live by the conditions of their leave.
- Patients **detained under Part 3** of the Act (excluding s47 & 48) are absent without leave if they:
- Are absent from the ward without authority granted by the remanding court -sections 35 & 36.

It should be noted Patients absent under S38 can only be arrested by police and returned to the court which made the order/remand.

- Fail to return from leave in accordance with Ministry of Justice directions - Sections 37 / 41; 47 / 49; and 48 / 49.
- Are absent without permission of the Ministry of Justice, from the address where they are specifically required to live as part of their Conditional Discharge – section 41.

CTO patients are absent without leave if they:

- Fail to attend hospital when they are recalled.
- Abscond from hospital after being recalled there.

Guardianship patients are absent without leave if they:

- Are absent without permission from the place where they are required to live by their guardian.

Detained Patients

Detained patients are those who are subject to lawful detention under the Mental Health Act, 1983.

Patients who are liable to be detained

People under this category are those who are subject to detention by virtue of an application made under Part II of the Act, or by order or direction under Part III and Hospital Managers have yet to receive the detention papers.

Restricted Patients

An offender can become a restricted patient by a number of routes and may be diverted from the criminal justice system to hospital for treatment by a court under the Mental Health Act 1983. The routes:

1. The court issues a Hospital Order (s37) with restrictions added under s41 (including those found unfit to plead and not guilty by reason of insanity).
2. An offender can be subsequently transferred to hospital from prison by the Secretary of State (s47) convicted prisoners with restrictions added under s49.
3. An offender can be subsequently transferred to hospital from prison by the Secretary of State (s48): remand and unsentenced prisoners, Immigration Detainees and Civil Prisoners transferred to hospital with restrictions added under s49.
4. Hospital directions (s45A/45B): patients with a parallel prison sentence who will be sent to prison if treatment in hospital is successful.

Critical concern

Where there is critical concern for the patient's or the public's safety that creates an Article 2 or Article 3 ECHR duty and requires an immediate police response include:

- where a patient is suicidal and there is concern that they have no intention of going home but are likely to go to a remote location to complete suicide,
- where a patient who has left a health facility is suffering serious mental health issues, is dangerous, and poses an immediate serious risk to the public's safety,
- where a patient is suffering from dementia, a learning difficulty, or is lacking capacity, and there is concern that they will be unable to find their way home safely,
- where a patient is suffering from a serious physical illness or injury and there is concern that before they arrive home, they may collapse, suffer serious bleeding, or exacerbate an injury that may result in a permanent disability or long-term medical complications. For example, a serious head injury, deep wound, compound or complicated fracture, or overdose.

The above is not an exhaustive list but are examples of the threshold that would justify immediately reporting a patient who has left a health setting as a missing person.
Considerations therefore include whether there is concern that:

- does not intend to go home and may complete suicide or cause serious self-harm,
- the person is dangerous,
- the person will be unable to make their way home safely, or
- the patient needs urgent treatment in the next few hours otherwise they may suffer life changing or life limiting injuries and they were either not aware of that when they made the decision to leave or the patient lacks capacity and is unable to understand the consequences of leaving.

Police Response if there is Critical Concern

1) Where a patient who is for the time being liable to be detained under this Part of this Act in a hospital —

(a) Absents himself from the hospital without leave granted under section 17 above; or

(b) Fails to return to the hospital on any occasion on which, or at the expiration of any period for which, leave of absence was granted to him under that section, or upon being recalled under that section; or

(c) Absents himself without permission from any place where he is required to reside in accordance with conditions imposed on the grant of leave of absence under that section, he may, subject to the provisions of this section, be taken into custody and returned to the hospital or place by any approved social worker, by any officer on the staff of the hospital, by any constable, or by any person authorised in writing by the managers of the hospital.

If the level of risk does not justify immediate police deployment, it is unlikely that the threshold of critical concern will have been met, and police forces are entitled to expect the health agency to

conduct reasonable actions to locate the patient, including checking the home address, before the police will respond.

However, even when there is an Article 2 or Article 3 ECHR duty, the framework recommends a partnership response to these emergency incidents. On many occasions in the past, the police have voluntarily assumed complete responsibility to locate missing patients despite Health, Ambulance, and Mental Health having the same Article 2 or Article 3 duty, as those duties apply to all statutory agencies.

Where more than one statutory agency is involved, the question is, which agency should be the lead agency? When a patient leaves a medical facility, if they are suffering a medical or mental health crisis, health or mental health should be the lead agency it is in the best interests of the patient if:

- a BSMHFT member of staff /mental health professional checks the home address if the person is suffering from mental health issues.

This is in recognition of the principle of deploying the most appropriate resource to the home address. Ambulance staff and mental health professionals have more relevant skills, training, and experience than the police to treat and advise the missing patient if the patient has managed to find their way home.

The police are better focussing on the co-ordination of area searches, mobile phone checks, and ANPR checks to locate the patient if the patient has not gone home.

it is not in the best interests of the missing patient for a police officer to attend the patient's home address on behalf of health agencies in order to persuade the patient to return to a hospital, surgery or clinic for treatment. If police officers do attend, they must rely on persuasion as the police have no powers to force a patient to return for treatment even if that treatment is considered life-saving and essential.

Police officers are not trained to explain the health consequences of not receiving treatment and should avoid attempting to do so as they may create legal liabilities. If the patient is suffering a mental health crisis, it can also exacerbate their condition if a uniformed police officer attends their home.

Police forces may therefore decide it is in the best interests of the patient to request an ambulance, health professionals, or mental health professionals to conduct the welfare check at the home address whilst they conduct area searches and other specialist enquiries.

If BSMHFT staff unable to check the home address due to the risk of harm posed by the missing person to BSMHFT staff being assessed as significant and this is not manageable without police support.

This should be conveyed to the police (via recorded 101 or 999 call) and recorded on rio
If there is an Article 2 or Article 3 ECHR duty and when the health agency refuses to deploy a mental health professional, the police should not also refuse to attend, as the failures of other

agencies does not absolve the police from their own Article 2 and Article 3 duties even if health agency is the lead agency and the most appropriate resource to respond.

If the Home Address is Unknown or the Patient is No Fixed Abode

If the home address of the patient is unknown or the patient is no fixed abode, then consideration should be given to whether the patient had capacity, was aware of their medical condition, was aware of the consequences of not receiving treatment and has made an informed decision to leave a health facility prior to treatment. An adult with capacity is entitled to refuse treatment even if they consequently suffer death or serious injury. If the health care setting has reported the patient missing to the police, the police should discuss that risk assessment with the health care setting to decide whether it is more appropriate to consider the patient as a self-discharge.

Police Response if there is No Critical Concern

Where the concern for the patient's safety is not critical and does not require an immediate police response, the police are entitled to expect health facilities to conduct reasonable actions to locate the patient and to establish for themselves whether a missing patient has gone home before reporting the matter to the police. Even if the staff at the health facility cannot themselves physically check the home address, the health facility is responsible for considering alternative ways of doing so. For example, the health facility may consider requesting a relative, friend, ambulance, the community health team, or the mental health team to check the home address on their behalf. Police forces may wish to ensure their local protocols address this issue.

Traditionally, police officers have felt obliged to take responsibility where health are struggling to deploy resources to the home address. However, if there is no critical concern that justifies an emergency police response, police forces may decide not to respond and allow the health facility to resolve the issue in their own time. The police do not owe a duty of care under the common law to conduct welfare checks on behalf of other agencies unless the police create a legal duty of care by agreeing to complete that welfare check. In those cases where the police decide not to complete the welfare check, the police will make it clear to the reporting person that the police will not be responding so that no legal duty of care is created.

If there is a delay in the home address being checked by health, this is acceptable as the risk assessment has indicated that there is no critical concern that justifies an emergency response.

The police do not need to be informed about these incidents where the health facility has not conducted reasonable actions to locate the patient and there is no critical concern.

If the Health Agency has Conducted Reasonable Enquiries.

If the health agency recontacts the police after conducting reasonable actions to locate the missing patient and confirms that the home address has now been checked, and the patient has not returned home as expected, and is therefore also missing from their home address, police forces may then decide to categorise the patient as a missing person if there are any suspicious or concerning circumstances. The police would then conduct a risk assessment and categorise the

risk as high, medium, low, or very low risk in accordance with their 'Missing Person policies' and respond in the same way that they would do to any other report of a person missing from home.

Audit and assurance

9 MONITORING TOOL – MISSING PATIENT POLICY

Elements to be monitored	Lead	Tool	Frequency	Reporting	Acting on Recommendations and Lead(S)	Change in Practice and Lessons to be shared
1A Has an incident form been completed on ECLIPSE for every patient who has been AWOL? (3.9.2)	Matron	Missing Patient Audit	Quarterly	CGC	Recommendations to be prescribed by nominated members of and received by CGC	As determined by the CGC
1B Missing patient form B (appendix B) and C(appendix c) is completed when a patient absents themselves from an inpatient setting (3.9.1)	Matron	Missing Patient Audit	Annual	CGC	Recommendations to be prescribed by nominated members of and received by CGC	As determined by the CGC

10 Appendices

APPENDIX A MISSING PATIENT MONITORING FORM

APPENDIX B MISSING PATIENT FORM 2

APPENDIX C RISK RATING

APPENDIX D POLICE PROCEDURE

APPENDIX E OBTAINING A WARRANT, s135

APPENDIX F AWOL CHECKLIST FOR NURSE IN CHARGE

Appendix A

PART 1: PATIENT REPORTED MISSING

NAME ..... Age .....

WARD / UNIT ..... MHA Section .....

..... Date Missing .....

PATIENT ID NO..... Time Missing .....

..... Time of Arrest .....

RISK CATEGORY: HIGH ☐ MEDIUM ☐ LOW ☐

NOTIFICATION OF PERSON MISSING BY

NAME ..... Band .....

SIGNED ..... Time / Date .....

PART 2: PATIENT FOUND AND RETURNED

CIRCUMSTANCES OF RETURN FOUND BY .....

.....

.....

.....

.....

.....

.....

NAME ..... Band .....

SIGNED ..... Time / Date .....

*Please ensure a copy of this form is sent to the MHA Administrator once Part 1 is complete

APPENDIX B
MISSING PATIENT FORM 2

NOTIFIED MISSING	DATE / TIME	BY WHOM	NOTIFIED RETURNED	DATE / TIME	BY WHOM
POLICE ***(Name, Rank & ID)***			POLICE ***(Name, Rank & ID)***		
Confirm that appendix C has been emailed or handed over to police or/and read out during phone call in full					
RC			RC		
CSN/M			CSN/M		
Switchboard Operator			Switchboard Operator		
Relative / Carer			Relative / Carer		
AMHP			AMHP		
GP			GP		
Care Co-ordinator			Care Co-ordinator		
MHA Administrator			MHA Administrator		
Missing patient form 1 sent					
CQC (If AWOL from a secure environment)			CQC (If AWOL from a secure environment)		

– ONE COPY TO SDM AND ONE COPY TO MHA ADMINISTRATOR**:**
WHEN COMPLETED

– SECOND COPY TO SDM AND ONE COPY TO MHA ADMINISTRATOR:
WHEN COMPLETED AND PATIENT RETURNED

APPENDIX C

RISK RATING informed by Trust Approved Risk Assessment Tool (level1 or HCR20)
(circle appropriate answer and give narrative as appropriate)
To be completed by Nurse In Charge when police are notified of missing patient.
A copy to be handed to Police Officer attending/ emailed to police /or read out during call to police ; a copy to patient's records and to the MHA Administrator

Risk Factor	**Suggest critical concern**	**Set out Why is this risk considered to be present**	
Detention under the Mental Health Act 1983	An application has been, or is being, completed. Patient is presenting a risk to themselves or others.		
Voluntary or Informal Admission	Patient **IS** presenting a risk to themselves or others.		
Features of mental illness such as psychosis , sever depression , mania hypomania	Yes		
Substance misuse?	Dependant on illicit drugs or substances		
Alcohol misuse?	Alcohol dependent		
Suspected imminent risk of suicide or self harm?	Yes		
Involved in a violent and / or racial incident immediately prior to assessment?	Yes - serious incident		
Out of character; *e.g. unusual behaviour prior to assessment; disappeared with no prior indication etc.*	Yes		

Family / relationship problems or recent history of family conflict or abuse	Yes	
Recent or ongoing victim of bullying or harassment trauma ; *e.g. racial, sexual etc.*	Yes	
Non-compliance with medication	Yes	

Appendix D

Advice to Police Forces on the Interpretation of the Multi-agency Response for Adults Missing from Health and Care Settings Framework

Introduction

The *Multi-agency Response for Adults Missing from Health and Care Settings Framework* was commissioned by the All-Party Parliamentary Group for Runaway and Missing Children and Adults and developed in consultation with a dedicated Task and Finish Group.

The framework provides a basis for multi-agency protocols for the strategic and operational response to adults who leave health and care settings including residential care homes. It seeks to ensure that the right care is provided by the right person in the best interests of patients and residents.

The framework can be accessed by clicking on the below link:

Policy paper overview: The multi-agency response for adults missing from health and care settings: A national framework for England - GOV.UK (www.gov.uk)

This supporting advice has been written to assist police forces to interpret the *Multi-agency Response for Adults Missing from Health and Care Settings Framework* in accordance with the intentions of the Task and Finish Group who developed the framework.

The NPCC Lead for Missing People is grateful to health and social care colleagues for acknowledging that the response to missing patients and residents from health and care settings requires a multiagency response and there should not be an over reliance on police resources.

The framework recommends that health and care professionals should make initial enquiries to ascertain the whereabouts of the missing patient or resident before contacting the police unless there is '***critical concern'*** for someone's safety. Police forces may wish to interpret the term ***'critical concern'*** in accordance with their legal duties as:

- a real, immediate risk of death or serious harm that creates an Article 2 ECHR duty and justifies an immediate police response,
- a 'real and immediate risk of cruel, degrading or inhuman treatment, and/or a prolonged period of pain or distress that creates an Article 3 ECHR duty that justifies an immediate police response,
- there are suspicious circumstances that indicate that the person may have been a victim of a serious crime.

The framework is intended to lead to a more consistent approach to missing from health and care settings throughout England.

This framework is currently England specific as the Task and Finish Group, as set-up, was not able to consider the different statutory pictures in Wales, Scotland, and Northern Ireland. However, it is felt that there is potential to extend the application of this framework to Wales, Scotland, and Northern Ireland, perhaps with local-specific amendments, if their national statutory organisations and bodies desire to do so.

Application of the Framework

The Missing Adults Framework only applies to adults who go missing from health and care settings, not to adults who go missing from their private or family home.
It therefore applies to:

1) Adult patients who go missing from temporary locations that they are visiting for treatment such as:
   a) Acute Hospitals,
   b) Doctor's Surgeries,
   c) Medical Clinics.
2) Adult patients who have either been detained under the Mental Health Act, or are voluntary patients, who have been admitted to a mental health hospital for treatment.
3) Adults with care and support needs who are living in a residential care home providing care and accommodation such as:
   a) residential care homes for the elderly; and
   b) residential care homes for people with disabilities or learning needs.

Section 1 - Acute Hospitals, Doctor's Surgeries and Medical Clinics

This section applies to patients who go missing from temporary locations that they are visiting for treatment such as Acute Hospitals, Doctor's Surgeries and Medical Clinics.

Not all Missing Patients who leave a Health Facility are Missing People

Not all patients who leave a health facility without being formally discharged are missing people. Many patients go home and consequently their whereabouts can be easily established. A missing patient is not a missing person if they are at home.

Forces may therefore wish to agree with partner agencies when they should report a patient who leaves a health facility without being formally discharged as a missing person to the police. For example, police forces may decide with their partner agencies that when a patient has left a hospital, doctor's surgery, or medical clinic:

1) the patient will be immediately categorised as a missing person where there is ***critical concern*** for the patient's or public's safety that justifies an **immediate police response** *(i.e., an Article 2 or Article 3 duty, or there are suspicious circumstances that suggest the patient may have been a victim of a serious crime);*
2) the patient will not be categorised as a missing person where there is ***no critical concern*** for the patient's or the public's safety unless the health agency has conducted reasonable actions to locate the patient, including checking the patient's home address, and the patient is now considered to be missing from home, as well as missing from the medical facility.

If there is critical concern that justifies an immediate police response, the police would normally record the patient as a missing person and conduct enquiries to locate the missing patient.

If there is no critical concern that justifies an immediate police response and the health agency has not conducted reasonable actions to locate the patient, including checking the home address, the police may decide to advise the health agency to conduct those reasonable actions, including checking the home address, and close the incident log as 'other agency dealing' without recording the patient as a missing person.

Examples of Critical Concern

Examples of where there is ***critical concern*** for the patient's or the public's safety that creates an Article 2 or Article 3 ECHR duty and requires an ***immediate police response*** include:

- where a patient is suicidal and there is concern that they have no intention of going home but are likely to go to a remote location to complete suicide,
- where a patient who has left a health facility is suffering serious mental health issues, is dangerous, and poses an immediate serious risk to the public's safety,
- where a patient is suffering from dementia, a learning difficulty, or is lacking capacity, and there is concern that they will be unable to find their way home safely,

- where a patient is suffering from a serious physical illness or injury and there is concern that before they arrive home, they may collapse, suffer serious bleeding, or exacerbate an injury that may result in a permanent disability or long-term medical complications. For example, a serious head injury, deep wound, compound or complicated fracture, or overdose.

The above is not an exhaustive list but are examples of the threshold that would justify immediately reporting a patient who has left a health setting as a missing person.

Considerations therefore include whether there is concern that:

- does not intend to go home and may complete suicide or cause serious self-harm,
- the person is dangerous,
- the person will be unable to make their way home safely, or
- the patient needs urgent treatment in the next few hours otherwise they may suffer life changing or life limiting injuries and they were either not aware of that when they made the decision to leave or the patient lacks capacity and is unable to understand the consequences of leaving.

Health Conducting a Joint Risk Assessment with Mental Health

In respect of patients suffering from mental health issues who go missing from Acute Hospitals, Doctor's Surgeries or Medical Clinics, it is best practice for the medical health professionals to contact their mental health professional colleagues to conduct a joint risk assessment before deciding to contact the police. The missing patient may already be known to mental health services and the mental health professionals will be able to assist the medical health professionals to assess whether there is ***critical concern*** for the missing patient's or the public's safety that would justify contacting the police.

Escalation before Contacting the Police

The Framework also recommends that *"the decision to report someone missing to the police should be agreed with an appropriate (in some cases more senior) member of staff"*. The rationale for this recommendation is that experience has shown that where acute hospitals have introduced an escalation process to a senior or more experienced member of staff before contacting the police to make the assessment on whether there is ***critical concern***, this has the biggest impact on reducing unnecessary reports of missing patients to the police, without having a significant impact on safeguarding.

Police Response if there is Critical Concern

If there is a real, immediate, substantial risk to life, serious injury, cruel, degrading or inhuman treatment, that creates an Article 2 or Article 3 ECHR duty, or suspicious circumstances that indicate the patient may have been the victim of a serious crime, the police must respond appropriately. Most forces would categorise these patients as ***high-risk missing persons*** and deploy immediately.

If the level of risk does not justify immediate police deployment, it is unlikely that the threshold of critical concern will have been met, and police forces are entitled to expect the health agency to conduct reasonable actions to locate the patient, including checking the home address, before the police will respond.

However, even when there is an Article 2 or Article 3 ECHR duty, the framework recommends a partnership response to these emergency incidents. On many occasions in the past, the police have voluntarily assumed complete responsibility to locate missing patients despite Health, Ambulance, and Mental Health having the same Article 2 or Article 3 duty, as those duties apply to all statutory agencies. Where more than one statutory agency is involved, the question is, which agency should be the lead agency? If there is a serious fire, no one ever questions that the Fire Service should be the lead agency. However, too often, the police assume primacy in some types of medical or mental health crises. When a patient leaves a medical facility, if they are suffering a medical or mental health crisis, health or mental health should be the lead agency. One controversial question is, which agency should check the home address?

The Task and Finish Group agreed that it is **in the best interests of the patient** if:

- a medical professional checks the home address if the person is suffering from a medical condition, and
- a mental health professional checks the home address if the person is suffering from mental health issues.

This is in recognition of the principle of deploying the most appropriate resource to the home address.

Ambulance staff and mental health professionals have more relevant skills, training, and experience than the police to treat and advise the missing patient if the patient has managed to find their way home.

The police are better focussing on the co-ordination of area searches, mobile phone checks, and ANPR checks to locate the patient if the patient has not gone home.

The Task and Finish Group acknowledged that it is not in the best interests of the missing patient for a police officer to attend the patient's home address on behalf of health agencies in order to persuade the patient to return to a hospital, surgery or clinic for treatment. If police officers do attend, they must rely on persuasion as the police have no powers to force a patient to return for treatment even if that treatment is considered life-saving and essential. Police officers are not trained to explain the health consequences of not receiving treatment and should avoid attempting to do so as they may create legal liabilities.

If the patient is suffering a mental health crisis, it can also exacerbate their condition if a uniformed police officer attends their home. However, across the UK, there has been a general assumption that the police should check the home address because of challenges around demands on ambulances and the unavailability of other health resources. This practice needs to change over time as we work towards the right care, right person principles.

Police forces may therefore decide it is in the best interests of the patient to request an ambulance, health professionals, or mental health professionals to conduct the welfare check at the home address whilst they conduct area searches and other specialist enquiries. In some force areas, an ambulance is now attending to check the home address in up to 50% of cases. No one expects the ambulance service to pick up this extra demand overnight, but we should be working as a partnership towards sending the most appropriate resource on all occasions.

If Health Refuse to Check the Home Address

Some health and mental health trusts are reluctant to deploy an ambulance or mental health professionals to conduct a welfare check at the home address until the police have attended and confirmed that the patient has returned home. However, the police have no legal duty to conduct welfare checks on behalf of other agencies. If a patient has left a health setting, that health agency not only may have an Article 2 or Article 3 ECHR duty, they also have a legal duty of care that continues even when the patient has left the health facility. Any health policy that requires the police to conduct a welfare check at the home address to confirm the patient has returned home before deploying an ambulance, health professionals, or mental health professionals should be challenged.

However, where there is an Article 2 or Article 3 ECHR duty and the health agency refuses to deploy an ambulance, health professional, or mental health professional, the police should not also refuse to attend, as the failures of other agencies does not absolve the police from their own Article 2 and Article 3 duties even if the other agency is the lead agency and the most appropriate resource to respond. However, any refusal of the health agency to check the home address should be escalated and challenged through partnership arrangements as they are the lead agency, and it is not in the patient's best interests that police officers are involved when that is not necessary.

In some partnerships, there has been agreement that the fire service will check the home address in these circumstances. The fire service has greater powers to force entry into premises, although it should be acknowledged that they are also not health and mental health professionals. However, how the fire service can assist when health resources are stretched is another issue that local partnerships may want to consider when developing their local protocols.

If the Home Address is Unknown or the Patient is No Fixed Abode

If the home address of the patient is unknown or the patient is no fixed abode, then consideration should be given to whether the patient had capacity, was aware of their medical condition, was aware of the consequences of not receiving treatment and has made an informed decision to leave a health facility prior to treatment. An adult with capacity is entitled to refuse treatment even if they

consequently suffer death or serious injury. If the health care setting has reported the patient missing to the police, the police should discuss that risk assessment with the health care setting to decide whether it is more appropriate to consider the patient as a self-discharge.

Police Response if there is No Critical Concern

The Task and Finish Group accepted that where the concern for the patient's safety is ***not critical*** and ***does not require an immediate police response***, the police are entitled to expect health facilities to conduct reasonable actions to locate the patient and to establish for themselves whether a missing patient has gone home before reporting the matter to the police. Even if the staff at the health facility cannot themselves physically check the home address, the health facility is responsible for considering alternative ways of doing so. For example, the health facility may consider requesting a relative, friend, ambulance, the community health team, or the mental health team to check the home address on their behalf. Police forces may wish to ensure their local protocols address this issue.

Traditionally, police officers have felt obliged to take responsibility where health are struggling to deploy resources to the home address. However, if there is no critical concern that justifies an emergency police response, police forces may decide not to respond and allow the health facility to resolve the issue in their own time. The police do not owe a duty of care under the common law to conduct welfare checks on behalf of other agencies unless the police create a legal duty of care by agreeing to complete that welfare check. In those cases where the police decide not to complete the welfare check, the police should make it clear to the reporting person that the police will not be responding so that no legal duty of care is created.

If there is a delay in the home address being checked by health, this is acceptable as the risk assessment has indicated that there is no critical concern that justifies an emergency response. Ambulance, mental health professionals and other health professionals have their own systems for prioritising calls for service and it is their responsibility to resolve the issue.

The police do not need to be informed about these incidents where the health facility has not conducted reasonable actions to locate the patient and there is no critical concern.

If the Health Agency has Conducted Reasonable Enquiries

If the health agency recontacts the police after conducting reasonable actions to locate the missing patient and confirms that the home address has now been checked, and the patient has not returned home as expected, and is therefore also missing from their home address, police forces may then decide to categorise the patient as a missing person if there are any suspicious or concerning circumstances. The police would then conduct a risk assessment and categorise the risk as high, medium, low, or very low risk in accordance with their ***'Missing Person policies'*** and respond in the same way that they would do to any other report of a person missing from home.

Section 2 - Mental Health Detained Patients

This section applies to voluntary patients and patients detained under the Mental Health Act who have been admitted to a mental health hospital for treatment. Most of these patients will have a permanent home that they will return to when released from hospital, although some may be homeless.

Notifying the Police

When a patient from a mental health hospital goes missing, or fails to return from authorised leave on time, the police are entitled to expect the hospital to conduct reasonable actions to locate the patient before contacting the police unless there is ***critical concern.*** Forces may therefore wish to agree partnership protocols whereby the hospital does not immediately notify the police of these incidents unless there is ***critical concern*** for the missing patient's or the public's safety that requires an ***immediate police response***.

If there is Critical Concern

The police should always be contacted immediately if there is ***critical concern*** for the patient's or the public's safety that requires an ***immediate police response***.

If there is a real, immediate, substantial risk to life, serious injury, cruel, degrading or inhuman treatment, that creates an Article 2 or Article 3 ECHR duty, the police must respond appropriately.

Most forces would categorise these patients as ***high-risk missing persons*** and deploy immediately. However, forces may wish to seek a partnership response to these emergency incidents and obtain agreement that hospital staff or mental health professionals will check the home address while the police conduct area searches, mobile phone checks and other relevant enquiries.

However, if there is critical concern and the hospital staff and mental health professionals are unable to attend the home address, the police will need to check the home address as there is an Article 2 or Article 3 duty on all statutory agencies. The failure of one statutory agency to respond, even if they are the lead agency and the most appropriate resource, will not negate the legal liability of the other statutory agencies.

If the Concern is Not Critical

Where the concern for someone's safety is ***not critical*** and ***does not require an immediate police response,*** the police do not need to be notified immediately. The hospital staff have a legal duty of care in these circumstances whereas the police do not.

Forces may therefore wish to consider requiring hospital staff to conduct reasonable actions to locate the patient, including checking their home address and allowing the patient a reasonable time to return of their own accord, before reporting the matter to the police.

On some occasions, the hospital may request the assistance of the police to conduct a joint home address check if there are concerns that the missing patient may be violent. The police may then

decide to attend to support the hospital or ambulance staff to prevent a breach of the peace and to assist the hospital or ambulance staff to recover the patient.

If the Missing Patient has not been found by the Hospital Staff

If the hospital staff have undertaken reasonable actions to try and establish the whereabouts of the missing patient and they have been unable to locate the missing patient, and the circumstances suggest that the patient is missing from home as well as missing from hospital, police forces may then wish to apply their ***'Missing Person policies'*** when they are contacted or re-contacted. The police would then conduct a risk assessment and categorise the risk as high, medium, low, or very low risk and respond in the same way that they would do to any other report of a person missing from home.

Powers and Responsibilities

Powers to Take a Patient into Custody and Return them to Hospital

Section 18 Mental Health Act 1983

If the missing patient was detained in a hospital under the Mental Health Act and is absent without leave (AWOL), the police will have a power to take the patient into custody and return the patient to hospital if found under Section 18 of the Mental Health Act 1983. However, police assistance in transporting a patient back to hospital should not be considered as a matter of routine.

S138 Mental Health Act 1983

If a patient has escaped from legal custody (for example from S136 detention), the police have a power to take the patient into custody under S138 Mental Health Act 1983 and a power to return the patient to hospital under S137 Mental Health Act 1983.

The College of Policing APP states:

According to the Mental Health Act 1983 Code of Practice, responsibility for the return transport arrangements rests with the hospital as follows:

- *where a patient who is AWOL 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;*
- *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 – decisions about the kind of transport to be used should be taken in the same way as for patients being detained in hospital for the first time;*
- *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.*

Similar guidance is given in chapter 17 of the Mental Health Act 1983 Code of Practice (for Wales).

Section 17(1) covers the responsible clinician's (RC's) entitlement to grant leave with any conditions that may be necessary in the interests of the patient or for the protection of other people. The RC also has a right under section 17(4) to recall patients from leave, revoking their leave of absence. Where a patient who has been granted leave fails to return to hospital on its completion, or where they fail to return if recalled from such leave when it is revoked, then they become AWOL under MHA 1983. This then entitles an AMHP, anyone on the staff of the relevant hospital, a constable or anyone else authorised (in writing) by the hospital managers to take the patient into detention under section 18 MHA 1983 and return them to the hospital.

There is no power of entry in respect of this authority. Should entry need to be forced in order to detain someone under section 18 who is AWOL from section 17 leave, then a warrant needs to be obtained under section 135(2) MHA 1983.

https://www.app.college.police.uk/app-content/mental-health/awol-patients/#police-involvementin-transporting-awol-patients

Although the above paragraph on power of entry is quoted from the Code of Practice for Wales, the power of entry arises from statute, not from the Code of Practice itself. The power of entry is identical in both England and Wales.

Powers of Entry

Section 17(1)d Police and Criminal Evidence Act 1984

This section states: *"A constable may enter and search any premises for the purpose of recapturing **[**any person whatever**]** who is unlawfully at large and **whom he is pursuing**."*

Under S17(1)d, the constable must be actively pursuing the individual. Basically, if the officer is chasing the patient and the patient runs into a house, the officer can then enter the house to pursue the patient. However, there is no power of entry under S17(1)d if the officer is not actively chasing the patient at the time. There is case law on what constitutes 'pursuing' but basically if there is any significant time lapse between chasing the patient and the patient entering the house, then it will not constitute a pursuit. Therefore, if the officer lost the patient and the patient is then seen to enter the house an hour later, the officer will no longer be considered in pursuit of the patient, so the officer will not have a power of entry.

Section 17(1)e Police and Criminal Evidence Act 1984

This section states: *"A constable may enter and search any premises for the purpose of saving life or limb or preventing serious damage to property."*

Under S17(1)e, there must be an actual immediate risk to life, limb or of serious damage that would render it inappropriate to wait for a warrant. This enables the police to enter if the person is in the process of attempting suicide, causing self-harm, or is smashing up the property.

S135(2) Mental Health Act 1983

Under this section, a Justice of the Peace can issue a warrant authorising a police officer to enter premises, using force if necessary, to take a patient who is liable under the Mental Health Act to be taken or retaken into custody. However, there must be reasonable cause to believe that the patient is to be found on the premises, and that admission to the premises has been refused or refusal is likely. The police officer can be accompanied by a doctor, and anyone authorised under the Act to retake the patient and return them to hospital.

Application of the Powers of Entry and Powers to Detain

1) If the police are chasing a patient who is unlawfully at large and the patient enters a premises, the police can enter under S17(1)d of PACE to search for the patient. If found, the police can then detain and return the patient under S18 of the Mental Health Act 1983.
2) If there are reasonable grounds to believe that the patient is about to commit suicide or cause serious self-harm, or the patient is smashing up the property, then the police can enter the premises under S17(1)e of PACE to save life or limb or prevent serious damage and then detain and return the patient under S18 of the Mental Health Act 1983.
3) Otherwise, a warrant needs to be obtained under S135 Mental Health Act 1983 that authorises the police to enter the premises, detain the patient, and return the patient to hospital.

Section 3 - Residential Homes providing Care and Accommodation

When an adult resident goes missing from a residential care home or fails to return to the residential care home on time, the police are entitled to expect those with responsibilities as carers to undertake reasonable actions to try and establish the whereabouts of the missing resident before contacting the police unless there is ***critical concern*** for the missing resident's or public's safety that requires an ***immediate police response***.

If there is Critical Concern

Where there is ***critical concern*** for the missing resident's or public's safety that requires an ***immediate police response,*** forces may decide to categorise the missing resident to be a missing person from the outset and apply their ***'Missing Person policies'*** even if the carer has not undertaken reasonable actions to try and establish the whereabouts of the missing resident.

If there is a real, immediate, substantial risk to life, serious injury, cruel, degrading or inhuman treatment, that creates an Article 2 or Article 3 ECHR duty, or there are suspicious circumstances that suggest the patient may have been a victim of a serious crime, the police must respond appropriately.

Most forces would categorise these patients as ***high-risk missing persons*** and deploy immediately.

If the Concern is Not Critical

Where the concern for the missing resident's or public's safety is ***not critical*** and an ***immediate police response is not required***, and the police are contacted before the carer has undertaken

reasonable actions to try and establish the whereabouts of the missing resident, forces may decide it is appropriate to delay police deployment until those reasonable actions have been completed and the resident has been given a reasonable time to return of their own accord.

If the Missing Resident has not been found by the Carer

If the carer has undertaken reasonable actions to try and establish the whereabouts of the missing resident but the carer has been unable to locate the missing resident, and the missing resident has been given a reasonable time to return of their own accord, police forces may then decide to apply their ***'Missing Person policies'*** when they are contacted or re-contacted. The police would then conduct a risk assessment and categorise the risk as high, medium, low, or very low risk in accordance with their ***'Missing Person policies'*** and respond in the same way that they would do to any other report of a person missing from home.

Patients who are Absent Without Leave (MHA)

Strategic Intention:

- Ensure the safety, the dignity and the rights of the public are placed at forefront of all WMP decisions on policing and mental health.
- Ensure collaborative partnerships operate effectively.
- Ensure deployments to support MHA Assessments are timely, proportionate, necessary and lawful.
- Ensure WMP fulfils its responsibilities under the Mental Health Act 1983 and it's Code of Practice.
- Ensure WMP is not operating beyond its legal authority.

- Ensure WMP officers are not operating beyond professional competence.

WMP Actions on being notified of AWOL –

- Officers will be deployed *immediately* it there is an urgent threat to life in respect of anyone, regardless of whether or not the patient's location is has been established.
- A missing person investigation can commence for someone whose location is not known, but WMP will request the reporting organisation will support their officers by undertaking enquiries which they are better placed to complete.
- The Code of Practice MHA (para 28.14) states that where reports relate to a patient whose location is already known, the police should be asked to return patients "where necessary" – this should relate to situations of urgency and / or serious risk. The fact that it has not been possible to identify responsibility within the relevant healthcare organisation in order to give effect to this provision is not sufficient justification to request police support and transport.
  The inquest after the death of Sasha Forster (2019) saw criticism of an NHS trust which could not provide staff to undertake the return of a patient who was known to be highly distressed by any involvement of police officers in their care – a Preventing Future Deaths report was issued.

WMP has a well-established role in locating patients whose location is not known or acting in an emergency to mitigate threats to life involving missing or absent without leave patients. However, a number of other agencies and organisations also owe a duty of care to patients who are missing or AWOL. As such it will often be the case that they have the lead in such matters and will continue to owe a duty of care when safeguarding patients.

WMP may support the return of AWOL patients in non-urgent circumstances where the risk of a Breach of the Peace is evident.

- **Para 28.17 Codes of Practice MHA** – reports that detained patients are AWOL should include the time scales which will apply to re-detention under the MHA. This is especially necessary where less-common provisions of the Act apply (e.g., s4, s5, or s7 MHA.)
- **Section 17 MHA leave / Community Treatment Order (CTO) recalls** – WMP has no power to return s17 leave or CTO patients unless their leave has been revoked or they have been recalled from their CTO, *in writing*. These are comparatively rare events for officers and if a police presence is required during service of revocation or recall notices because a Breach of the Peace is anticipated, this should be specified. As failure to return from leave or a recalled CTO renders the patient AWOL, health services should seek assistance to "return an AWOL patient".

BREACH OF THE PEACE

A breach of the peace occurs where *"Harm is done or likely to done to a person or, in their presence, to their property; or puts that person in fear of such harm being done through an assault, affray, a riot, unlawful assembly or other disturbance."*

Any request for police intervention should make express reference to the threat and risk assessment generated by information supplied to WMP in 999 calls, or any other communications.

WMP has a well-established, but limited, role to play in the response to patients who go missing or are 'Absent Without Leave' (AWOL) under the MHA 1983. It is important to distinguish between someone who is AWOL and someone who is missing (as defined by the Force policy). Not all AWOL patients are 'missing' and the duty of care owed when patients are AWOL will usually sit with hospitals or mental health trusts. Upon receipt of a contact, the following questions will be essentially to identifying the appropriate police.

- **Is there an urgent threat to life emergency? –** the police have a duty to protect life and where the location of an AWOL patient is known, the need to act swiftly may justify police attending on their own to making use of their powers. Where such urgency does not exist, other agencies or a slower multi-agency response should be relied upon rather than WMP
- Is the patient's location known – if not, the force missing policy must be followed, regardless of questions arising about the person's MHA or AWOL status. *If the patient's location is already known, then additional questions will be necessary:*
- What is the patient's legal status? – they may be a voluntary patient or detained under one of the many 'sections' of the MHA which allow for compulsory treatment. Most usually reports will relate to a s2 or s3 patient, but they could relate to a number of other provisions – ask for precise clarification in order to establish what the requirement is for WMP to attend / support.

Response

FOUR OPTIONS

- Threat to life emergency = deploy officers in accordance with normal deployment principles as such a situation is potentially life-changing or life-threatening.
- Location not known = refer to WMP missing person policy.
- Location known, voluntary patient, no emergency = Police officers would have no legal powers to respond and act and will also not be best placed to assess safety or wellbeing of patients. << See the Offer on welfare checks.
- Location known, detained MHA patient, no emergency = Paragraph 28.14 of the Code of Practice MHA stipulates it is for hospitals to arrange return of their patient. Police support can be provided, where justified (see below).

POLICE SUPPORT

Where healthcare staff seek police support in their attendance to return an AWOL patient, this can be offered where a patient is likely to be 'violent or dangerous' in order that officers can prevent a breach of the peace. Agreeing to joint attendance against this threshold is perfectly permissible and often necessary to prevent serious risks to healthcare staff.

West Midlands Police will not agree to meet another police force 'half way' if they have decided to return an AWOL patient to expedite their return.

WMP officers will be deployed to incidents of missing or AWOL patients in some circumstances

- **Urgent threat to life** – where an AWOL patient is at immediate risk of serious harm, an emergency response will be justified and officers have powers by which to mitigate the risk.
- **Missing persons** – where a patient's location is not known and they are reported missing, force policy will apply, regardless of their AWOL status or specific MHA considerations.
- **Paragraph 28.14 Code of Practice MHA** – where the location of an AWOL patient is already known, it is the hospital's responsibility to return the patient. Police may support healthcare staff where the patient is 'violent or dangerous' and a Breach of the Peace may be anticipated.

AWOL / SECTION 17 LEAVE / COMMUNITY TREATMENT ORDERS

The definition of AWOL status is that a patient has been detained in hospital and has a) absconded without permission; b) had authorised (s17 MHA) leave 'revoked'; c) been 'recalled from a Community Treatment Order; or d) failed to return from authorised (s17) leave. In each situation: the patient is AWOL. Should there be any confusion arising from the way in which these matters are reported or during discussion with MH professionals, the *key question* to be considered is –

"Is this patient AWOL under the MHA now?"

- If not – the only legal power available under the MHA will be s136 MHA, where officers have encountered the patient outside a domestic dwelling. Otherwise, there is no legal power to act.
- If they are AWOL now – one further question is required: "When does the s18 MHA authority expire?" If a patient is AWOL, there *may* be a limited timescale for continued / further detention and detail should be sought from the reporting professionals – they have an obligation to specify this timeframe to you. *(Para 28.17 of the MHA CoP).*

AWOL POWERS

- Section 18 MHA – officers can re-detain an AWOL patient under s18, however there is no power of entry available, unless s17(1)(e) of PACE applies to protect life or limb.
- Section 135(2) MHA – where PACE does not apply, a warrant must be secured under s135(2) MHA to gain entry to the premises. Police can apply for this warrant, if necessary, but in the first instance it should be done by the staff from the patient's hospital.

ABSCONDING FROM MHA

AWOL status does not apply to anyone who *absconds* from s135 or s136 MHA or *absconds* after being 'sectioned' but before they arrive at hospital – such patients may be re-detained under s138 MHA and taken (back) to the Place of Safety or hospital as long as they are re-detained within relevant timescales – see the next page, for detail of timescales which apply.

It is the legal responsibility of the detaining hospital to arrange for the return of their patient. Inquiries and inquests have examined critical incidents involving mental health patients being moved long distances in police vehicles and the Code of Practice MHA states conveyance by police vehicle should be *exceptional* and only where justified by risk. Even where a patient is 'violent or dangerous', long journeys will require clinical supervision and may be better managed by specialist clinical transport which can be arranged by the hospital.

See WMP 'Offer' on Conveyance regarding return to hospital once an AWOL patient is re-detained. Where WMP officers have re-detained an AWOL patient, their legal duty is to return that patient to the hospital from which they are missing, or to which they have been recalled. << See the Offer on Conveyance regarding the four 'NEVER EVENTS' which should be applied to consideration of the journey to return the patient to hospital.

If it will take time for a hospital to make the necessary arrangements to return their patient, consideration needs to be given to that person's immediate care. Nothing prevents a local NHS trust being asked to accommodate the AWOL patient in a Place of Safety until arrangements are complete. Whilst they are not obliged to assist, nothing prevents them from doing so if their facility is not in use and this should be attempted wherever possible.

If it is unavoidable, nothing prevents an AWOL patient re-detained by the police under s18 or s135(2) MHA from being temporarily held at a police station. The law prohibiting the use of police stations as a Place of Safety apply only to those detained under s135(1) or s136 MHA and whilst it is preferable to avoid police stations, it is not prohibited if there are no other practical options.

Where a patient from the West Midlands is re-detained elsewhere, no obligation is created for WMP to be involved – the patient's return is a matter for the hospital and the other force

West Midlands Police will not meet another police force 'half way' if they decided to return an AWOL patient by police vehicle in order to expedite the patient's return.

TIMESCALES – REDETENTION OF AWOL / ABSCONDED PATIENTS

AWOL or absconded, *an AMHP, a constable or anyone authorised by the hospital may act.*

- s2 – up until 28 days after their original admission to hospital
- s3 – up to six months after the date on which they become AWOL
- s4 – up to 72hrs after their original admission to hospital
- s5(2) – up to 72hrs after their original detention under 5(2).
- s5(4) – up to 6hrs after their original detention under 5(4).

- s7 – up to six months after the date on which they become AWOL
- s17A – up to six months after the date on which they were recalled.
- s37 – up to six months after the date on which they become AWOL
- s37/41 – any time after they become AWOL.
  Unusual Circumstances – *only the police may re-detain*
- s35, 36 and 38 patients may all be retaken in to custody under powers specific to those sections (see s35(10), s36(9), s38(7) MHA) at any time after they abscond: BUT! –

  NB: all s35, 36 or 38 patients must then be taken to back to court, not to hospital!

APPENDIX E

OBTAINING A WARRANT UNDER s135 MENTAL HEALTH ACT 1983

Mental Health Act, 1983

Instructions for Obtaining a Warrant under section 135(2)

1. When a warrant is required

1.1.1 Section 135(2) provides for the issue of a warrant by a magistrate authorising entry by police to remove a patient who is liable to be returned to hospital or into custody under the Act. Such a warrant may be used to return a patient who has absconded, if access to the premises where they are stating has been refused or is likely to be refused.

1.1.2 When a warrant issued under section 135(2) is being used, it is good practice for the police officer to be accompanied by a person with authority from the managers of the relevant hospital, usually the AMHP.

2. Application Process

2.1 Where a patient subject to detention under the Act is absent without leave from hospital and located, or there is reasonable cause to believe the patient is at, the premises to which access has been or may be refused, the staff member involved in the search should contact the appropriate service manager for the Division.

2.2 *The manager must make contact with the police station serving the area where the patient is believed to be to alert the police of the intention to apply for a warrant and to make the arrangements for the police to execute the warrant dial 101 and the log will be put through to Mission Support for Allocation*

It is imperative that the police receive as much information about the patient and the circumstances as are available in order that they can undertake their own risk assessment and allocate suitable resources to the execution of the warrant.

(Please see, Information Governance Policy)

2.3 The manager is then responsible for producing a written application for the warrant that should include the following;

- *The name of the person making the application (i.e. the Trust manager)*
- *The name of the patient sought*
- *That the patient is liable to be detained under the Act, and the relevant section*
- *The address of the premises where the patient is believed to be*
- *The name and address of the hospital where the patient is required to reside under the terms of his/ her detention*

2.4 During the hours in which the court sits, the manager will instruct a member of staff to take the application to the appropriate magistrate's court. Where the patient is

located in Birmingham, the application is made to the Birmingham Magistrates' Court at Victoria Law Courts, Corporation Street, Birmingham, B4 6QA.

2.5 *Where an application is to be made during court hours, the manager will telephone the respective Court Office at either the Birmingham (0121 212 6600), or Sutton Coldfield Magistrates' Courts (Listings Officer, , 0121 362 1302) and inform them that the application is in transit. For the Birmingham Magistrates Court, the manager may also contact the probation office at the court to inform them that an application is being made. The probation service will lend assistance to the member of staff when they arrive at that court.*

2.6 *On arrival at the court, the member of staff should present the application to a court official. At Birmingham Magistrates Court the probation office will provide assistance if requested.*

2.7 *Out of court hours, for all areas within the West Midlands, the manager should telephone the West Midlands Communication Force at Bourneville Lane (0121 626 4040) who will alert the on-call magistrate and advise on the arrangements for making the application. The manager should have the following information available when contacting the police communication centre;*

- *That an application is being made for a warrant under section 135(2) of the Mental Health Act to return to hospital a patient who is liable to be detained under the Act;*
- *The patient's name;*
- *The address where the patient is believed to be;*
- *The name and contact number of the manager making the application*

2.8 *Once the warrant is obtained, the police should be advised and the arrangements confirmed to execute the warrant, including the name and profession of the member(s) of staff attending and the arrangements for delivering the warrant to the officers to execute.*

2.9 *The arrangements for transporting the patient back to hospital should also be agreed before the warrant is executed. Responsibility for the safe return of patients rests with the detaining hospital. Transportation by Trust staff is the preferred method, but the police may assist or provide transport if deemed necessary so to do* (refer to the joint policy on' Conveying Patients').

APPENDIX F

AWOL CHECKLIST FOR NURSE IN CHARGE OF THE PATIENT'S WARD

HAVE ALL STAGES OF THE TRSUST MISSING PATIENT POLICY BEEN FOLLOWED?		TICK
STAGE 1 Patient Missing or Unaccounted For	• Inform Nurse in Charge of patient's ward	
	• Inform the patient's RC immediately (or as soon as possible if the AWOL was out of hours)	
	• Inform CS/NM (Or Senior on call Manager)	
	• Inform MHA Administrator (MHAA)	
	• Complete Part 1 of the Missing Patient Form 1 and send to MHAA	
STAGE 2 Initial Search	• Confirm that the patient is not within the confines of the building	
	• Organise a thorough search of the ward and other areas within the building	
	• If the patient is not located, other wards, departments or services on the same campus or site must be informed and request that a similar, thorough search is undertaken within those buildings.	
	• If the patient is located outside of the ward and in the hospital grounds, staff should attempt to persuade the patient to return.	
	• If the patient was on hospital grounds and refused to return, was a nurses' holding power used under s5 (4) of the MHA?	
If the patient is not located after Stage 2 is completed, proceed to Stage 3 below		
STAGE 3 Determining the Category of Risk	• Consult entries relating to the patient's current risk status in the patient's care record (RiO)	
	• When determining whether to notify the police service, complete and document an initial risk assessment and the risk rating in Appendix C of the policy	
If the patient is not located after Stage 3 is completed, proceed to Stage 4 below		
STAGE 4 Notification	• Contact the following people where appropriate:	
	• Nearest Relative (detained patients) within 1hr	
	• Next of Kin (Informal/Voluntary patients) within 1hr	
	• Agencies involved in child or victim protection issues	
	• Contact police immediately if high risk, medium risk and low risk	
	• Care Quality Commission (CQC) for detained patients AWOL from secure environments (including PICUs)	
STAGE 5	• Complete an ECLIPSE Incident report	
STAGE 6 Notification of Patient's Return	• All agencies informed of patient's return	

Name of Person completing the checklist……

Signed……

Date……

APPENDIX G

Ministry of Justice

HM Prison & Probation Service

NOTIFICATION OF ESCAPE OR ABSCOND OF A RESTRICTED PATIENT

Patient's Name:
MHCS Reference No:
DOB:
Detaining Hospital:
Level of Security:

Ward name:
Ward Telephone No:
Contact Name:
Name of RC:
RC's Email:

Date of Escape/Abscond:
Have the Police been Notified: YES/NO
(if YES, please provide the police reference no.)

Circumstances of Escape/Abscond:

Please provide a brief summary of Patient's mental state at time of Escape/Abscond (when completed, please email to **MHCSMailbox@justice.gov.uk**

Ministry of Justice

HM Prison & Probation Service

NOTIFICATION OF THE RETURN OF A RESTRICTED PATIENT FROM ESCAPE OR ABSCOND

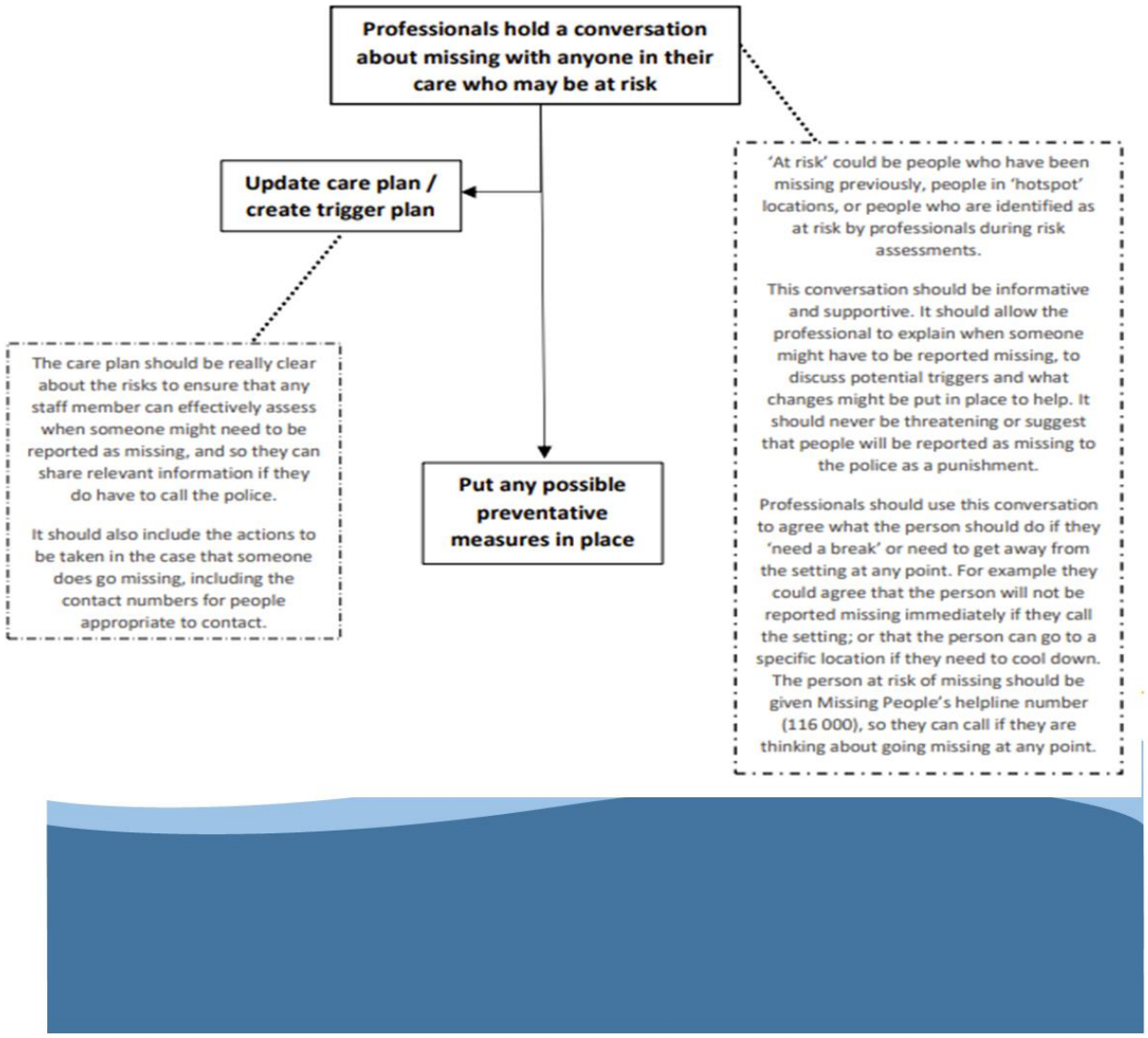
Patient's Name:
MHCS Reference No:
DOB:

Date of Escape/Abscond:
Date of return from Escape/Abscond:

Abscond Report
(This section should provide an update on the Patient's mental state, his reasons for absconding, any incidents of concern, the patient's whereabouts and what the patient did while absent. When completed, please email to **MHCSMailbox@justice.gov.uk**)

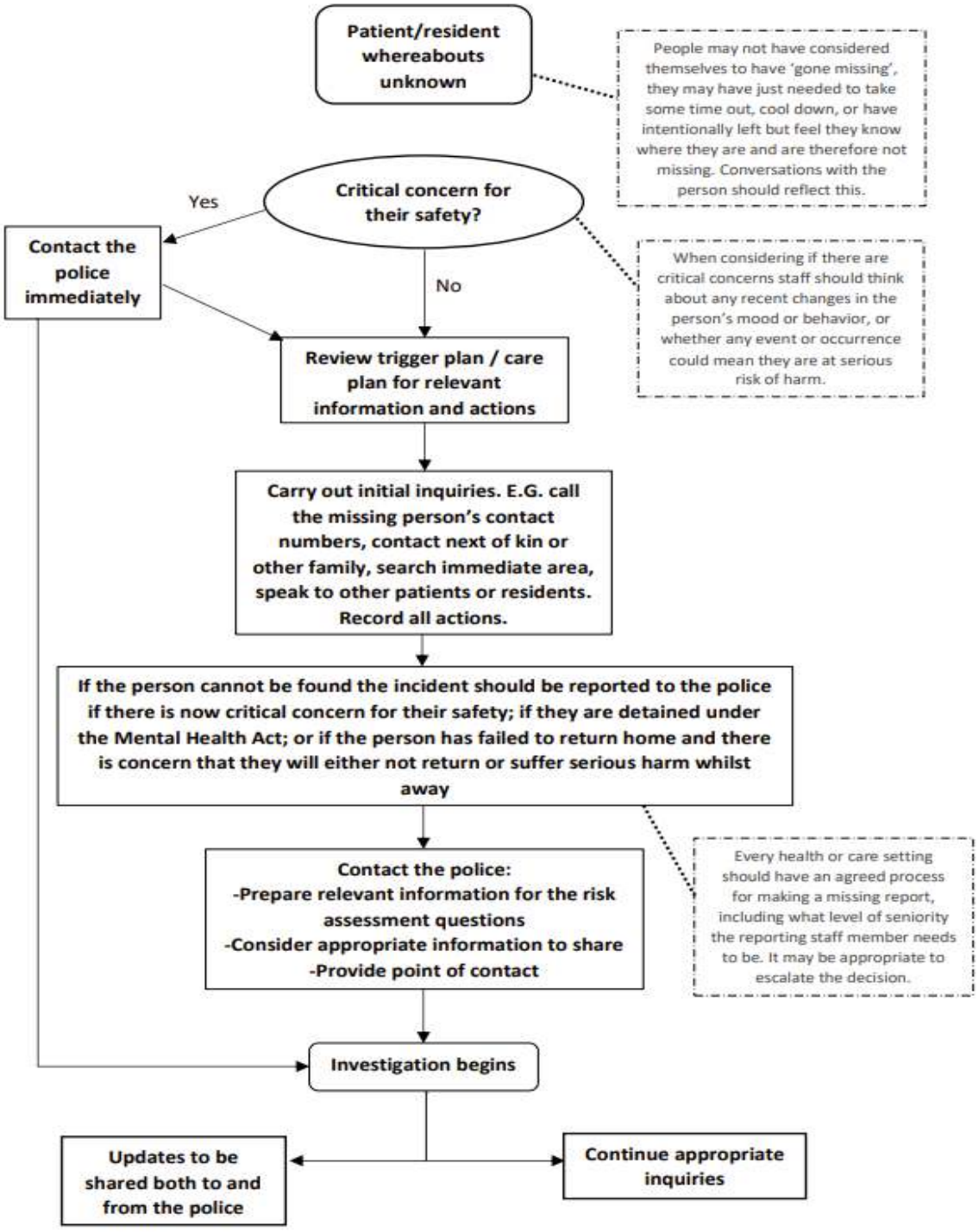
Appendix H

Prevention of Patients Missing from Health Care Setting



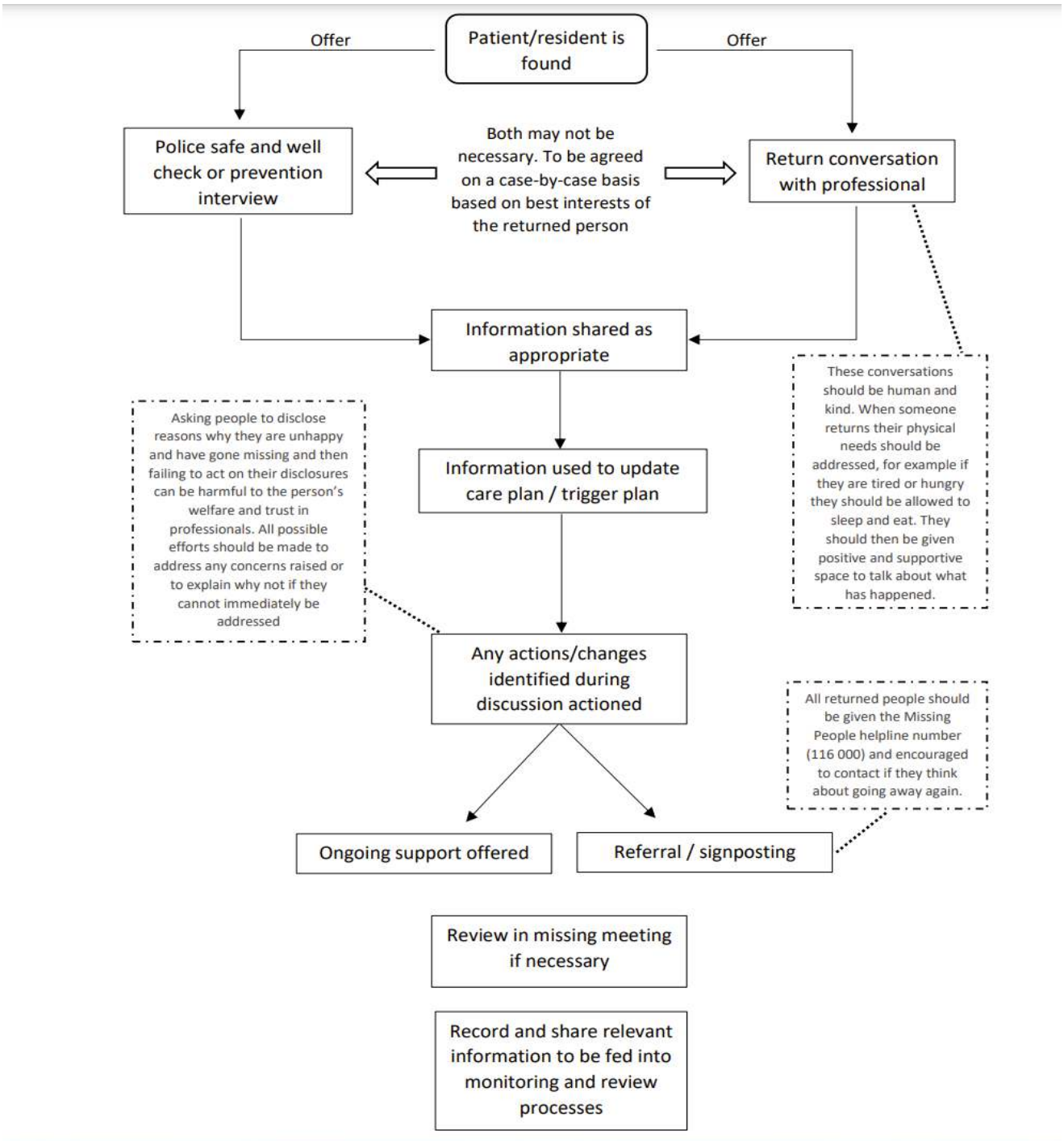
Appendix I

Missing Person from Health Care Setting



Appendix J

Missing Person when found



Appendix K

Right Care, Right Person

Escalation Point of Contact for Partner Agencies to

West Midlands Police

If any partner has a concern that the RCRP policy and partnership agreement has been incorrectly applied in particular where they believe there is a Is there a real and immediate risk to life, or real and immediate risk of significant harm occurring to an identified person or the public this escalation process will apply 24/7 from 2200hrs on 9th February 2024.

- Operational colleagues in the organisation with the concern should escalate the issue expeditiously through their own internal processes

- If the senior manager then believes that this then needs immediate escalation to a senior West Midlands Police leader as the original decision does not align with the RCRP agreed approach they should call the Force Duty Manager on the below number

0844 589 6674

The Force Duty Managers are Chief Inspectors based in West Midlands Police Force Contact Centre.

They are trained in RCRP and aware of this escalation process.

Action to be taken

On receipt of the call they will ensure the original decision is reviewed and where required appropriate action initiated.

They will share the detail of the escalation with the below colleagues for further discussion with partners and to ensure that the nature of the incident is understood and any appropriate action take to prevent similar escalations

SRO for RCRP Chief Superintendent Madill
SME for Mental Health – Chief Inspector Stephen Taylor
MH Coordinator – Inspector Kat Sibley

Appendix L

Equality Analysis Screening Form

A word version of this document can be found on the HR support pages on Connect:

http://connect/corporate/humanresources/managementsupport/Pages/default.aspx

Title of Proposal	Missing Patient Policy		
Person Completing this proposal	Hugh McCreedy	Role or title	Urgent Care Nurse
Division	Acute	Service Area	Urgent Care
Date Started	1st February 2022	Date completed	1st February 2022

Main purpose and aims of the proposal and how it fits in with the wider strategic aims and objectives of the organisation.

To meet the Trust's duty to provide safe and effective services for those who are receiving a service from the Trust. This document lists the actions to be taken when a patient is missing from a community or inpatient setting or absent without leave (AWOL). This ensures staff are aware of their legal requirements in relation to missing patients and provides a framework for their return to a safe environment.

Who will benefit from the proposal?

Patients, the public and the Trust

Impacts on different Personal Protected Characteristics – Helpful Questions:

Does this proposal promote equality of opportunity? Eliminate discrimination? Eliminate harassment? Eliminate victimisation?	Promote good community relations? Promote positive attitudes towards disabled people? Consider more favourable treatment of disabled people? Promote involvement and consultation? Protect and promote human rights?

Please click in the relevant impact box or leave blank if you feel there is no particular impact.

Personal Protected Characteristic	No/Minimum Impact	Negative Impact	Positive Impact	Please list details or evidence of why there might be a positive, negative or no impact on protected characteristics.
Age	X			Actions required are same regardless of age

Including children and people over 65
Is it easy for someone of any age to find out about your service or access your proposal?
Are you able to justify the legal or lawful reasons when your service excludes certain age groups

Disability			X	It is likely all patients impacted by this policy would meet the legal definition of disability. The policy will set out safeguards in relation to legal rights and provides a framework for returning patients to a safe environment
Including those with physical or sensory impairments, those with learning disabilities and those with mental health issues Do you currently monitor who has a disability so that you know how well your service is being used by people with a disability? Are you making reasonable adjustment to meet the needs of the staff, service users, carers and families?				
Gender	X			The policy does not differentiate on gender.
This can include male and female or someone who has completed the gender reassignment process from one sex to another Do you have flexible working arrangements for either sex? Is it easier for either men or women to access your proposal?				
Marriage or Civil Partnerships	X			The impact of the policy is the same regardless of marriage of partnership status
People who are in a Civil Partnerships must be treated equally to married couples on a wide range of legal matters Are the documents and information provided for your service reflecting the appropriate terminology for marriage and civil partnerships?				
Pregnancy or Maternity	X			The impact of the policy is the same regardless of maternity status
This includes women having a baby and women just after they have had a baby Does your service accommodate the needs of expectant and post natal mothers both as staff and service users? Can your service treat staff and patients with dignity and respect relation in to pregnancy and maternity?				
Race or Ethnicity	X			The impact of the policy is the same regardless of an individual's race or ethnicity
Including Gypsy or Roma people, Irish people, those of mixed heritage, asylum seekers and refugees What training does staff have to respond to the cultural needs of different ethnic groups? What arrangements are in place to communicate with people who do not have English as a first language?				
Religion or Belief				The impact of the policy is the same regardless of beliefs
Including humanists and non-believers Is there easy access to a prayer or quiet room to your service delivery area? When organising events – Do you take necessary steps to make sure that spiritual requirements are mvet?				
Sexual Orientation	X			The impact of the policy is the same regardless of sexual orientation
Including gay men, lesbians and bisexual people Does your service use visual images that could be people from any background or are the images mainly heterosexual couples? Does staff in your workplace feel comfortable about being 'out' or would office culture make them feel this might not be a good idea?				

Transgender or Gender Reassignment	X			The impact of the policy is the same regardless of Transgender or Gender Reassignment
This will include people who are in the process of or in a care pathway changing from one gender to another Have you considered the possible needs of transgender staff and service users in the development of your proposal or service?				
Human Rights			X	The policy sets out processes and procedures for the protection of patients safety and legal rights.
Affecting someone's right to Life, Dignity and Respect? Caring for other people or protecting them from danger? The detention of an individual inadvertently or placing someone in a humiliating situation or position?				

If a negative or disproportionate impact has been identified in any of the key areas would this difference be illegal / unlawful? I.e. Would it be discriminatory under anti-discrimination legislation. (The Equality Act 2010, Human Rights Act 1998)				
	Yes	No		
What do you consider the level of negative impact to be?	High Impact	Medium Impact	Low Impact	No Impact

If the impact could be discriminatory in law, please contact the Equality and Diversity Lead immediately to determine the next course of action. If the negative impact is high a Full Equality Analysis will be required.

If you are unsure how to answer the above questions, or if you have assessed the impact as medium, please seek further guidance from the Equality and Diversity Lead before proceeding.

If the proposal does not have a negative impact or the impact is considered low, reasonable or justifiable, then please complete the rest of the form below with any required redial actions, and forward to the Equality and Diversity Lead.

Action Planning:
How could you minimise or remove any negative impact identified even if this is of low significance?

How will any impact or planned actions be monitored and reviewed?
How will you promote equal opportunity and advance equality by sharing good practice to have a positive impact other people as a result of their personal protected characteristic.
Please save and keep one copy and then send a copy with a copy of the proposal to the Senior Equality and Diversity Lead at **bsmhft.hr@nhs.net** . The results will then be published on the Trust's website. Please ensure that any resulting actions are incorporated into Divisional or Service planning and monitored on a regular basis.