

MISSING PERSON PROCEDURE

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PROCEDURE SUMMARY

This procedure provides a clear set of action that staff are expected to follow to assess and to manage risk to patients to maximise patient safety in all cases where a patient is deemed absent from Trust inpatient units without negotiated and agreed leave.

The procedure also applies to patients subject to Guardianship under the Mental Health Act or Community Treatment Order (CTO) patients that do not return to hospital when recalled, and/or CTO patients that have been recalled to hospital and then abscond.

This procedure also applies to residents of a nursing home.

'Patient' will be the terminology used throughout this document and will refer to a patient, client, resident or service user.

The Trust monitors the implementation of and compliance with this procedure in the following ways;

All incidents of missing patients are discussed with Ward/Team Leaders at the relevant local team meetings.

Statistics and trends analysis are reported to the Executive Team on a monthly basis via the Performance report and any resulting action plans are therefore monitored through the Clinical Governance & Quality Committee and Health Safety and Security Committee monthly.

Services	Applicable	Comments
Trustwide	✓	
Essex MH&LD		
CHS		

The Director responsible for monitoring and reviewing this procedure is the Executive Director of Nursing

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1.0 INTRODUCTION

- 1.1 The Trust and its staff have a “duty of care” to all patients who are receiving care and treatment from the Trust’s services. Episodes of unexplained or unauthorised absence from care and treatment may serve to disrupt recovery and prevention of such episodes is considered an integral component of risk management plans for all patients.
- 1.2 Our commitment to patient safety is paramount and as such the purpose of this document is to provide guidance to staff when responding to a patient who is deemed missing from a Trust In-patient Unit/Nursing Home.
- 1.3 The term missing patient includes all patients on all Mental Health inpatient setting whether subject to the mental health act, informal who are found to be missing from the ward or nursing home, patients who abscond while being escorted and Community Treatment Order (CTO) patients that do not return to hospital when recalled and/or CTO patients that have been recalled to hospital and then abscond.
- 1.4 However, any patient regardless of their Mental Health Act status who is absent from the ward or nursing home without having previously arranged leave or advised staff that they would be absent is defined as a missing person.
- 1.5 Information in this procedure includes input from Essex Multi-Agency Protocol which takes account of Guiding Principles within the Mental Health Code of Practice (MHA CoP 2008).

2.0 PURPOSE

- 2.1 The purpose of this procedural is to set out the actions and reporting arrangements the nurse in charge of the ward or nursing home will undertake in the event of a missing patient:
 - identify when a patient should be regarded as missing or AWOL
 - ensure the actions required are clear and can be completed in an effective and timely manner
 - minimise the risks to patients and others including the risk of disruption to their treatment and care plan
 - ensure everyone involved in the patient’s care is informed as necessary

3.0 DEFINITION

3.1 The following definitions from DOH 2009 apply to high, medium and low secure mental health services. However for the purposes of this procedure, these definitions will be covered by the term “missing patient”.

3.2 The definitions will apply when reporting the incident on Datix, MDT and partner agencies.

- The **Association of Chief Police Officer’s definition of missing** is:
 - “Anyone whose whereabouts is unknown whatever the circumstances of the disappearance. They will be considered missing until located and their well-being or otherwise established”.
 - In Essex under the Multi-agency protocol for People with Mental ill Health and Learning Disabilities who are Missing or AWOL there will be several levels of missing person which are dependent on risk and whether they are detained under a statutory order.
 - Where the location of the person concerned is known, they will NOT be considered as missing under this protocol and should not be reported as such by the organisation having the care of that individual.
- **Escape** – a detained patient escapes from a secure unit/hospital unlawfully gaining liberty by breaching the secure perimeter that is the outside wall, fence, reception or declared boundary of that unit.
- **Attempted Escape** – a failed or prevented attempt by a patient to breach the secure perimeter that in the nature of the incident demonstrated intent to escape.
- **Abscend** – a patient unlawfully gains liberty from the originating unit/hospital which is not a secure unit/hospital by breaching the secure perimeter that is the declared boundary of that unit, or a patient unlawfully gains liberty during escorted leave of absence by breaking away from the custody/supervision of staff.
- **Failure to Return** – a patient fails to return from authorised unescorted leave.
- **Informal Patients** – those patients assessed as not requiring detention under the mental health act.
- **Detained Patients** – those patients assessed as subject to detention under the mental health act.
- **Absent Without Official Leave / Unauthorised absence** - any incident where a patient is missing, failed to return following leave or absent without official leave (AWOL). In these cases the location of the person will often be known or may be ascertained by staff following enquiries. For example:
 - Where a person has been given approved leave but fails to return at the appropriate time. Enquiries show that the person is at their home address and conversations with them indicate that they will be returning within an agreed time scale and there is no additional risk to themselves or others.
 - A detained person smokes and leaves the ward or home to go for a ‘smoke’ without notifying staff first. Here knowledge that the person smokes and the place they will go to do this will locate the person.

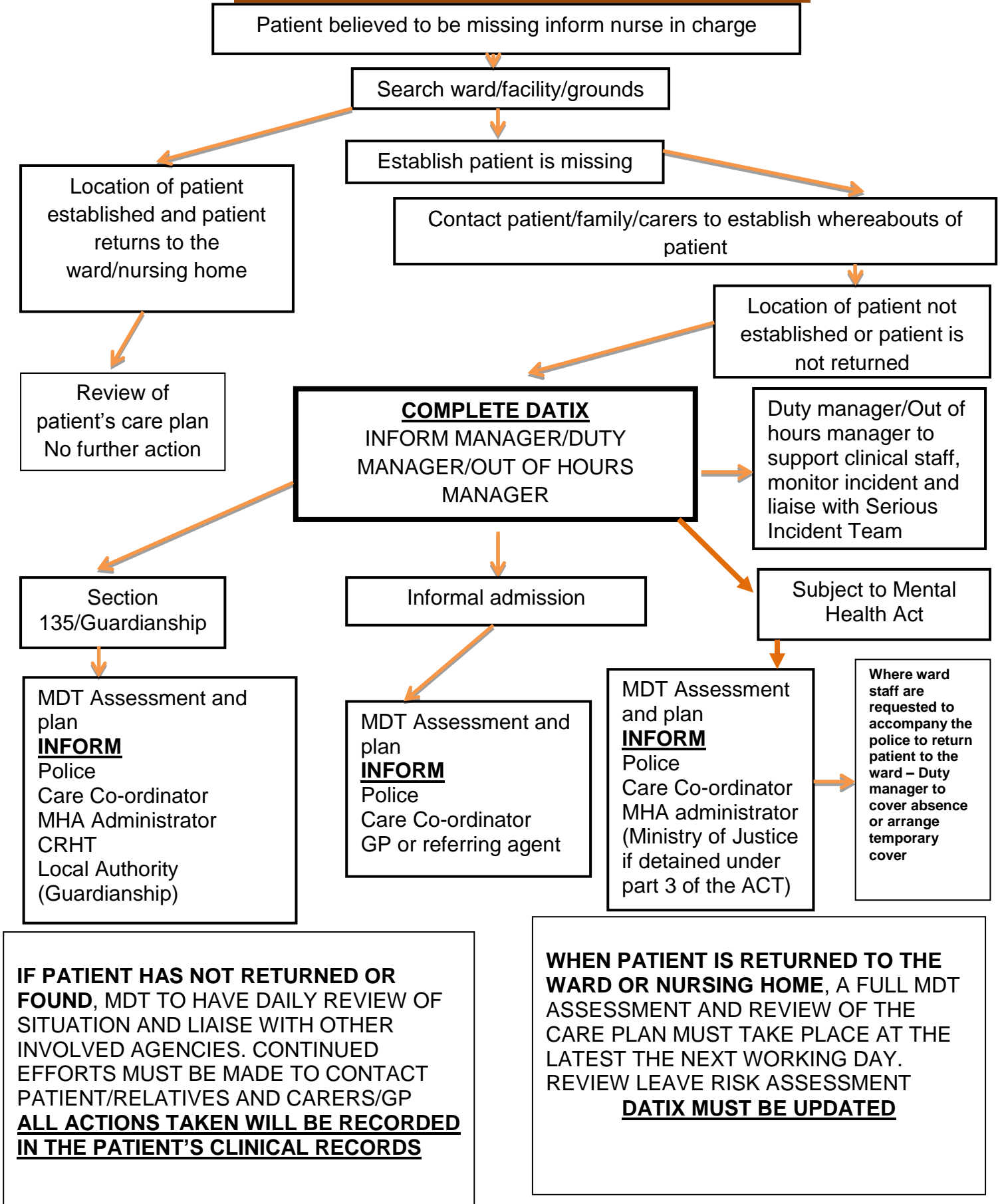
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- **Detained patients failing to return following Home Leave Detained**
- This includes patients on section 17 leave.
- **Community health services** – applies to non-mental health teams such as district nursing, dental care, continence services, etc.

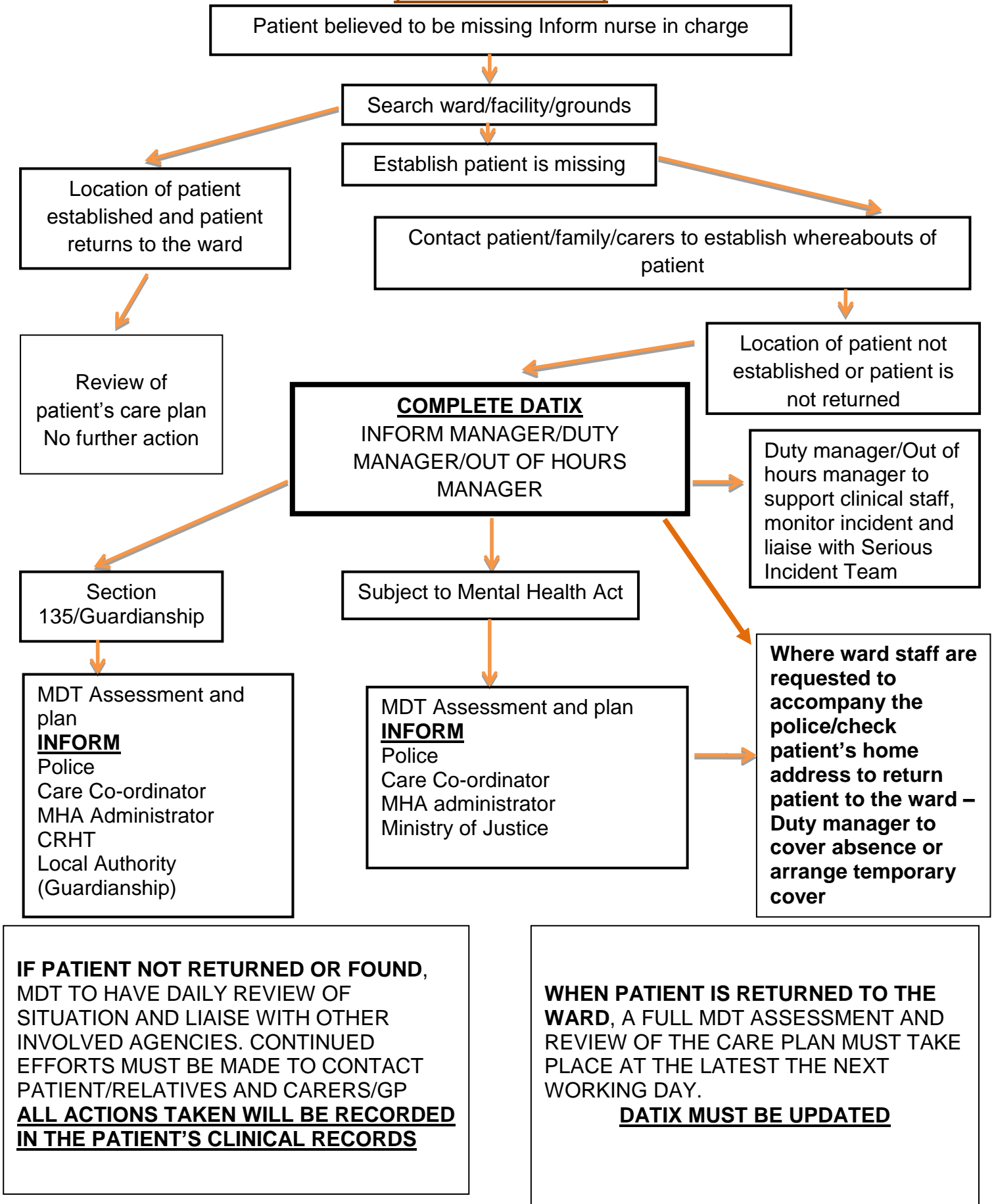
Procedure continues below

4.0 MISSING PATIENTS STANDARD CLINICAL OPERATING PROCEDURE FLOW CHARTS

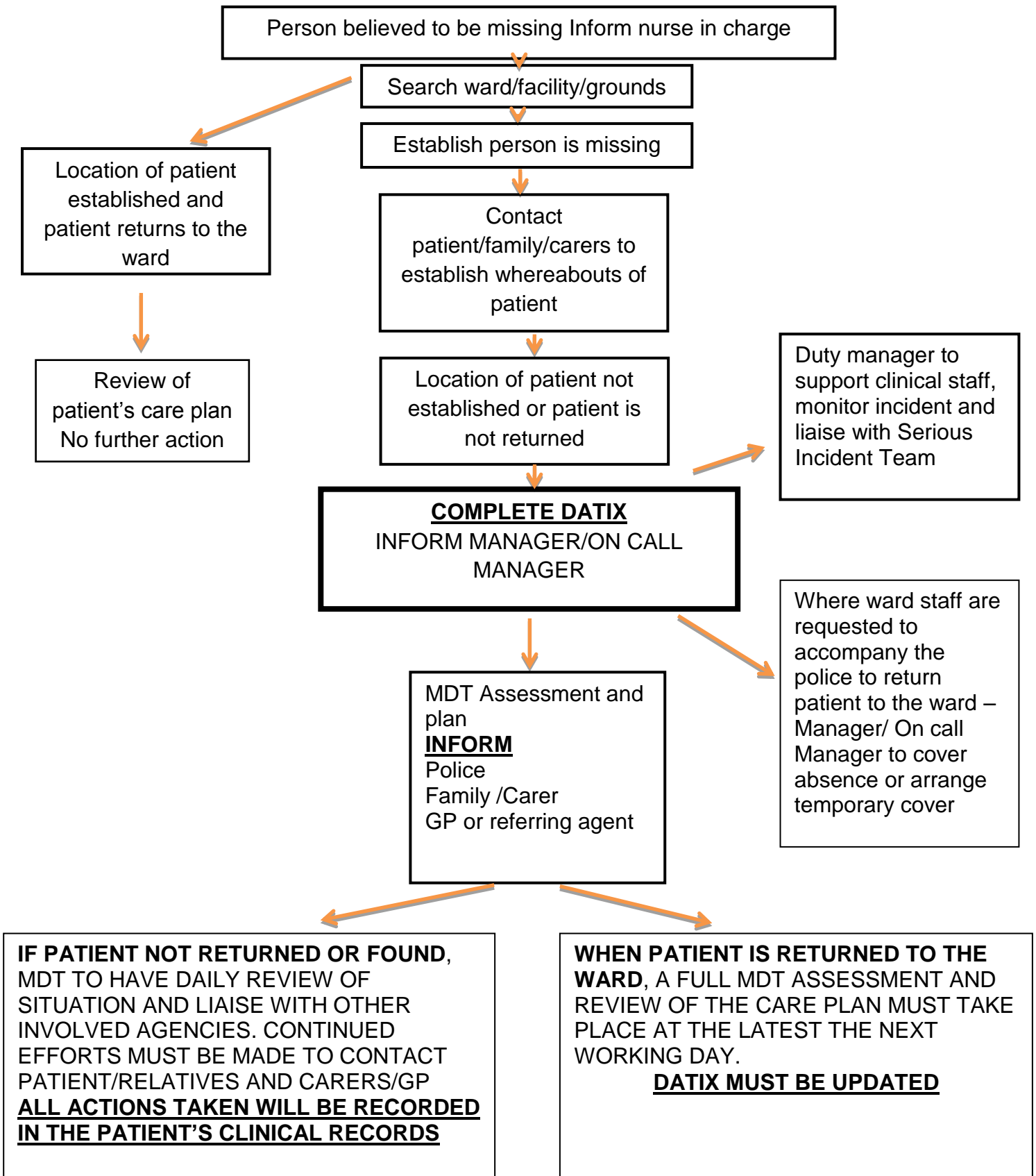
4.1 MENTAL HEALTH / LEARNING DISABILITY/ NURSING HOMES



4.2 **STANDARD CLINICAL OPERATING PROCEDURE MISSING PATIENT
(SECURE SERVICES)**



4.3 Standard Clinical Operating Procedure Missing Patient (Community Health Services)



5.0 GOOD PRACTICE GUIDANCE

- 5.1 All patients, as part of the inpatient admission process should have documented records of an accurate description of their appearance and any distinguishing features. Any significant changes in appearance during the patient's stay should be recorded clearly in patient's notes.
- 5.2 Full up to date demographic information including ethnicity should be held in the patient's record. This includes clarification as to any distinction between next of kin and nearest relative for contact purposes in line with the Mental Health Act 1983 as amended by the Mental Health Act 2007. These will require checking and reviewing on each and every admission and amending as appropriate.
- 5.3 Staff should utilise CCTV and any photographs to ensure that all relevant information to maximise the ability of the emergency services to safeguard the patient safety are made available.
- 5.4 Where a risk of absconsion from an inpatient unit or failure to return from leave is indicated in the risk assessment, staff must note the clothing patients are wearing each day in the ward diary
- 5.5 If a patient has a known history of absconsion, their care plans must highlight:
- Previous antecedents
 - Where they were found
 - Known associates, etc.
 - Planning for missing/missing person report should be completed as part of the admission process (see PAN Essex protocol)
- 5.6 Where there is an identified or considered risk to others, staff should give consideration to informing those at risk via the Police should the patient is missing.
- 5.7 Staff in Essex must also read this procedure in conjunction with **Appendix 1** - the Multi-agency Protocol for People with Mental Ill Health or Learning Disabilities who are Missing or Absent Without Leave from Care.

6.0 ACTIONS TO BE TAKEN WHEN A PATIENT IS DEEMED AS MISSING

- 6.1 If any member of staff discovers, or is informed that a patient appears to be missing, they will immediately inform the nurse in charge of the ward/nursing home.
- 6.2 Unless informed reliably that the patient has left the ward/nursing home, the nurse in charge will organise as many staff as possible to conduct a thorough and systematic search of the ward/nursing home, the adjoining departments and immediate grounds. This would include a search of the patient's area to see if they have taken their belongings with them.

- 6.3 If appropriate, other patients on the ward/nursing home should be asked whether they are aware of the person's whereabouts, when they last saw the patient and if anything was said to indicate where the person may have gone.

7.0 MISSING PERSON CONCERN FOR WELFARE

- 7.1 Where a planned contact cannot be made and there is an identified significant risk to self and / or to others, a noted deterioration in mental health, identified significant/key events and all initial attempts above have been completed then the Missing Person Concern for Welfare escalation protocol is to be implemented, alerting the police to respond.
- 7.2 The practitioner raising the concern is to complete the Missing Person Concern for Welfare Escalation form (Appendix 1). Staff should fill in information as much as possible. Completion of this form will provide the police with the required information to be able to respond in the most appropriate manner.
- 7.3 For all those under the care of mental health services with a crisis plans, this must include escalation arrangements and time scales to follow should there be a concern for a person's welfare. This should be implemented no longer than 24 hours after last planned contact. All crisis plans are to include a full description of the person on the Personal Description Form (Appendix 2).

8.0 ACTIONS TO BE TAKEN WHEN THE PATIENT RETURNS TO THE WARD/NURSING HOME

- 8.1 If following these actions the patient's whereabouts are established and agreement is reached on a return time, the nurse in charge will co-ordinate arrangements for return as soon as possible.
- 8.2 This may include arranging transport and staff escort or the patient returning on his or her own. This will be done in agreement with the Responsible Clinician and Duty Doctor out of hours who will consult the on call consultant.
- 8.3 Where a patient is missing from a nursing home this will be completed with the agreement of the nurse in charge and the nursing home manager.
- 8.4 When the patient returns, a review of the patient's care plan should be undertaken by the care team and all actions recorded in the patient's clinical records.

THE NEXT STEPS TAKEN BY THE NURSE IN CHARGE WILL DEPEND ON THE LEGAL STATUS OF THE MISSING PATIENT

9.0 ACTIONS TO BE TAKEN WHEN THE PATIENT IS NOT FOUND OR DOES NOT RETURN TO THE WARD/NURSING HOME

- 9.1 If the patient is not found or returns, then the nurse in charge will (in consultation with the ward / nursing home staff) assess whether there are real and immediate risks and contact the responsible clinician (or Duty Doctor if out of hours). In the case of a nursing home the nurse in charge will contact the nursing home manager to discuss any immediate risks.
- 9.2 The nurse in charge will consult the patient's care plan, risk assessment and other records for information (where it exists) regarding contingencies already planned in the event of the patient leaving unexpectedly. The nurse in charge must implement the contingency care plan if there is one.
- 9.3 Although each individual case will need to be considered, patient confidentiality will not usually be a barrier to providing basic information about a patient's absence to people (such as those the patient normally lives with or is likely to contact and who may be able to help with finding the patient).
- 9.4 The unit manager (or on-call manager if out of hours) should only be informed if there are real and immediate risks identified by the nurse in charge/nursing home manager /responsible clinician or if there are any difficulties in enacting this procedure i.e. securing police assistance – consider level of risk and why there are concerns when contacting police.
- 9.5 The nurse in charge will attempt to contact the patient by telephone and at their place of residence or the place where the leave was to be taken. The times of all attempts to contact the patient and responses must be recorded in the patient's clinical records.
- 9.6 The nurse in charge will also attempt to contact any carer, relative or any previously identified persons who the patient may be associated with to establish the patient's whereabouts. The times of all attempts to contact family, carers or associated persons and responses must be recorded in the patient's clinical records.
- 9.7 If no contact is made with the patient or their whereabouts cannot be confirmed and it is confirmed that they remain missing, the nurse in charge will complete a Datix form.
- 9.8 The nurse in charge will contact the police immediately where the patient is:
- considered vulnerable
 - considered a risk to self or others
 - subject to restrictions under Part III of the Mental Health Act.
- 9.9 If the patient is not found, the nurse in charge should ensure the following people are notified by the next working day:
- the In-patient Services Manager/Modern Matron
 - the patient's Care Co-ordinator
 - the Mental Health Act Administrator.

10.0 ACTIONS TO BE TAKEN IF THE PATIENT IS SUBJECT TO THE MENTAL HEALTH ACT / DEPRIVATION OF LIBERTY (OR DOLs)

- 10.1 The nurse in charge will consult the patient's care plan, risk assessment and other records for information of any contingencies already planned in the event of the patient leaving unexpectedly.
- 10.2 The nurse in charge must implement the contingency care plan if there is one.
- 10.3 If there is no contingency care plan the following procedures should be followed and clearly documented:
- a. the nurse in charge should consult with other nurses and assess the patient's last reported/recorded mental state and level of risk (ensuring that the Responsible Clinician or Nursing Home Manager is informed of the situation)
 - b. where the risk (to self or others) has been assessed as high (as agreed between the nurse in charge/nursing home manager /Responsible Clinician (or Duty Doctor if out of hours), and there is concern regarding the safety of the patient or the public, the police should be informed by senior nurse/clinician i.e. site officer, bleep holder, nursing home manager.
 - c. when informing the police, the nurse in charge/senior clinician/ nursing home manager should provide them where indicated with information regarding:
 - 1) level of risk and why there are concerns
 - 2) circumstances of absence
 - 3) description
 - 4) diagnosed condition
 - 5) social history (for example friends, family, other contacts)
 - 6) medication – Date and time next due, whether they are carrying medications and effects of not having that medication
 - 7) section details – type, start time
 - 8) care History and risk assessment
 - 9) history of attempted suicide of self-harm
 - 10) whether Multi-agency Public Protection Arrangements (MAPPA) are involved.
 - d. If police are involved in the return, the nurse in charge where appropriate must ensure they are aware of any time limits in relation to the mental health act for retaking the patient into custody.
 - e. The police should only be asked to assist if absolutely necessary. If the patient's location is known the role of attending police should only be to assist a suitably qualified and experienced mental health professional in returning the patient to hospital.

- f. Section 135 (2) is concerned with taking or retaking a patient liable to be detained under the Mental Health Act 1983. It empowers a Justice, based on the evidence of a constable or authorised person, to issue a warrant to a constable for the purpose of entering specified premises to search for and remove a person or patient as above. (Refer to MHA18 –Section 135 MHA 1983 which is on Trust intranet).

11.0 ACTIONS TO BE TAKEN IF THE PATIENT IS SUBJECT TO A COMMUNITY TREATMENT ORDER (CTO)

- 11.1 The whereabouts of the patient is established, the receiving in-patient ward will have to ensure (with the help of bed management team or site bleep holder as may apply) that a bed is available.
- 11.2 The Community Mental Health Team or Home First / Crisis Resolution and Home Treatment Team involved with the patient should assist with the patient's return to hospital.
- 11.3 If the patient is considered subject to immediate risk, arrangements should be made for the police to return them to the ward as soon as possible.
- 11.4 A warrant under s135(2) should be applied for where :
- someone who is detained under the MHA was missing or AWOL has been located but refuses to allow staff access to them.
 - someone who is subject to Community Treatment Order has been recalled to hospital but refused to allow staff access to them or to return to the hospital
 - A suitably qualified and experienced mental health professional must accompany the police when they exercise the warrant.
- 11.5 If the patient is felt to be at no immediate risk, consideration should be given to consulting with the RC/Police/Care Co-ordinator/AMHP and/or relevant others as to the safest method of contact, re-assessment and conveyance.

12.0 ACTIONS TO BE TAKEN IF THE PATIENT IS INFORMAL

- 12.1 The nurse in charge will consult the patient's care plan, risk assessment and other records for information of any contingencies already planned in the event of the patient leaving unexpectedly.
- 12.2 The nurse in charge must implement the contingency care plan if there is one.
- 12.3 If there is no contingency care plan the following procedures should be followed and clearly documented:
- 12.4 The nurse in charge should consult with other nurses and assess the patient's last reported/recorded mental state and level of risk (ensuring that the consultant or nursing home manager is informed of the situation).

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- 12.5 Where the risk (to self or others) has been assessed as high (as agreed between the nurse in charge and the Consultant in charge (or Duty Doctor out of hours) or nursing home manager and there is concern regarding the safety of the patient or the public, the police should be informed. Police could detain the patient under Section 136 if the patient is found in a public place and it is felt that the person needed to be taken to a place of safety.
- 12.6 If the whereabouts of an informal patient is known but they cannot be persuaded to return voluntarily, but are assessed by the nurse in charge, or nursing home manager, Consultant in charge and/or Duty Doctor as not considered to be at risk to self or others, a home visit must be arranged. This is co-ordinated by the nurse in charge liaising with the appropriate Community Mental Health Team or Home First / Crisis resolution Home Treatment Team. In the case of a nursing home the nursing home manager will be responsible for co-ordinating a home visit.
- 12.7 If the whereabouts of an informal patient is known but the patient cannot be persuaded to return voluntarily, and they are assessed by the nurse in charge, nursing home manager, Responsible Clinician and/or Duty Doctor as at risk to self or others, the nurse in charge must co-ordinate arrangements for a home visit. In the case of a nursing home a home visit must be arranged via referral from the GP.
- 12.8 Approved Mental Health Professional (AMHP) can, upon request, use section 135(1) of the Mental Health Act to take an Informal patient from a private place to a place of safety for the purpose of assessment.
- 12.9 Where community patients subject to Community Treatment Order have been recalled to hospital and failed to return, it will be the role of the Responsible Clinician and the Care Co-ordinator to organise their return. They may be supported by the police, where a risk assessment indicates that this is required or wherever a warrant under s135 (2) MHA needs to be executed to gain entry to premises.
- 12.10 This would include an assessment of whether home treatment was an option or MHA assessment for formal admission. In this instance General Practitioner, Care Co-ordinator, Community Mental Health Team or Home First / Crisis resolution Home Treatment Team will be informed by nurse in charge of inpatient area. All case discussions and decisions will be recorded at the MDT meetings

13.0 ACTIONS TO BE UNDERTAKEN FOR PATIENTS SUBJECT TO GUARDIANSHIP

- 13.1 The nurse in charge and responsible consultant will work with the accountable Social Services Manager to ensure the necessary actions are taken in line with the Mental Health Act Code of Practice.

13.2 A warrant under s135(2) should be applied for where:

- access is needed to retake someone subject to Guardianship who has left the place where they are required to be by their Guardian.

14.0 ACTIONS TO BE TAKEN WHEN THE PATIENT RETURNS TO THE WARD/NURSING HOME

14.1 The nurse in charge of the ward/nursing home accepting the patient should ascertain the patient's immediate mental and physical health status and needs. The nurse should also establish whether a search of the patient is necessary.

14.2 The nurse in charge will notify the following of the patient's safe return: the patient's RC (or deputy)/Nursing Home Manager/GP so that a decision can be made as to whether a medical examination of the patient needs to be undertaken;

- the Service Manager/Modern Matron
- the Bleep-Holder
- the Nearest Relative, Next of Kin, Carer (if notified of the absence)
- the police service (if notified of the absence – staff in Essex refer to **Appendix 1** – the multi-agency protocol).
- the Mental Health Act Administration Office (or by next working day).

14.3 The nurse in charge will record the following information in the nursing record:

- date and time of return
- where the patient was found (plus an account of the patient's whereabouts during the absence)
- details of police involvement (i.e. ID number of the police officer(s))
- mental state of the patient on return
- physical state of the patient on return
- details of any untoward incident that occurred during the patient's period of absence without leave
- an assessment of "triggers" or reasons for going missing.

14.4 The nurse in charge will arrange for a full re-assessment (including updating the care plan and reviewing the risk assessment) of the patient by the multidisciplinary team with the addition (or revision) of a contingency plan for further episodes of absence without leave.

14.5 A review of the leave risk assessment undertaken prior to the patient leaving the ward/nursing home must be included in the review to ensure all relevant risks associated with the patient prior to commencing leave were considered and risk rated appropriately. This review will facilitate learning going forward.

14.6 If the patient is detained, the nurse in charge should check whether 28 days has elapsed since they went missing and report this to the Responsible Clinician and MHA Administrator to take actions to review the continuing detention.

15.0 REFERENCE TO OTHER POLICIES

15.1 The following EPUT Policies should be used to assist staff in decision-making in the event of a patient going missing:

- EPUT Adverse Incidents Policy/Procedure
- EPUT Engagement and Formal Observation Policy/Procedure
- EPUT Clinical Guidelines for the Assessment and Management of Clinical Risk
- EPUT MHA 18 – Section 135 MHA 1983

15.2 In Essex staff should also read this procedural in conjunction with the Multi-Agency Protocol for People with Mental Ill Health or Learning Disabilities who are Missing or Absent Without Leave from Care: This memorandum of Understanding is signed by:

- Southend Safeguarding Vulnerable Adults Board
- Essex Safeguarding Adults Board
- Thurrock Safeguarding Adults Board

END