Livewell Southwest

Absent Without Leave (AWOL) and Missing Inpatients

Version 2
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Notice to staff using a paper copy of this guidance

The policies and procedures page of LSW intranet holds the most recent version of this document and staff must ensure that they are using the most recent guidance.

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2.0	Updated	December 2016	MHA Manager	Update of the policy relating to Section 128.

Absent Without Leave (AWOL) and Missing Inpatients

1. Introduction

The objective of this Policy and Procedure is to ensure that the necessary key agencies are involved in finding and returning patients safely when they go missing from hospital or other healthcare settings. Devon and Cornwall Police, Plymouth City Council Social Care and Livewell Southwest have been identified as the key agencies with responsibility for working together to ensure a person is safely returned to the appropriate healthcare setting. All of the aforementioned agencies have agreed to the dissemination and implementation of this policy and have agreed to the following of the procedures contained within it. The safety of the missing individual or the safety of others is of paramount importance and must be the main priority when reporting and finding missing patients, however there is also a need to reduce unnecessary reporting and instances of patients who regularly go missing. This policy applies to all age ranges and all healthcare settings.

1.2 Any course of action taken under the Mental Health Act 1983 (MHA'83) (as amended 2007) must be done with consideration to the Guiding Principles contained within chapter 1 of the Code of Practice Revised 2015 (the Code). https://www.gov.uk/government/news/new-mental-health-act-code-of-practice

All professionals involved with the care and treatment of persons who are detained under the MHA'83 must be familiar with the Principles contained in chapter 1 of the Code.

The Guiding Principles are:

- Least restrictive option and maximising independence.
- Empowerment and involvement.
- Respect and dignity.
- Purpose and effectiveness.
- Efficiency and equity.

1.3 In addition to the Guiding Principles, all professionals involved with the care and treatment of detained individuals must have detailed knowledge of the Code of Practice (revised 2015), including its purpose, function and scope. Chapter 28 of the Code is of particular importance relating to this policy. This chapter provides guidance on action to be taken when patients are absent without leave (AWOL) or have otherwise absconded from legal custody under the Act, including when patients are to be considered to be AWOL.

1.4 The Code is statutory guidance for registered medical practitioners (doctors), Approved Clinicians, managers and staff of providers, Approved Mental Health Professionals (AMHPs), Local Authorities and their staff. For commissioners of health services, police, ambulance services and others in health and social services the Code is not statutory guidance but is beneficial to those persons in carrying out their duties. It is important that these persons have training on the Code and ensure they are familiar with its requirements.

1.5 Where the Code uses the term "must" it reflects obligations which it is essential

to follow. There are no exceptions. Where the Code uses the term “should” and the guidance is statutory, any exceptions to why the Code is not being followed should be documented and recorded including the reason for this. Where the Code uses the words “may/could/can” the guidance is to be followed where possible. This is recognised as good practice but exceptions are permissible.

1.6 Whilst the Act does not impose a legal duty to comply with the Code those listed above must have regard to the Code. Any departure from the Code could give rise to legal challenge; therefore the reasons for departure must be recorded and sufficiently convincing in order to justify the departure.

1.7 The Reference Guide to the Mental Health Act 1983 (revised 2015) Chapter 11 provides further information relating to detained patients who abscond and are Absent Without Leave.

2. Purpose

To provide a working definition of what is meant by the terms “missing patient”.

To provide a working definition of what is meant by being an Absent Without Leave (AWOL) patient.

To determine the risk of the patient and the actions which must occur following an assessment of their risk.

To provide all the agencies with an agreed process which will be followed when a patient is reported as missing by any of the agencies within the Plymouth area.

Identify the agencies which will need to be involved in returning the patient and the allocation of the tasks to be carried out by those agencies.

To outline the reporting process.

To outline the process to follow on the return of missing patients.

To provide guidance on record keeping relating to missing and AWOL patients.

To provide guidance on what needs to happen if a patient is assisted to go AWOL.

3. Duties and Responsibilities

3.1 Locality Managers/ Assistant Locality Managers

To have an overall responsibility in supporting clinical staff in the management of missing or AWOL patients.

3.2 Clinical Team

To decide when patients should be classified as missing or AWOL.

Review and manage the risk whilst the patient is absent.

In the event that an “informal mental health patient” is missing (note:- that informal patients are not AWOL patients) the police will advise the ward or unit manager as to the circumstances the patient was found in and whether they would be likely to return to the ward/unit on their own volition. It will be the responsibility of the ward / unit manager to contact the patient’s Consultant or On-Call Consultant if Out of Hours, Care Co-ordinator or community nurse to establish whether a Mental Health Act assessment is required or whether a visit to the person by a member of the clinical team would be sufficient.

For normal working hours in non-mental health units, the nurse in charge of the ward will be responsible for liaising with the police and for ensuring that the appropriate follow up action is completed.

Out of Hours (OOH) – Site co-ordinator will be responsible for liaising with the police and for ensuring that the appropriate follow up action is completed, this includes supporting and advising the nurse in charge.

3.3 Nurse in Charge (NiC)

To undertake a risk assessment, initiate and allocate the actions to be followed when patients are classified as missing or AWOL.

The NiC is responsible for completing paperwork Appendix A and B when required.

The NiC is required to complete the Care Quality Commission (CQC) AWOL Notification form http://www.cqc.org.uk/content/mental-health-notifications and forward to the MHA office, whenever a detained patient is missing from a low, medium, high security or Psychiatric Intensive Care Units (PICUs). A folder containing all CQC forms is kept by the MHA manager and is available for audit purposes if required.

The MHA node on SystmOne is to be updated by the NiC or ward clerk the next working day, for all detained patients, as soon as it is recognised the detained patient is AWOL.

Once completed a copy of Appendix A and B are to be forwarded to the Matron for each service and scanned to the patient’s records.

3.4 The Responsible Clinician/Consultant

To review the status of missing patients together with the clinical team, assisting in the assessment of the risk and making the decision regarding the circulation of missing patient details.

If the RC (for detained patients) decides to complete a renewal report, Form H5 *(Renewal of authority for detention)* or a H6 *(Authority for detention after absence without leave for more than 28 days)* on the return of the patient, the patient must also be informed about this by the RC.

Further guidance regarding the completion of statutory documentation when a patient is AWOL can be obtained via the Manager or Deputy Mental Health Act Manager.

3.5 Staff Working in Mental Health Units

All staff (including temporary staff) working in Mental Health Units with detained patients have a duty to be aware of and follow the guidance contained in the Mental Health Act 1983, Code of Practice (Reviewed 2015). Chapter 28 *Absence without leave* is of particular relevance regarding this procedure.

The Mental Health Act 1983, Reference Guide 2008 Chapter 11 is also of relevance as it describes the provisions in the Act which relate to keeping patients in legal custody and retaking them if they abscond.

3.6 Staff Working in Non-Mental Health Units

Be familiar with this policy and procedure. The Nurse in Charge of the ward also has responsibility for informing:

Normal Working Hours – Contact Site Co-ordinator.

OOH – Contact Site Co-ordinator.

3.7 The Mental Health Act Manager

To provide CQC with information relating to missing detained patients as requested.

To provide the AWOL Notification reference number for the CQC form and forward the form to the CQC.

To liaise with ward and social care staff to obtain information as necessary.

In the event of the death of a missing detained patient, the MHA Manager will inform the Care Quality Commission and co-ordinate any information and responses they may request. There may be occasions when this would be more appropriately dealt with by a senior nurse, manager or someone from the risk management team in which case this will be agreed between the MHA Manager and the person undertaking the duty.

3.8 Risk Management Team

To collate details of missing patients from incident forms and provide reports as necessary.

3.9 Police Critical Incident Manager

This is the police point of contact for updating missing persons following the review of risk. A nominated police officer is allocated responsibility for the investigation/enquiry on each shift. Contact Number 101.

3.10 Police

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

The police should always be informed immediately if a patient is missing who is:

- considered to be particularly vulnerable
- considered to be dangerous, and/or
- subject to restrictions under part 3 of the Act (restricted patients) (see paragraphs 22.53 – 22.60 of the Code).

There may also be other cases where, although the help of the police is not needed, a patient's history makes it desirable to inform the police that they are AWOL in the area.

Whenever the police are asked for help in returning a patient, they must be informed of the time limit for taking them into custody.

Where the police have been informed about a missing patient, they should be told immediately if the patient is found or returns.

A missing person should always be conveyed in the manner which is most likely to preserve their dignity and privacy, consistent with managing any risk to their health and safety or to other people.

S17(1)(e) of the Police and Criminal Evidence Act 1984 Act provides the police with the power to enter and search any premises, if such action is required, to save *'life and limb'* or to prevent *'serious damage to property'*. The police need to be assured that there are justifiable reasonable grounds before they will proceed to use this entry power. It does not provide the police with authority to remove any person from the premises.

A Police Constable or other authorised person may apply for a warrant under S135(2) of the MHA, which provides for the retaking of an already detained patient who is absent without leave, "A constable may be accompanied by a registered medical practitioner; or by any person authorised by or under this Act...to take or retake the patient".

In practice a police constable will rarely apply for a warrant, this is normally undertaken by an Approved Mental Health Act Practitioner (AMHP) or any officer on the staff of the hospital, or any person authorised by the hospital managers, or in the case of a patient subject to guardianship by the guardian or a local social services authority. For community patients the applicant will normally be the care co-ordinator or a member from the relevant community team. If absolutely necessary the MHA Manager / Deputy may also apply for a warrant.

Police do not have the authority to return patients who have capacity and refuse to return to hospital unless they are detained under the Mental Health Act.

The police have no conveying powers to return patients who lack capacity and

refuse to return to hospital, unless the patient is becoming a risk to the public, they will have little involvement.

The police must be informed if a patient has been assisted to go AWOL. It is an offence under S128 of the MHA'83 to induce or help a patient escape from custody or absent themself from hospital or somewhere they are required to be (without leave) or to harbour or prevent the recapture or return of detained patients.

4. Definitions

DOLS	Deprivation of Liberty Safeguards
MCA	The Mental Capacity Act 2005
MHA	The Mental Health Act 1983
RC	Responsible Clinician
SCT	Supervised Community Treatment
PCIM	Police Critical Incident Manager (24 hrs.)
AWOL	Absent Without Leave
MPP	Missing Patient Procedure
NiC	Nurse in Charge
OOH	Out of Hours

5. Definition of Missing or Absent Without Leave Patient

5.1 It is important to differentiate between patients who are AWOL and those who are missing. Only detained patients should be referred to as AWOL, however all patients regardless of where they are receiving their care may become missing and require the implementation of the Missing Patient's Procedure. (MPP)

5.2 Any patient detained under the Mental Health Act (MHA) who leaves the hospital from where they are detained without authorised Section 17 Leave, or who fails to return from authorised leave by the agreed time, is AWOL. A patient will also be classed as AWOL if they are absent from the place where any conditions of leave require them to be. Patients who are detained under S136 (mentally disordered persons found in a public place) who go missing from the place of safety within the 72 hours assessment period are also considered to be AWOL.

5.3 Patients subject to Supervised Community Treatment (SCT) who have been recalled to hospital and do not comply with a recall notice will be AWOL.

5.4 Where a patient is missing for more than a few hours, their nearest relative should normally be informed (if they have not been already), subject to the normal considerations about involving nearest relatives (see paragraphs 4.32 – 4.37 The Code).

5.5 Any inpatient who has not agreed with the ward staff that they would like to

leave the ward or unit and who have not been medically discharged or discharged themselves from the ward/unit and whose continued absence becomes confirmed can be considered as missing.

5.6 Judgement must be used by the clinical team to decide when a patient is actually to be classed as 'missing' and when the MPP is to be implemented e.g. a detained patient who is an hour late returning from leave may not yet be classed as missing and the decision made not to implement the MPP; however this patient is still AWOL. For detained patients all AWOLs must be recorded on the MHA node on SystmOne. The same patient three hours later who has had contact and whose whereabouts are known/not known may be considered AWOL and require the MPP to be implemented.

5.7 Patients who are not detained may be classified as missing the moment their whereabouts are not known and due to their risk the MPP may need to be implemented immediately. The responsibility for making the decision as to when the MPP is to be implemented will be made by the NiC of the ward/unit.

5.8 All incidences of missing patients whether detained or not should be recorded in the patient's tab journal on SystmOne and an incident form completed.

6. Requirements

LSW actions in response to a missing patient

6.1 As soon as a patient is classed as missing, the NiC must contact the appropriate people (see Appendix A Section 2)

6.2 Although every case should be considered on its merits, 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 – who may be able to help with finding the patient.

6.3 The NiC should undertake an assessment of the level of risk. This will be done by:

- Considering the patient's most recent risk assessment.
- Considering the patient's care plan and most recent entries in the clinical notes.
- Review the above considering the patients recent behaviour, the circumstances of the patient going missing, the patient's legal status and anything else such as their capacity regarding decisions to leave the ward/unit and anything else that is considered relevant at the time.

6.4 When clinical judgment has determined that a patient is missing and this needs to be reported, the Missing Patient Search Sequence Record Appendix A must be completed and this policy followed. If the decision is made not to activate the MPP this must be recorded on the patient's tabbed journal. Any record must include the rationale behind the decision not to report.
Within the mental health services, the NiC is responsible for reviewing the risk with the consultant within 2 hours, to determine whether the patient is classed as missing and whether the MPP should be implemented or an alternative

management plan agreed.

For non-mental health wards/units the risk and the plan for the patient's return would have already been decided.

6.5 To assist in the completion of missing patients forms, all service users should have a description of their physical characteristics included in the nursing notes on admission. (Mental Health Units only).

6.6 A detained person who persistently goes AWOL from hospital or their place of residence must have a multi-disciplinary care plan to assist with the reduction and management of their absence. The RC should ensure that the managing of the AWOL is discussed at ward round or care plan reviews. The person's care plan should state whether the person would like their nearest relative/carer or other person informed if they go AWOL.

6.7 Examples of information to be contained in all care plans, which might assist should the person go AWOL are, useful contact numbers, places where the person may go, persons the absconder may contact, details relating to previous AWOL episodes i.e. always returns within 2 hours, found in pub etc. A time-scale by which the police should be informed should also be recorded. The care plan must also contain details of any person who may be at risk from the patient whilst AWOL. The care plan must contain details as to whether the care co-ordinator should be informed of the person's AWOL and any input the care co-ordinator or community team would be required to give or may be able to provide.

6.8 In the areas where it has been agreed that photographs of patients are to be added to SystmOne these may be provided to the necessary agencies when patients go missing or are AWOL.

6.9 The RC and the Modern Matron/Unit Manager must be informed by the ward manager or NiC when a patient becomes AWOL more than three times. A review of the care plan will be required to ensure that appropriate measures are put in place to reduce the AWOL episodes. The police are to be informed of the measures which have been taken.

6.10 The risk will need to be re-assessed and reduced/increased in light of any further information provided to the MDT. A change in circumstances or the prolonged period of absence may be a factor to consider, as well as any information provided by a third party such as a family member or friend. The PCIM must be informed of any changes in risk whether reduced or increased in order that any resource issues may be addressed.

Implementing a missing persons procedure

6.11 The Nurse in charge will ensure that the following actions are taken when a patient is considered to be missing or AWOL and the MPP is applicable:

- Missing patient's Search Sequence Record is completed (Appendix A). When the form is completed this must be scanned into SystmOne. Appendix

A is also available on S1 in the Questionnaire section.

- Consultant / Responsible Clinician notified as soon as possible.
- Inform the patient's nearest relative (or other named contact). Inform person with parental responsibility if the patient is under 18 years of age.
- Inform the Care Co-ordinator / Home Treatment Team (if applicable).
- Inform the On Call Manager / Matron.
- Inform the local Police on 101 and record the police OIS LOG number plus PID / RID missing person reference.
- Inform any individual who may be at risk from the missing person.
- For Lee Mill detained patients, complete the CQC AWOL notification form. http://www.cqc.org.uk/content/mental-health-notifications
- Complete the CQC Death of detained patient notification form if relevant. (Detained patients only). http://www.cqc.org.uk/content/mental-health-notifications
- Where it is suspected that a patient have been assisted to go AWOL this information also needs to be reported to the police as an offence, not just for information. A log number must be recorded, so that any information which comes to light after the patient returns or sooner can be reported.

6.12 The hospital / unit grounds will be searched by hospital staff immediately, if there are reasonable grounds for believing that the patient may be there. A search of the hospital / unit by the police will only be undertaken when there is evidence to suggest a more thorough search is required.

6.13 Where it is known that a patient is off site (e.g. at home) the hospital / unit will not need to be searched until there is evidence that the individual may have returned and is still considered to be missing.

6.14 The police will immediately be notified by telephone, once the MPP is implemented. A completed copy of the missing patient's form, Appendix B (Information regarding missing and AWOL patients) Section 1 is to be faxed to the police within 30 minutes of them being notified by telephone on 01752 751376. Section 2 of Appendix B will assist in deciding what resources will need to be allocated to finding or returning a missing person. Appendix B could be supported by a patient's photograph (if available) or additional risk assessment information if there are over-riding public safety concerns. Under no circumstances will the police accept an e-mail or fax without an initial phone call and police reference number.

6.15 The NiC in conjunction with the bleep holder / matron and the police will agree a joint action plan to manage risk and ensure the patient is safely returned. The NiC will set the initial overall risk using the police definitions, within Appendix B Section 2. This risk will be the subject of continued review with the matron / ward manager and patient's consultant / RC.

6.16 The joint action plan should include:

- What each agency will do.
- Actions to be taken if police locate the service user.
- Contingency planning.
- Named staff responsible for particular actions and agreed timescales.

6.17 Joint Action Plans should be based on the premise that neither agency should be expected to work on their own and that the safe return of missing patients requires joint action.

6.18 Legal requirements must be taken into account at all times. In particular it should be remembered that:

- The police must respond to the above by attempting to retake (if they have the person in their presence) a missing detained patient, even where the patient appears safe and well. The managers of the hospital from which the patient is absent are responsible for making sure that any required transport arrangements are put in place for the patient's return if the police are unable to return them.

- When making arrangements for the return of the patient temporarily held in police custody, the NiC should bear in mind that police transport to return the individual will not normally be appropriate. Decisions about the most suitable transport to be used to return the individual should be made in the same way as for any patient being taken to hospital. A missing person should always be conveyed in the manner which is most likely to preserve their dignity and privacy consistent with managing any risk to their health and safety or to other people. Guidance on factors to consider when conveying patients can be found in the Mental Health Act 1983, Code of Practice (Reviewed 2015) *Chapter 17 Transport of patients.*

- Appendix G provides a table of time limits for retaking patients who are absent without leave or otherwise liable to be retaken.

- There is no such time limit for retaking restricted patients. They may be retaken for as long as they remain subject to restrictions.

- A patient who is liable to be detained under the Mental Health Act may be returned to the hospital by an Approved Mental Health Professional (AMHP), officer on the staff of LSW, any police officer or any person authorised in writing by the Hospital Managers. This includes patients on Section136 who go AWOL and Supervised Community Treatment patients who do not respond to the recall are classed as AWOL.

- A patient who has been required to reside in another hospital as a condition of leave of absence can also be taken into custody by any member of that hospital's staff or by any person authorised by that hospital's managers.

- Responsibility for the safe return of patients rests with the detaining hospital. If the absconding patient is retaken to another hospital, that hospital may, with the written authorisation of the managers of the detaining hospital, keep

in custody the patient whilst arrangements are made for their return. In these (and similar) cases, the hospital will require a faxed or scanned copy of a written authorisation as evidence that they have the necessary authority to keep in custody the AWOL patient. They may also require copies of the detention papers.

- If the criteria are met, a Section136 can be used by a police officer to detain and remove to a place of safety someone who has been reported as missing and who is found in a public place but only if they appear to be mentally disordered and in immediate need of care and control. This does not apply to patients who are already detained under the MHA.

- A patient liable to be detained who is at home or in any other private premises can be retaken, but only where a warrant under Section135 (2) of the Mental Health Act has been obtained.

- The police are to be advised if the patient is currently under any bail or prison restrictions. This should be identified on Appendix B Section 1.

- When non-detained patients who lack capacity to make decisions regarding their care and treatment go missing, a clinical judgement as to whether the patient needs to be returned must be made by the NiC /Consultant. The risk and vulnerability of the patient whilst absent will need to be considered. A plan must be put in place as to how the patient will be returned and under what authority. Where it is decided that the patient lacks capacity to make a decision about their return to hospital the best interest decision making process must be applied and recorded. If a patient is lacking capacity and refuses to return to hospital, the hospital remains responsible for ensuring that the patient's continued care and risk is managed by involving the appropriate community teams, GP and other health/social care professionals.

The Mental Capacity Act 2005, Code of Practice Chapter 6 "*What protection does the Act offer for people providing care or treatment*" provides guidance on acting in the person's best interests. Consideration must be given to the following points:

- Has the best interests checklist been applied and all relevant circumstances considered?
- Is a less restrictive option available?
- Is it reasonable to believe that the proposed action, i.e. returning the patient to hospital is in the person's best interests?

The Code also provides guidance on *Understanding possible limitations on protection from liability.* The questions to consider before restraint is used when returning an individual are:

- If restraint is being considered, is it necessary to prevent harm to the person who lacks capacity, and is it a proportionate response to the likelihood of the person suffering harm – and to the seriousness of that harm?
- Could the restraint be classed as a 'deprivation of the person's liberty'?
- Does the action conflict with a decision that has been made by an attorney or deputy under their powers?

If the risk/concerns are assessed as being imminent and the clinicians are unable to obtain access to the patient, decisions made relating to previously known information is sufficient. There are no police powers associated with the MCA which enable a police officer to obtain a warrant and gain access to a property. The police would access a property if they believed the person inside was at imminent danger or immediate risk (usual police powers of entry, S17 PACE 1984). If the patient lacks capacity to consent to hospital admission and is in need of care and treatment, conveyance to hospital would be under the Mental Capacity Act provisions. The most suitable form of transportation needs to be used according to the patient's risk and health needs.

6.19 If the risk is assessed and considered to be less imminent and clinicians find themselves in the position where they are unable to access the patient, but have concerns for the safety of the individual it would be most appropriate to refer them to social services under the Vulnerable Adults process.

6.20 When any patient remains missing for more than 24 hours, a clinical review with the RC or Consultant and the ward manager / deputy must take place every 24 hours until the issue is resolved. The purpose of the review is to formulate a plan, identifying responsibilities, tasks and timescales. The PCIM may need to be involved in the review if there is a need for further police involvement. The ward manager is responsible for co-ordinating this review and for documenting and distribution of the plan.

6.21 The next of kin / nearest relative should be informed and updated of the plan, if appropriate.

Action to be taken in response to high risk patients

6.22 When the patient is of high risk, consideration will be given to distributing missing patient details throughout the NHS. Authorisation for this level of distribution of patient information must be agreed by LSW's Caldicott Guardian. The Multi-Disciplinary Team will need to provide the Caldicott Guardian with details relating to the patient's risk, vulnerability and concerns regarding possible outcomes if the patient is not found. Appendix A and B are to be provided with this information. The LSW's Communications and Marketing Manager will arrange for the dissemination of the missing patient's details. If necessary a press release may also be requested. The LSW's communications and Marketing Manager will advise on the suitability of doing this. The police have mechanisms in place to distribute missing patient details throughout the country. If the decision to distribute information is so urgent that it cannot wait until the next working day the on-call manager and on-call director must be advised of the urgency and risk.
Missing patient information must not be distributed until it has been agreed with the on-call manager and on-call director.

Detained patients who leave the country whilst missing

6.23 Detained patients who go missing and are found in Scotland, Wales, Northern Ireland, the Channel Islands and the Isle of Man can be re-taken, held in custody and returned to the detaining Hospital. The Mental Health Act Office can provide further guidance on the relevant legislation and any paperwork required. The Reference Guide to the Mental Health Act 1983 (Reviewed 2015) Chapter

1, *Legal custody, absconding and returning* also provides useful information regarding the retaking of detained patients who go missing from England and Wales.

6.24 The issue of arranging transport for the patient's safe return, and bearing the cost, should be negotiated with the organisation that holds the patient. It is normal for the detaining authority or the hospital who wants the patient returned to pay costs.

6.25 Detained patients who abscond from the UK cease to be subject to English Law and are not therefore detained under the MHA whilst abroad. In certain cases patients who are convicted offenders or are accused of a crime may be extradited back to England, if the necessary warrants have been issued.

The effect of section 40(6) is that if a restricted patient is detained overseas under extradition arrangements, the patient is treated as having been taken into custody under section 18 when first held on the basis of the extradition warrant in the country in question, rather than when returned to the UK. It may be that some patients are detained under the Mental Health legislation of another country, in which case arrangements may be made for their extradition by the detaining country. If returned to the UK within the legal timescales of their section, the patient may be retaken and returned to the UK's detaining hospital.

Actions to be taken when discharging patients still missing

6.26 Low risk patients either on the mental health or non-mental health wards/units who are not detained may be discharged from hospital whilst absent, (they are of voluntary status and therefore entitled to absent themselves from hospital). If their absence does not lead to heightened risk and therefore occasions no particular alarm a decision to discharge will be made at the MDT review and documented in the clinical notes. All discharge paperwork will be completed as for any other patient. The patient's capacity to make the decision not to return must be recorded. All involved parties including the risk management team will be advised of the discharge decision.

6.27 All other missing patients must be followed up via CPA or other Reviews until either the patient is found or no reasonable hope can be held of them being found. The case can then be closed to the organisation and the patient recorded as discharged from a hospital bed. If there is death of any AWOL or missing patient the appropriate policies must be adhered to. Details relating to the death are to be entered onto SystmOne.

6.28 The CQC Notification of death of a detained patient form must also be completed and sent to the MHA Manager.
http://www.cqc.org.uk/content/mental-health-notifications

Actions to be taken on return of missing patients

6.29 As soon as missing patients are found the appropriate people must be informed including:

- The Consultant / Responsible Clinician.
- Relative / Next of Kin / Person with Parental responsibility.

- Care Co-ordinator.
- Ward Manager.
- Modern Matron.
- Police (if they do not already know).
- MHA Office if notified of missing patient. (Detained patients).

6.30 A Management Plan to prevent the patient from going missing again must be completed on the patient's return. This plan must be reflected in the patient's Care Plan.

6.31 Additionally all incidents of patients going missing and AWOL will be reported via an incident report form.

6.32 It is good practice when a patient returns after a substantial period of absence without leave always to re-examine the patient to establish whether they still meet the criteria for detention, a CTO or guardianship. Where patients (other than restricted patients) have been AWOL for more than 28 days, section 21B of the Act requires such an examination to take place within a week of the patient's return and the provision of a report that the criteria for continued detention or being subject to a CTO or guardianship are still met. Otherwise, the patient's detention, CTO or guardianship will end automatically.

Missing detained patients and the Mental Health Act Office

6.33 When patients are missing for more than 24 hours it is important that the MHA Manager knows of missing detained patients because they have a role in:

- Informing Hospital Managers, where appropriate.
- Advising the ward staff about the changing legal position of detained AWOL patients e.g. expiry dates, procedure after 28 days missing.
- Liaising with other authorities regarding the return of patients who are missing (e.g. to authorise them to hold the patient until arrangements can be made to return the patient).
- Forwarding the CQC AWOL notification form (for Lee Mill patients) if required and maintaining a central record.

Learning from missing patient episodes

6.34 Missing patients take up time and resources for LSW staff, police and others. Any reduction in the incidences of patients going missing will result in these resources being more available for direct patient care. Additionally missing patients are always at heightened risk to their health, safety or the safety of others.

6.35 When patients are returned there will be a review of their care plan to try to address the reasons why they went missing and prevent a re-occurrence. If necessary, where the patient is detained under the MHA, the granting or the conditions of Section 17 leave should be reviewed. This review must be documented in the clinical record.

6.36 The management of missing patient incidents and any related matters will be discussed with the appropriate agencies as part of a review to establish what lessons can be learned, including lessons about ways of identifying patients most at risk of going missing.

Training

6.37 This policy will be on Healthnet, where all staff should access it.

6.38 This Policy will feature in relevant training.

6.39 Ward / Unit and Team Managers are responsible for briefing staff about the requirements of this policy. Ad hoc training on this policy will be carried out as necessary.

7 Section 128 – Assisting patients to absent themselves without leave, etc.

7.1 Patients who are detained under the MHA'83 are often vulnerable and could be at risk of exploitation or harm from members of the public or family and friends.

7.2 The Mental Health Act '83 makes it an offence for a person to assist a detained patient to go AWOL, or harbour them, preventing them from being retaken if they are found to be AWOL.

7.3 The patient does not commit an offence by absenting themself without leave, only the person who assists the individual commits the offence. Local social services authorities may institute proceedings for an alleged offence if they are advised to.

7.4 If it is suspected that an offence has been committed to assist someone to go AWOL or prevent them from returning to hospital, it may be useful to speak to the MHA Manager for advice or contact the organisation's legal advisor.

7.5 When information is provided or found out about someone assisting a patient to go AWOL this information needs to be added to the tabbed journal and an incident form completed. This record may need to be referred to if any prosecutions take place. Accurate record keeping is of paramount importance.

8. Monitoring Compliance and Effectiveness

8.1 To ensure that the incidence and outcome of missing patient episodes is kept under scrutiny. LSW will monitor missing patient episodes as follows:

- Figures on the number and outcome of missing patients' events will be included in the Quarterly Statistics, and the accident / incident monthly reports.

All policies are required to be electronically signed by the Lead Director. Proof of the electronic signature is stored in the policies database.

The Lead Director approves this document and any attached appendices. For operational policies this will be the Locality Manager.

The Executive signature is subject to the understanding that the policy owner has followed the organisation process for policy Ratification.

Signed:

Date:

Missing Patient – Search Sequence Record

FAX TO: Devon & Cornwall Police 01752-751376

Section 1

Patient Details and Search Record

Date			
Patient's Name			
NHS Number			
Ward			
Date of Birth		**Is the person under 18**	Yes / No
Date of Admission			
Mental Health Act Status			
Time Patient discovered missing			

Summary of Risk

Key event	Not applicable	Time	Outcome / reason Including name of person spoken to	Printed Name Designation	Signature
Search					
Ward					
Grounds					
The Environment. If there is a risk of immediate suicide / risk to others the police must be contacted immediately at this stage					

Section 2

Persons to be notified

Key event	Not applicable	Time		Outcome / reason Including name of person spoken to	Printed Name Signature Designation
		Informed	Response		
Notify					
Care Co-ordinator / Community Team as per Care Plan. If person is under 18 Social services.					
Site Co-ordinator					
The Manager / On Call Manager					
Consultant / Duty Consultant in charge of the patient's care if clinically indicated					
Nearest Relative / Carer / or any other person as identified on Care Plan					
Review of missing patient every 24 hours (Record Review events on new Appendix A Form)					
MHA Office should be informed of missing detained patents when they have been missing for more than 24 hrs.					
Enter onto SystmOne					

Information Regarding Missing and AWOL Patients

Section 1

Details for police

To be completed when reporting to the Police any missing patient

Time reported to Police	
Police Log Number	
Time Police contacted the Ward	
Police PID number	
Police RID number	
Ethnicity	
Distinguishing marks / unique features To include what the Patient was wearing when last seen	
Reasons for request / disclosure for information to Police – including any Bail / Probation Restrictions. Was anyone else involved in assisting the patient to go AWOL?	
Requested by	
Signature	
PRINT Name	
Date	
Contact Person	
Telephone Number	
Form Faxed to	01752 751376
Time / date	
By whom	

Information Required

Ethnicity		Hair Type	
Height		Hair Colour	
Build		Facial Hair	
Shoe Size		Accent	
Nominated Doctor and Surgery		Eye colour	
Social Worker and Contact No		Jewellery	
Mobile Phone Company		Other	

Section 2
Category of Risk

✓	Risk	High Risk ✓	Medium Risk ✓	Low Risk ✓	Comments Effect on risk Reason or grounds for risk
❑	Is there any information that the person is likely to cause self-harm or attempt suicide?				
❑	Violence towards others				
❑	Do you believe that the person may not have the ability to interact safely with others or in an unknown environment?				
❑	Is the person familiar with the local area?				
❑	Violence towards property				
❑	Weapons				
❑	Abuse of illicit drugs / alcohol / prescription medication (delete as required)				
❑	Does the missing person have any physical illness, disability or mental health problems?				
❑	Failure to take medication				
❑	Does the missing person need essential medication or treatment not readily available to them?				
❑	Are there any effects if medication is not taken?				
❑	Does the missing person have cognitive impairment?				
❑	Is the person suspected to be subject of a crime in progress, e.g. abduction or assault etc.? Is there anyone that may have assisted the person to go AWOL or missing?				
❑	No fixed abode				
❑	Fear of uniforms				
❑	Adverse reaction / fear of authority				
❑	Is the person vulnerable due to age, infirmity or any other factor?				

✓	Risk	High Risk ✓	Medium Risk ✓	Low Risk ✓	Comments Effect on risk Reason or grounds for risk
❑	Has the person been the subject of bullying or intimidation?				
❑	Are there inclement weather conditions that would seriously increase risk to health, especially where the missing person is a child or elderly person?				
❑	Has the person been involved in a violent, homophobic and / or racist incident or confrontation immediately prior to disappearance?				
❑	Has the person previously disappeared and suffered or been exposed to harm?				
❑	Is the behaviour out of character and likely to be an indicator of their being exposed to harm?				

Comments		
High risk	The risk posed is immediate and there are substantial grounds for believing that the subject is in danger through their own vulnerability or may have been the victim of a serious crime or risk posed is immediate and there are substantial grounds for believing that the public is in danger	☐
Medium risk	The risk is likely to place the person in danger or a threat to themselves or others	☐
Low risk	There is no apparent threat of danger to the person or the public	☐

Action to be taken when Patient is found by Police	
Arrest Section 2, 3, 37 MHA and return	☐
Arrest other	☐
Voluntary request to return ☐ I.e. Patient not detained, but it is in their best interest to return.(explain why)	

Date and Time of Review and any Changes	
Print Name **Designation**	
Signature	
Date And Time	

Appendix C

Record Form – Outcome of Patient Being Found

Section 1
Outcome

Key event	Time		Printed Name Signature Designation	Outcome / reason Including name of person spoken to
Outcome				
Patient found (state where patient found and by whom)				
Patient returned to hospital (state method of return)				
Complete Incident Form				
Assess and search person on return in accordance with Search Policy if clinically indicated				
Update Risk assessment, CPA and SystmOne				
Inform of Outcome				
Please inform all people identified in Section 2				
Outcome				
Advise Police of outcome of their intervention and whether someone committed an offence by assisting the patient to go AWOL.				

For monitoring purposes form to be placed in:	Scanned to SystmOne Copy to Matron for Countersigning
CQC Form to be completed (If relevant)	Scanned to SystmOne To be sent to the MHA Office
Matron Name	
Signature	
Date & Time	
Follow Up Action	

NHS No:

Mental Health Act 1983 s. 17(1) – Leave of Absence Recall Form

For further guidance refer to: The Code of Practice (Revised 2015) 27.32-36
Reference Guide (Revised 2015) 25.16-25.20

To: .....

Hospital Number:..... NHS Number: ……

at present "liable to be detained" on ..... Ward under Section ..... MHA 1983

As your Responsible Clinician I write to confirm that you are to be recalled to hospital and that your Section 17 Leave of Absence is being revoked for the following reasons:

……

……

……

……

……

……

……

……

……

……

Responsible Clinician: _____

Signed: _____

Date: _____

Cc Ward
Mental Health Act Office

Author: MHA Manager Leave of Absence Recall Form V2 Asset Number 753

Appendix E

Recall From S17 Leave and Obtaining S135(2) Warrant

NOTE: A refusal to take medication would not on its own be a reason for revocation, although it may need to be considered.

Only the RC can revoke the patient's leave if he/she **considers** it necessary, in the interests of the patient's health or safety or for the protection of other people. The RC must consider what effect being recalled to hospital may have on the patient.
NOTE: The On-Call Consultant (If an Approved Clinician) is the RC for all patients detained to Livewell Out of Hours.

NOTE: A Fax or photocopy copy is acceptable

↓

The RC must discuss with the Community Care Team, and care co-ordinator:

- the need for the patient to be recalled,
- the urgency of the recall,
- the likelihood of the patient's returning to hospital of their own free will,
- any known risk associated with the patient.

↓

The RC must confirm with the Unit manager/Bed co-ordinator the availability of a bed before recalling the patient to hospital. The patient can only be recalled to the hospital they went on S17 leave from.

↓

The **RC must arrange for a notice in writing** to the patient revoking the leave or on the person who is for the time being in charge of the patient. The full reasons for revoking the leave are to be fully explained and a copy of the form or letter placed on SystmOne.

NOTE: Patients cannot be recalled after they have been discharged or after the authority for their detention has expired.

↓

The RC must consider the likely reaction of the patient, the most appropriate person to inform the patient and what resources are required to carry out the transportation of the patient back to hospital. The mode of transport will generally be dependent on the amount of resistance of the person.

How To Obtain A S135(2) Warrant If The Person Refuses To Return To Hospital

NOTE: Whenever the police are asked for help in returning a patient, they must be informed of the time limit for taking them into custody. (Date section is due to expire.) Where the police have been informed about a missing patient, they should be told immediately if the patient is found or returns.

If the patient refuses to return to the detaining hospital, he/she becomes absent without leave and may be taken into custody and returned to hospital by any

- Approved Mental Health Professional (AMHP),
- by any member of the hospital staff,
- any police officer,
- Or anyone authorised in writing by the hospital managers.

If a warrant is required the community team and the ward must decide who is most suitable to apply for the warrant. An individual must be nominated to co-ordinate the process of obtaining and executing the warrant.

The person applying for the warrant must know the patient well enough to answer any questions the magistrate may have relating to the reasons for the recall.

A warrant can be obtained by contacting Plymouth Magistrates Court on Tel. 206200 (office hours) and arranging for a convenient time to collect the warrant.
When attending the Court the applicant will need to advise the receptionist of their name and the time agreed to collect the warrant.

The applicant will need to take

- Appendix F and G from the AWOL policy.
- Fee of £20.00.
- Good quality copy of section papers (if possible) (MHA Office).
- Good quality copy of S17 Leave Form (Ward).
- Good quality copy of RC's letter, recalling the patient, (the original must be given to the patient).
- Staff identification.

When the Magistrate is available the applicant will be asked to provide their name, profession and why the warrant is required. If satisfied that the warrant is necessary the Magistrate will issue a warrant.

The warrant is valid for 28 days, but must be executed as a matter of urgency. A copy of the warrant must be left at the address at which it is served, a copy is to be retained by the police and a copy must be placed in the patient's records.

The police should be asked to assist in returning a patient to hospital only if necessary. 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.

APPENDIX G

Summary of time limits for returning patients who are absent without leave or otherwise liable to be retaken

(Mental Health Act 1983 Reference Guide Figure 44)

A patient who, at the time of may not be retaken after absconding, was (or is treated as)	**Time runs from**
Liable to be detained on the basis of a nurse's record under section 5(4)	6 hours starting at the time the nurse made the record
Liable to be detained on the basis of the report of a doctor or an approved clinician under section 5(2)	72 hours starting at the time the doctor or approved clinician furnished the report, or If the patient was first held under section 5(4) following a record made by a nurse, 72 hours starting at the time the record was made
Being conveyed to hospital on the basis of an application for admission for assessment or treatment under section 2 or 3	14 days starting with the day the patient was last examined by a doctor for the purposes of a medical recommendation in support of the application
Being conveyed to hospital on the basis of an emergency application under section 4	24 hours starting at the time the patient was last examined by a doctor for the purposes of the medical recommendation in support of the application
Detained on the basis of an emergency application under section 4, where the second medical recommendation has not yet been received	72 hours starting at the time the patient was admitted (or treated as admitted) to the hospital on the basis of the emergency application
Detained on the basis of an application for admission for assessment under section 2 (or under section 4, where the second medical recommendation has since been received)	28 days starting with the day the patient was admitted (or treated as admitted) on the basis of the application
A patient on a community treatment order who has been recalled	The later of: six months starting with the day the patient went absent; or the date on which the community treatment order is due to expire (ignoring any possibility of it being extended or revoked and any extension allowed because of the patient's absence)
Subject to a restriction order, limitation direction or restriction direction (whether or not conditionally discharged)	The restriction order, limitation direction or restriction order ceases to have effect (which may not be until the patient dies)

Subject to guardianship on the basis of an application for guardianship under Part 2	The later of: six months starting with the day the patient went absent; or the date on which the authority under which the patient was subject to guardianship at the time the patient went absent is due to expire (ignoring any possibility of it being renewed and any extension allowed because of the patient's absence)
Subject to a guardianship order under Part 3	
Detained in a place of safety under section 135 or 136	The earlier of: 72 hours from the time the patient absconded; or the end of the period for which the patient may be detained, i.e. 72 hours from the start of the patient's detention in the place of safety
Subject to a remand under section 35 or 36 or an interim hospital order under section 38	No time limit is specified. The patient may be arrested by any police officer (or other constable) and, when arrested, must be brought before the court that made the remand or interim hospital order as soon as practicable.
Being conveyed in England or Wales en route to Scotland, Northern Ireland, the Isle of Man or any of the Channel Islands, in accordance with a transfer warrant	The period during which the patient could be retaken if no transfer was being attempted. (This is because, until the transfer is complete, they remain subject to detention or guardianship in England)
Being conveyed in England or Wales en route from detention in Scotland or Northern Ireland, in accordance with a transfer warrant (or its equivalent), or from the Isle of Man under section 84, but yet to arrive at the hospital to which they are to be admitted	The end of the period during which the patient could be retaken if they had already been admitted to hospital in England or Wales and had then gone AWOL. This will vary depending on the type of application, order(s) or direction(s) to which they would be treated as subject on completion of the transfer
Being conveyed from the Isle of Man or any of the Channel Islands, in accordance with a transfer under section 85, but yet to arrive at the hospital to which they are to be admitted	The end of the period during which they could be retaken had they absconded while still in the Isle of Man or the relevant Channel Island