Worcestershire Acute Hospitals NHS Trust

Missing in Patient Guideline (16yrs +)

Department/ Service:	Corporate
Originator:	Head of Safeguarding Interim Director of Estates and Facilities
Accountable Director:	Director of Estates and Facilities
Approved by:	Trust Management Board
Approved by Medicines Safety Committee: *(When medicines are included in the document)*	N/A
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Revision due: This is the most current document and should be used until a revised version is in place	19th June 2028
Target Organisation(s):	Worcestershire Acute Hospitals NHS Trust
Target Departments:	Trustwide
Target Staff Categories:	All Clinical Staff All Security Staff

Guideline Overview:

The Trust has a duty of care for the safety of its patients. At the same time, patients deemed to have mental capacity have a legal right to leave the hospital unless they are detained under the Mental Health Act (MHA) 1983 or Deprivation of Liberty Safeguards.

A patient who leaves the ward /department without formal discharge or prior arrangement is classified as missing. This document advises staff of action to be taken, and by whom, in the event of an inpatient being identified as missing.

This guideline will enable staff to:

- Identify when a patient should be regarded as a missing patient
- Take the appropriate action in a timely and effective manner
- Reduce the possibility of any harmful outcomes to the patient
- Ensure that relatives of any missing patients are informed as soon as possible and kept informed of all developments
- Establish the principles for the recognition and search for patients missing from the ward/hospital

Key amendments to this guideline

Date	Amendment	By:
18/12/12	Adding patient alert to OASIS, Sections numbered	Suzanne Hardy
06/03/2015	Change in definition of missing	Suzanne Hardy
06/03/2015	Use of the patient's mobile phone to establish where they are	Suzanne Hardy
06/03/2015	Additional information to follow if a patient is detained under the Mental Health Act or Deprivation of Liberty Safeguards	Suzanne Hardy
03/07/2017	Revision of Police liaison arrangements. Inclusion of The College of Emergency Medicine – Best Practice Guideline (May 2013) The Patient who absconds	Deborah Narburgh
05/12/2017	Sentence added in at the request of the Coroner	
03/08/2018	Amendment to include Worcestershire Safeguarding Adult Board (WSAB) Missing Person Guidance in relation to Mental Capacity and past tendencies. Approved Safeguarding Committee 03.08.2018	Deborah Narburgh
February 2020	Document approved with Safeguarding pathway	Safeguarding Committee/ CGG
February 2023	Document extended for 6 months whilst review in process	Deborah Narburgh
October 2023	Document extended for 6 months whilst review is in place	Deborah Narburgh
2nd May 2024	Document extended for 6 months whilst under review	Deborah Narburgh
Feb 25	Document extended for 6 months	Deborah Narburgh
March 2025	Guidance and Appendices updated pending full guideline revision.	Deborah Narburgh
June 2025	Full guideline review and update.	Deborah Narburgh Emma King

Worcestershire Acute Hospitals NHS Trust

Contents page:

1. Introduction

The Trust has a duty of care for the safety of its patients. At the same time, patients deemed to have mental capacity have a legal right to leave the hospital unless they are detained under the Mental Health Act (MHA) 1983 or Deprivation of Liberty Safeguards.

Worcestershire Acute Hospitals NHS Trust assumes a duty of care once a patient is booked in.

Where the MHA (1983) is engaged, this has primacy over the Mental Capacity Act (2005).

A patient who leaves the ward without formal discharge or prior arrangement is classified as missing. This document advises staff of action to be taken, and by whom, in the event of an inpatient being identified as missing.

The Trust needs to be vigilant in the care of all patients, particularly those deemed as at risk which include those that are:

- Self-harming
- Experiencing suicidal ideation or at risk of death by suicide
- Lack of cognitive ability (permanent or temporary) due to physical condition or medical treatment
- Lacking the mental capacity to self-discharge
- Depressed state of mind or have an identified mental illness and are potentially detainable under the MHA 1983
- Under the age of 18yrs
- Clinical condition poses a threat to patient safety
- Possibly lack requisite decision making autonomy (but this has not yet been formally assessed)

This guideline will enable staff to:

- Identify when a patient should be regarded as a missing patient
- Take the appropriate action in a timely and effective manner
- Reduce the possibility of any harmful outcomes to the patient
- Ensure that relatives of any missing patients are informed as soon as possible and kept informed of all developments
- Establish the principles for the recognition and search for patients missing from the ward/hospital
- Involve external agencies as appropriate.

This guideline applies to all wards and departments within Worcestershire Acute Hospitals NHS Trust.

1.1 Collateral history (information gathered from someone other than the patient) of missing episodes

Staff should be alert to any past tendency of the patient to seek to leave the care environment and any reasons for this. This should then inform risk assessments and actions to be taken in order to maintain the individual's physical safety.

1.2 Partnership Working

Worcestershire Acute Hospitals NHS Trust is committed to the safeguarding of vulnerable individuals by fulfilling our legal and statutory obligations in this regard. In order to achieve this, we will work with partner agencies in order to safeguard those most at risk to either themselves, or others.

In some cases, it may be necessary to refer cases into the Multi-Agency Safeguarding Hub (MASH) and convene a 'strategy meeting' where all relevant partners can come together, facts can be shared and an informed decision made. Where this is deemed necessary, further information can be found via the Trust Safeguarding Policy & Procedures.

1.3 Links to other Relevant Trust Policy & Procedure

This guideline should be used alongside the following:

- Safeguarding Adults & Safeguarding Children Policy
- Mental Capacity Act (2005) Policy & Procedure
- Mental Health Act Policy & Procedure
- Deprivation of Liberty Safeguards Policy & Procedure
- Restrictive Interventions Policy – Adults
- Consent to Treatment

1.4 Police Response

Police response /call for service will be based upon their assessment of the individual case in accordance with Right Care Right Person (RCRP) national guidance launched July 2023.

When calls for Police service are made, the Police will undertake their triage process asking:

1. Is there a statutory policing role?
2. Are Police the most appropriate agency?

Where Police accept the call for service and take on the Duty of Care, they will utilise the THRIVE assessment model to allow for the appropriate decision making in relation to the grading and allocation of the call for service.

Where staff do not agree with the Police response then this should be escalated to the Duty Superintendent who will act as the final arbiter.

1.5 Police Response and Children /Young People (16-18yrs)

The threshold for call for service for children and young people is generally considered to be lower than that for an adult.

Police have statutory responsibilities in accordance with Working Together to Safeguard Children (updated 2023):

- Identification of children who might be at risk from abuse and neglect
- Investigation of alleged offences against children
- Inter-agency working and information sharing to protect children; and
- The use of emergency powers to protect children.

1.6 Missing Children / Young People (under 16yrs)

The Trust Policy for Missing/abducted infant, child or young person from ward/department should be followed. Available via SharePoint Key Documents page of the Trust intranet (within the Safeguarding Children & Young People Policy).

1.7 Mental Capacity and decision to leave the care environment

Where any doubt exists regarding the persons Mental Capacity to make a decision to leave the care environment a formal assessment of mental capacity should be completed. The outcome of the capacity assessment should inform a proportionate risk assessment to maintain the person's physical safety. If the person is admitted to the Trust, an application for a standard authorisation under Deprivation of Liberty Safeguards (DoLS) may also be required.

The assessment process should identify amongst other aspects a review of the past tendency of the person being assessed to seek to leave their care environment and the reasons for this.

The assessment process should clearly address the provider's ability to maintain the physical safety within the provider's care environment.

Key information for staff:

Mental Capacity Act (2005) Policy & Procedure available on the Trust intranet (Sharepoint) via A-Z Key Documents

The following forms should be completed:

Form MCA 1 - Assessment of Capacity
Form MCA 2 - Best interest Decision Making

1.8 Self-Discharge (patients deemed to have mental capacity to make an informed decision)

A patient who wishes to leave the hospital / department without assessment and / or treatment may do so, but they should complete a self-discharge form with a healthcare professional. This form includes an assessment of mental capacity. The healthcare professional should record that the individual is taking their own discharge against medical advice and any associated risks associated with this decision should be explained to the patient and recorded.

Key information for staff:

Form WR6009 available through Evolve / Sunrise

1.9 Patients who voluntarily return to hospital

Patients who have absconded but who either return voluntarily to the hospital or are brought back by the Police service should be considered high risk for further episodes of absconding and their clinical assessment prioritised.

Clinicians should be mindful that after a period of absconding the patient's condition may have changed for a variety of reasons (e.g. ingestion of alcohol or illicit substances) and previously instituted management plans may need to be reviewed in light of the new clinical assessment following the patients return. These patients should be seen by the most senior doctor available.

2. Scope of this Document

This guideline covers all **patients in adult clinical areas (aged 16 years and above).**

This guideline provides guidance to WAHT employees on what action to take when a patient goes missing or absent without leave (AWOL).

Every effort should be made within in-patient services to ensure that staff know the whereabouts of all patients in their care. However, due to the majority of in-patient areas not being locked and therefore allowing a degree of freedom of movement, there may be times when a patient cannot be found on the ward and staff are not able to account for their whereabouts.

The risk of a patient being missing, or AWOL is that they may either actively or passively harm themselves or others, be exploited by others, or suffer harm due to an inability to care for themselves whilst they are away from the hospital environment.

This guideline highlights the distinction between a patient who is missing and a patient who is AWOL and when a patient is classed as missing or AWOL.

It also highlights when there should be escalation to the Police, under what circumstances this applies, and what the internal trust escalation processes are in these situations.

This guideline is also underpinned by the Mental Health Act (MHA) Code of Practice Guidelines 2015 and sets out the trust's approach to managing the risk of missing and AWOL patients in its inpatient services subject to detention under the Mental Health Act.

This guideline also covers patients subject to Deprivation of Liberty Safeguards. For a patient subject to the Deprivation of Liberty Safeguards (DoLS) who leaves an in-patient service without the knowledge or agreement of the clinical team, the DoLS only authorises the stay on the ward; so if someone leaves there is no authority to bring the patient back under the safeguard. They would be classed as a vulnerable missing person.

3. Definitions

Definition	Description
Missing Person	College of Policing definition: ***Anyone whose whereabouts cannot be established will be considered as missing until located, and their well-being or otherwise confirmed.*** This is a broad definition, intended to ensure that all cases of people suspected of being missing who are reported to the police are considered for a policing response. The nature of the response is for operational decision makers. Not all reports of missing people will require immediate deployment of police resources West Midlands Police definition: ***'Anyone whose whereabouts cannot be established and where the circumstances are out of character or the context suggests the person may be subject of crime or at risk of harm to themselves or another'***.
Absent Person	The National Police Chiefs' Council (NPCC) definition: ***"A person not at a place where they are expected or required to be and there is no apparent risk"***
Absent Without Leave - AWOL	AWOL is an abbreviation for absent without leave, meaning away without permission

4. Responsibility & Duties

All Staff
All staff have a duty to ensure that this Policy and Procedure is followed.
All staff have a duty to undertake mandatory training requirements in relation to safeguarding, MCA & DoLS at a level in accordance with their job role.
All staff have a duty to escalate concerns in relation to a missing or AWOL patient immediately in order for the Trust Policy and Procedure to come into effect.

Specific Responsibilities
e.g. Ward Manager, Matron, Medical Team, Clinical Site Manager (CSM), Security Team, Portering, Executive Director

As detailed within steps for Procedure to be Followed.

Trust Board
Is accountable for ensuring the safety of all patients.

Chief Nursing Officer
Is accountable for the governance and oversight of safeguarding activity.

Director Estates & Facilities
Has responsibility for ensuring this Policy & Procedure is fit for purpose and disseminated across the Organisation.
Has responsibility to ensure all security staff are aware of their responsibilities in the delivery of this Policy & Procedure in keeping patients /staff safe.
Has responsibility to ensure that information is available / shared in a timely manner with the relevant authorities to aid investigation e.g. CCTV

Divisional Leads /Heads of Service
Are responsible for the cascading of, and compliance with this Policy & Procedure

Police
Police response /call for service will be based upon their assessment of the individual case in accordance with Right Care Right Person (RCRP) national guidance launched July 2023.
Where staff do not agree with the Police response then this should be escalated to the Duty Superintendent who will act as the final arbiter.
Where Police accept the Duty of Care and agree to a course of action they will advise the caller accordingly. Likewise, Police will advise where they do not accept the Duty of Care as they do not deem Police to be the most appropriate agency.

Divisional Governance Teams / Patient Safety
Will review all reported incidents in accordance with the Trust Incident reporting Policy & Procedure.

Incident Reporting Process
Refer to Appendices. Incidents will be recorded on the Datix incident reporting system.

5. Policy detail

Procedure to be followed:

STEP 1 – IMMEDIATE ACTION (USE IN CONJUNCTION WITH STEP 3 TO DETERMINE THE CATEGORY OF RISK)

Stage 1: Determining if the patient is missing

Is the patient missing? i.e. their whereabouts cannot be established and:

- The patient is particularly vulnerable e.g. dementia, cognitive impairment – **go straight to step 3 – determining the category of risk (to determine whether there is a *CRITICAL* concern). Escalation process to be followed as detailed below.**
- Adverse contributory factors are present which may increase the risk to the vulnerable patient e.g. weather conditions –**go straight to step 3 –**

determining the category of risk (to determine whether there is a *CRITICAL* concern). Escalation process to be followed as detailed below.

- The context suggests the person may be a victim of crime
- The person is at risk of harm to themselves or another person(s)
- 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.

Supporting documents:

APPENDIX 1 – QUICK REFERENCE GUIDE

STEP 2 - ESCALATION PROCESS FOR A PATIENT DEEMED TO BE MISSING OR AWOL

Escalation Process:

1. Escalation – **in hours**
   Escalate to Ward Manager / Matron who should then advise the Clinical Site Manager (CSM) / Executive Team
2. Escalation – **out of hours**
   Escalate to site bleep holder who should escalate to the On-call Matron for onward escalation to the CSM who will inform the Senior Manager on Call and Executive Director
3. **If there is a risk of serious harm to the patient as a result of their medical condition, cognitive status or other adverse conditions e.g. weather conditions, if not found; the CSM is responsible for immediate escalation to the Police due to the critical level of risk.**

   **** Is the patient known to have a Herbert Protocol in place – if known, Police should be directed to this.**

4. On-call Matron to inform Medical team **- see Step 4 for actions in relation to specific requirements for patients detained under the Mental Health Act**
5. **Does the concern pose a risk of significant harm or risk of death to the patient or others – immediate escalation to Police and Executive Director who will consider with the Emergency Planning Response team**

whether a critical incident response is required involving partner agencies and specialist equipment support

6. **Risk to staff to undertake search should be considered and informed by any known risks e.g. forensic history, carrying weapons, use of illicit substances**

Escalation process complete:
To whom:
By whom:
Date / time:

Media Interest

All press contact should be channelled through the Trust's Director of Communications who will be responsible for liaison with the media and communication with the Chief Executive Office.

STEP 3 – DETERMINING THE CATEGORY OF RISK

1. Where there is no *Critical concern*

- The patient is considered not to present any danger / risk to themselves or others.
- The patient is deemed to have mental capacity to make an informed decision to leave and not return
- The patient's medical condition and mental state are considered to present little or no risk.
- The patient is not subject to a detention order e.g. Mental Health Act

The medical and nursing team will continue to attempt to establish contact with the patient.

The decision to stand down will be made based on any known risk/s, jointly between the medical and nursing team alongside the CSM / Executive Director.

2. Where there is a *Critical concern* – Police threshold, other agency support

When assessing the needs and expectations of all callers, West Mercia Police will apply two key questions within their TRIAGE process;

1. Is there a statutory policing role?
2. Are Police the most appropriate agency?

The Multi-Agency Response for Adults Missing from Health and Care Settings Framework recommends that health and care professionals should make initial enquiries to ascertain the whereabouts of the missing patient before contacting the police unless there is **'critical concern'** for someone's safety.

Where there is no **real, immediate and unconditional threat to life or other immediate and avoidable significant harm** and the request relates to an incident which would benefit from a joint agency response, agencies will be referred to the standard operating procedures for working together, where the joint response can be planned and agreed within defined joint agency strategy or multi agency meetings.

The below 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***. Staff should always consider whether a joint agency response is required e.g. Police and Ambulance service and request accordingly.

- The missing patient presents a risk to themselves or others.
- 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 attempt / undertake death by suicide.
- 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.
- 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 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.
- The patient may be subject to a detention order under the Mental Health Act, Deprivation of Liberty Safeguards, or they may be informally or voluntarily detained.
- Other factors that need to be considered include any potential victims or child protection issues.
- 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 Mental Health Act is automatically in the critical concern

category if they are absent without leave and the Ministry of Justice must be informed.

Consideration of Critical Incident Response – Executive Director

The Executive Director will discuss with the Emergency Planning Response team whether a critical incident response is required. This will be ascertained on an individual case basis dependent upon any identified associated risk to the patient or others.

Children & Young People (16-18yrs)

Note: **in the case of children (<18yrs) who have absconded, then the threshold will generally be considered to be lower for calling for help from the Police service early.** Any children who abscond with or without an accompanying adult should be considered a safeguarding concern unless evidence to the contrary exists: local safeguarding procedures should be followed.

Supporting documents:

APPENDIX 2 - Calls for Police Assistance – TEMPLATE

STEP 4 – THE INITIAL SEARCH CHECKLIST

Action	Date/time	Signed
All Missing Patients:		
NiC to inform Matron and CSM (see escalation)		
CSM to inform Security team to assist with search (this should include the hospital premises / grounds) and review of CCTV footage (in the event staff on duty cannot access the CCTV then this should be immediately escalated to the Duty Facilities Manager or on call Facilities Manager) The Security Team should		

be provided with a full description of the missing person to aid the search.		
Matron to undertake thorough search of ward / surrounding areas and check if person is attending another department		
Matron to check if anyone saw the patient leave e.g. other patients, visitors		
Matron to liaise with persons in charge of other wards/departments to complete a search of their area		
Matron to inform and update patients family /next of kin. Check if patient has returned home or is there anywhere known that the patient is likely to head to? *Remember to ask if the patient has a Herbert Protocol in place (The Herbert Protocol is an early intervention and risk reduction scheme to help the Police find vulnerable people who are at risk of going missing. The Herbert Protocol form provides information such as places of importance to the individual at risk of going missing, often visited places, health issues and places they have been found in the past if reported missing. Ownership and responsibility for updating the form remains with the family). **If a Herbert Protocol is in place, ensure you advise Police**		
CSM to check clinical systems to see if there are Alerts recorded - to inform the risk assessment?		
Matron to inform the Medical team (see escalation)		
CSM/NiC to complete Missing inpatient checklist – **Appendix 3**		
NiC of ward to complete Datix incident report form		
Patient Found:		
CSM calls search off and notifies all persons involved		
Matron/NiC informs Family /next of kin		
NiC updates patient care plan and health records		
NiC to consider need for alert on clinical systems for 'absconding risk'		
Patient not found:		
Senior Manager on Call will liaise with the Police who will undertake their enquiries and action in accordance with Policing responsibilities If the continued concern poses a risk of significant harm or risk of death to the patient, or others the Executive Director will discuss with the		

Emergency Planning Response team whether a critical incident response is required.		
Patients Detained Under Deprivation of Liberty Safeguards (DoLS)		
If the patient is detained under a DoLS the CSM to inform the Police and Local Authority along with any involved Advocate.		
Patients Detained Under the Mental Health Act **Detained patients are those who are subject to lawful detention under the Mental Health Act, 1983.**		
The detained patient is absent from the hospital without having Section 17 leave granted?		
The CSM to inform the Responsible Clinician (RC), Police, Mental Health Liaison Team and Social Services (if appropriate) immediately		
The Matron to inform the patients nearest relative (where there is consent to share information)		
The Matron to complete a Datix incident report form *(to include Police incident reference number)*		
Patient found:		
CSM calls the search off		
NiC updates Patient care plan and health record		
CSM updates RC, Police, Mental Health Liaison Matron informs Family/Next of Kin		
If the detained patient is in a public place they can be picked up by Police, or if in a private residence a warrant can be applied for, to gain entry. Dependent on a risk assessment the patient can be brought back to hospital by: • AMHP • Any member of staff from the ward/unit • Police Officer • Any other person authorised by the CSM.		

**It is the responsibility of the detaining authority to arrange for the patient to be conveyed back to the place where they are liable to be detained. Transport will normally be arranged by the detaining ward.*		
Patient died whilst missing - in the event any patient detained under any section of the Mental Health Act dies whilst in hospital – the Senior Manager on call is to notify the Mental Health Act Administrators immediately: WHCNHS.MHAAdminWHCT@nhs.net Tel: WRH – 01905 681303 ALEX – 01527 488861		
Mental Health Act – Informal Patients		
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 by a clinical member of staff to return. A security presence can be requested in order to ensure staff safety, should this be required.		
Where the patient is refusing to return, the CSM should seek advice from Mental Health Liaison or Police if imminent risk to patient safety /others		
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 assessment. *(please state Police incident reference number)* CSM to contact the police to request support in this situation.		
Mental Health Act – Voluntary Patients		
If a voluntary patient has left the ward, and is found in the hospital grounds, but is unwilling to return to the ward CSM to contact Mental Health Liaison immediately. A voluntary patient does not have to consent to return to the hospital. In the event staff are concerned regarding the patient's mental state, mental capacity or wider risk to the patient or others, then this should be escalated accordingly.		
Midwifery & Maternity		
If an antenatal or postnatal patient is missing, in addition to the above the		

midwife in charge must contact the local community midwife who will visit the patient's home address – if the patient cannot be located and there are concerns for mother or baby a national alert to all maternity units must be made. For postnatal patients where there are concerns for the baby's safety an urgent referral to the Emergency Duty Team must also be made. A Police referral may be required if the level of risk is deemed a critical concern.		
Staff working in Emergency Depts.		
Staff working in the Emergency Dept should follow the Royal College of Emergency Medicine - Best Practice Guideline - The Patient Who Absconds: Best_Practice_Guideline_The_Patient_Who_		

STEP 5 – POST INCIDENT REVIEW
Should be undertaken to update risk assessments / any further action required or identified learning.

General advice on helping to reduce the risk of absconding can be found in APPENDIX 4.

Guidance for contacting the Police Service for patients who have absconded from the Emergency Department

The emergency department (ED) strives to maintain a good working relationship with the Police service and this includes understanding the pressures that the Police services are under and not contacting them unnecessarily. The ED has a duty to maintain patient confidentiality.

This guidance does not cover those occasions when the ED has a duty to contact the Police service (e.g. knife wounds, gunshot wounds and serious crimes) or when the Police service need to be contacted as a result of a criminal act committed in the emergency department or the contact of relatives of seriously ill patients.

Before contacting the Police service it is important to realise that the Police do not have the power to bring patients back to the emergency department (ED) against their will unless they are under arrest (i.e. have committed a crime) or have been placed under section 136 (authorises a Police officer to remove a person to a place of safety if he believes that person is suffering from a mental illness). The Police are not a 'taxi' service to bring back patients who have absconded from the ED. The ED is not a classified as a place of safety.

Before contacting the Police service for patients who have absconded from the ED the following criteria should be present:

There exists a real and substantial risk to the patient if they are not brought back to the ED for medical assessment and/or treatment.
The risk is such that action needs to be taken with urgency.
Efforts to contact the patient by telephone have failed.
No other person or service is able to facilitate the return of the patient e.g. GP, SW, parent, relative.
Both the ED co-ordinator and the senior doctor on duty are in agreement that contacting the Police is the correct course of action.

Note in the case of **children** (<18yrs) who have absconded from the ED then the threshold will generally be considered to be lower for calling for help from the Police service early. Any children who abscond with or without an accompanying adult should be considered a safeguarding concern unless evidence to the contrary exists: local safeguarding procedures should be followed.

Also the threshold will be lower for those patients in whom there is reasonable evidence that they lack capacity or who may be considered vulnerable (e.g. those with dementia).

Once the Police service have been contacted to retrieve a patient who has absconded from the ED then an incident report (DATIX) **must** be completed.

Good Practice Principles for those at risk of absconding from the Emergency Dept

Practitioners should follow the Royal College of Emergency Medicine Best Practice Guideline (2020): The Patient who absconds.

Key information for staff:

Royal College of Emergency Medicine Best Practice Guideline (2020): The Patient who absconds.

Best_Practice_Guideline_The_Patient_Who_

Practical steps to reduce risks of absconding

On arrival, patients at risk of absconding should undergo **mental health triage** in order to formally assess and document the risk of absconding and self-harm. Each department should have its own processes for mental health triage. Department's should undertake regular audits of their mental health triage processes. Please refer to the RCEM Mental Health Toolkit for more information.

- Part of the initial assessment for patients at risk of absconding should include **the assessor making a judgement regarding whether the patient has autonomy/capacity**. Capacity must be assessed for specific decisions. The specific question the triage nurse should be considering is "Do you think this patient has the capacity to decide to leave?". Ask the patient if they understand and agree with the initial treatment plan (provided at triage). Agreement with this initial treatment plan can be used to help assess capacity. If at a later time it is discovered that a patient has left the department without warning, then the nurse's initially assessment of capacity to decide to leave will help inform decision making at this stage.

- Patients who are at risk of absconding should have their **physical description recorded during their initial assessment (triage)** to facilitate subsequent identification (e.g. by police) in the event of absconding. It is essential to ensure the **patient's contact details are up to date.**

- Following triage, they should be informed of the likely time to see a clinician as well as who to contact if they have any questions whilst they are waiting.

- **Those patients at risk of absconding should be prioritised for early assessment,** e.g. direct streaming to mental health team (where there is no co-existing 'medical' problem) or placed in a priority triage category. Parallel assessment of physical and mental health needs should be standard.

- **Patients considered to be at high risk of absconding (or of self-harm) should be observed**, either intermittently (e.g. every 15 minutes) or continuously if at very high risk. Training should be given to staff who carry out these observations. There should be documentation of observations in the patient's notes.

- **If a patient is threatening to leave, a senior decision-maker should assess the patient** whilst at the same time trying to de-escalate the situation, addressing the patient's reasons for wanting to leave and making a rapid determination of the patient's autonomy/capacity.

- **If the assessing clinician believes the patient lacks autonomy and decides that restraint is appropriate (proportionate and in the patient's best interests), then this should be clinically led.** If restraint is needed for more than 10 minutes, then Rapid Tranquilisation should be administered. The legal basis for restraint or Rapid Tranquillisation should be recorded in the patient's notes.

6.Implementation

6.1 Plan for Implementation

The latest version of this Policy can be found on the Trust Sharepoint intranet site Key Document and Safeguarding pages.

6.2 Dissemination

Staff will be advised of the updated Policy via dissemination by attendees of the Trust Integrated Safeguarding Committee and associated Governance Forums.

6.3 Training and Awareness

All staff receive mandatory training in respect of the Mental Capacity Act and Deprivation of Liberty Safeguards at a level in accordance with their job role. This level of training is assigned in the staff members Electronic Staff Record (ESR).

Training compliance is reported on a monthly basis via the Trust Divisional Compliance Dashboard.

Security staff will be trained to Security Industry Authority (SIA) and MAYBO training standards in accordance with their licence to practice.

7. Monitoring & Compliance

Section / page no:	Key control:	Checks to be carried out to confirm compliance with the policy:	How often the check will be carried out?	Responsible for carrying out the check:	Results of the check reported to: *(Responsible for also ensuring actions are developed to address areas of non-compliance)*	Frequency of reporting:
No.	**WHAT?**	**HOW?**	**WHEN?**	**WHO?**	**WHERE?**	**WHEN?**
Section 5: Procedure to be followed	Detailed procedure to be followed	Process followed, checklists completed	In accordance with Datix incident review timeframes	Datix incident reviewer. Divisional Governance teams.	Divisional governance meetings with escalation into relevant governance forums e.g. ISAG, patient safety	In accordance with divisional reporting requirements
Missing incident reports	Datix incident reporting	How many missing incidents, found/not found /capacity or not	Quarterly reporting	Health & Safety Manager	H&S LMS Report. Security Committee. H&S Committee.	Quarterly and annual report
Policy detail	Scheduled review to ensure Policy meets requirements in practice	Policy review and revision as indicated by learning from incidents, changes to legislation, best practice	Every 3 years or as required prior to this date	Policy owner /s	Key Documents	In accordance with Key Document review schedule

8. Policy Review

This Policy will be reviewed every 3 years in accordance with WAHT Key Document review process or in the event of any significant change to legislation or procedure.

9. References

College of Policing: Missing Persons
Missing persons | College of Policing

Mental Health Act 1983

Mental Capacity Act 2005

Mental Capacity Act 2005 Code of Practice
Mental Capacity Act Code of Practice - GOV.UK

NHSE Guidance to support implementation of the Mental Capacity Act in Acute Trusts for adults with a learning disability (March 2025)

NHS England » Guidance to support implementation of the Mental Capacity Act in acute trusts for adults with a learning disability

National Police Chiefs Council: Improving the response to missing people
Improving the response to missing people

Royal College of Policing: Right Care Right Person (RCRP) national guidance launched July 2023.
Right Care Right Person (RCRP) national guidance launched | College of Policing

Royal College of Emergency Medicine Best Practice Guideline (2020): The Patient who absconds.

Working Together to Safeguard Children (updated 2023)

Worcestershire Acute Hospitals NHS Trust Policy & Procedures: SharePoint, Key Documents:

Safeguarding Adults Policy

Safeguarding Children & Young People Policy

Mental Capacity Act (2005) Policy & Procedure

Mental Health Act Policy & Procedure

Deprivation of Liberty Safeguards Policy & Procedure

Restrictive Interventions Policy – Adults

Consent to Treatment

10. Background

10.1 Equality requirements
Refer to equality assessment Supporting Document 1

10.2 Financial risk assessment
Refer to financial risk assessment Supporting Document 2

10.3 Consultation

Contribution List This key document has been circulated to the following individuals for consultation:	
Name	**Designation**
Integrated Safeguarding Committee representatives	Divisional representatives ICB representative Non-Executive Director
J Walton	Chief Medical Officer
David Raven	Consultant, Emergency /Speciality Medicine
Ed Mitchell	Deputy Chief Medical Officer
Emma King	Deputy Director Estates & Facilities
Karen Apps	Patient Safety Team
Legal Services – Rebecca Ollivere - Solicitor	Herefordshire & Worcestershire Combined Legal Services
Rachael Hayter	Director of AHP
Kate Haddigan	LGBTQ+ Network Vice Chair on behalf of Bec Harris LGBTQ+ Network Chair
Reena Rane	EmbRACE network (Chair)
Donna Scarrott	DAWN Network
Julie Webber	Learning Disability Lead
This key document has been circulated to the chair(s) of the following committees / groups for comments:	
Integrated Safeguarding Committee	
Improving Safety Action Group (ISAG)	

10.4 Approval Process

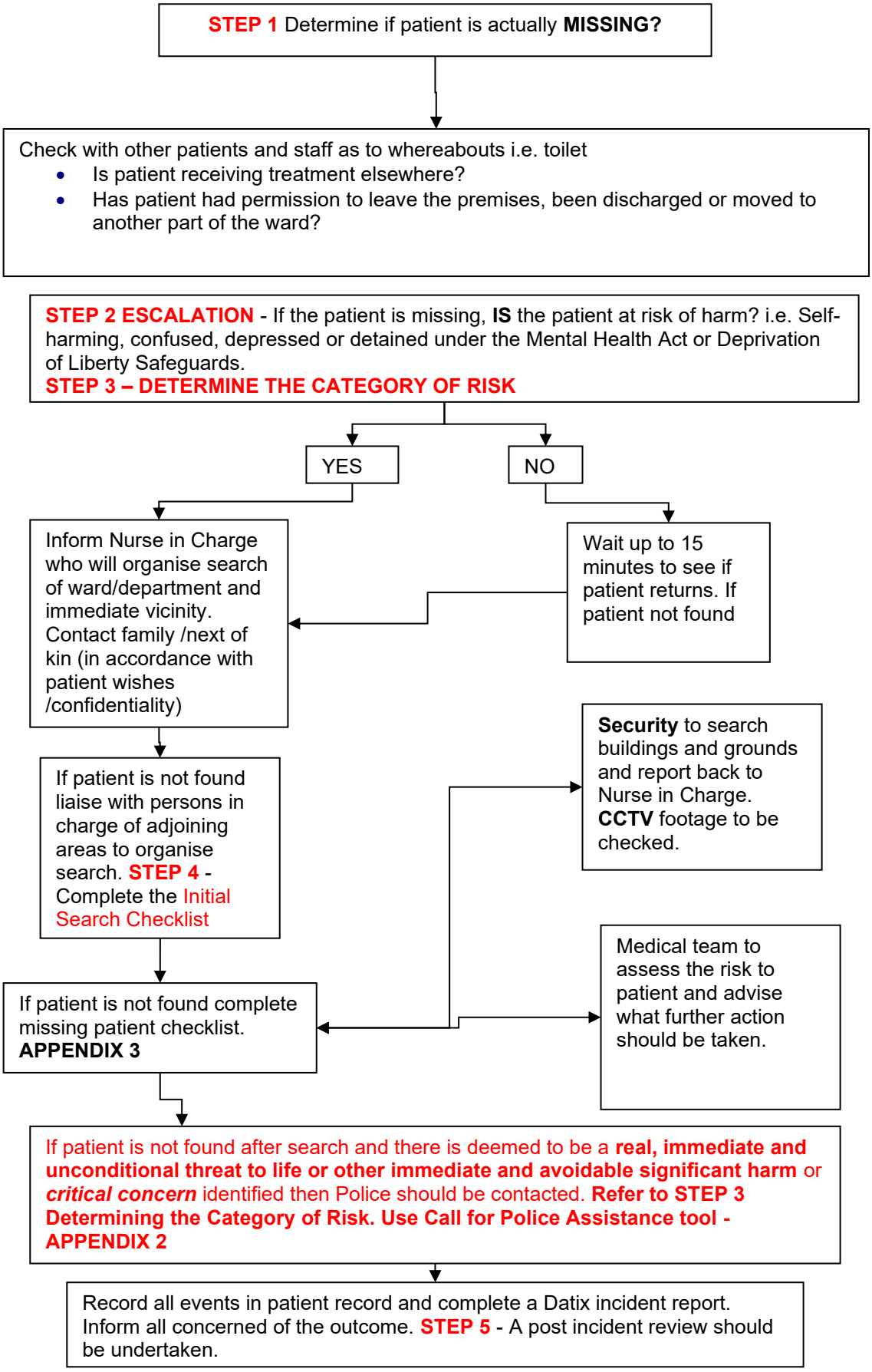
Approval of this Policy will be via the Integrated Safeguarding Committee and Improving Safety Action Group (ISAG).

10.5 Version Control

Date	Amendment	Approved by:
12.06.2025	Full guideline rewrite and update.	Trust Management Board 16.06.2025

11. Appendices

APPENDIX 1 Quick Reference Guide



Worcestershire Acute Hospitals NHS Trust

Calls for Police Assistance – TEMPLATE

Staff should give as much information as possible to the Police to inform their THRIVE assessment which will be used to establish whether the specific Police request falls within core policing responsibilities or whether another agency is better equipped to respond.

T - Threat

H - Harm

R – Risk

I - Investigation

V – Vulnerability

E – Engagement

If the criteria for Police response is not met, then the request for Police assistance may be declined.

Staff are able to escalate any professional disagreement with the decision reached to the Duty Superintendent who will have the final decision.

During the THRIVE assessment, the Police will undertake an assessment as to whether there is an immediate risk to life or serious harm to an identified person and determine who is the most appropriate agency to mitigate that risk.

A real risk is one that is **present and continuing. The risk does not have to be a probability but the risk has to be substantial and has to relate to death, serious harm or some other form of degrading or inhumane treatment.**

Calls regarding suicidal ideation by people who are within their place of residence is not routinely a matter for the police since there are exceptionally limited powers within the Mental Health Act and the legal precedents that have been defined by the judiciary. Most mental health matters would be best resolved by the primary attendance of Mental Health Services or in their absence the Ambulance Service

To ensure your handover of information is as robust as possible to inform the risk to the patient or others the following Police triage process (THRIVE) will be used to aid decision making:

	Police considerations	Prompts	Comment
T - THREAT	What is the overall threat posed, not only to the victim, but to the immediate family, children, community and location?	Ask yourself **what is the risk to life. Consider:** Known previous history – attempted suicide – is the	

		patient considered to be a high suicide risk? Access to firearms Impact of medical condition on risk e.g. Alzheimer's – Herbert Protocol Is it a child? *remember to look at historical information	
H - HARM	What is the impact of the threat? Consider not just the victim or witnesses, but also the community impact.	**Death, serious harm or other inhumane treatment** e.g. Domestic Abuse and threats to kill, presentation with non-fatal strangulation	
R -RISK	What risks are obvious or yet to be determined? What resources and specialist assets are needed to safeguard the victim or community?	Infection – HIV, hepatitis, IV drug user Firearms Weapons Sepsis –risk of death requires time critical response for treatment in order to prevent significant harm or death – patient may be non-compliant /combative as a result of delirium Known risks to professionals who may attend – combative Mental Capacity – has this been assessed and if not what are the perceived risks	

		Does the patient have dementia?	
I -INVESTIGATION	What is the legality, necessity, proportionality in relation to the offence being reported?	Is the concern related to a crime – e.g. assault	
V -VULNERABILITY	What are individual or community vulnerabilities? Identify how police and partners best safeguard against harm.	Is it a child? Is the adult especially vulnerable or dangerous to themselves or others? Who is currently involved e.g. Adult Safeguarding, MARAC – what is the level of concern? Do others in the household pose a risk to the patient or are known to have caused harm e.g. assault, county lines, cuckooing, domestic abuse Is the person homeless? Do the family lack insight as to the risk posed to the patient? Is the patient detained under the Mental Health Act or Deprivation of Liberty Safeguards and therefore not free to leave?	
E - ENGAGEMENT	What is the safest means of engagement for the victim and what is the most effective means?	Consider domestic abuse – safest contact means	

In the event the Police do not accept transfer of the duty of care to provide a Police response then the following 'appropriate agencies' could be considered to provide support:

- Crisis intervention - Mental Health
- WMAS – Medical emergency
- GP –Primary Care Services
- 111 – access to OOH GP
- Relatives / carers / parent
- Social Services / Local Safeguarding Procedures – use of urgent strategy discussions

Worcestershire Acute Hospitals NHS Trust

APPENDIX 3

Missing in Patient Checklist – Patient Details

Name of patient #call me	
Age Date of birth	
Photograph of patient if available or, Full description of patient – Gender, build, height, skin colour, hair colour/length, facial features, disabilities/ distinguishing features e.g. tattoo	
Full description of clothing worn	
Is the patient confused or deemed to lack mental capacity?	
Does the patient have any physical disabilities or medical conditions that may increase risk e.g. diabetes	
Are there any environmental factors increasing the risk of harm for the patient e.g. weather, temperature etc?	
Does the patient have a Herbert Protocol in place ?	
Does the patient have any known likely destinations or previous haunts /areas they are likely to frequent?	
Known risk to themselves or others. Likelihood of aggressive behaviour?	
Any known dependencies – alcohol /drugs	
Does the patient have any invasive devices insitu? *Please state*	
Is the patient prescribed any critical medication e.g. insulin?	
How mobile is the patient, any aids used?	

Does the patient have car/door keys?	
Does the patient have any communication difficulties e.g. aphasia, dysphasia, hearing impairment	
Language barriers /interpreting needs?	
Possible destinations and transport options – access to money, cards, mobile phone	
Any other pertinent information?	

Worcestershire Acute Hospitals NHS Trust

APPENDIX 4

GENERAL GUIDANCE TO HELP REDUCE THE RISK OF ABSCONDING

Practical Steps to reduce the risk of absconding

1. **Mental Capacity** - Part of the initial assessment for patients at risk of absconding should include the assessor making a judgement regarding whether the patient has autonomy/capacity. Capacity must be assessed for **specific decisions**. The specific question the professional should be considering is “Do you think this patient has the capacity to decide to leave?”. Ask the patient if they understand and agree with the initial treatment plan. Agreement with this initial treatment plan can be used to help assess capacity. If at a later time it is discovered that a patient has left the department without warning, then the initial assessment of capacity to decide to leave will help inform decision making at this stage.
2. **Physical Description** – should be recorded. This will inform subsequent search / identification
3. **Contact details** –should be checked and up to date
4. **Priority of assessment** - ED Triage – those at risk of absconding should be prioritised for early assessment.
5. **Levels of Observation** - Patients considered to be at high risk of absconding (or of self-harm) should be observed, either intermittently (e.g. every 15 minutes) or continuously if at very high risk. Training should be given to staff who carry out these observations.
6. If a patient is threatening to leave, a senior decision-maker should assess the patient whilst at the same time trying to de-escalate the situation, addressing the patient's reasons for wanting to leave and **making a rapid determination of the patient's autonomy/capacity.**
7. **Risk Assessment** based upon known information and risks of harm to the patient or others

Supporting Document 1 – Equality Impact Assessment Form

To be completed by the key document author and included when the document is submitted to the appropriate committee for consideration and approval.

NHS Worcestershire Acute Hospitals NHS Trust

Herefordshire & Worcestershire STP - Equality Impact Assessment (EIA) Form
Please read EIA guidelines when completing this form

Section 1 - Name of Organisation (please tick)

Herefordshire & Worcestershire STP		Herefordshire Council		Herefordshire CCG	
Worcestershire Acute Hospitals NHS Trust	✓	Worcestershire County Council		Worcestershire CCGs	
Worcestershire Health and Care NHS Trust		Wye Valley NHS Trust		Other (please state)	

Name of Lead for Activity	Deborah Narburgh Emma King

Details of individuals completing this assessment	**Name**	**Job title**	**e-mail contact**
	D Narburgh	Head of Safeguarding	deborah.narburgh@nhs.net
	E King	Deputy Director Estates & Facilities	emma.king64@nhs.net
Date assessment completed	12.06.2025		

Section 2

Activity being assessed (e.g. policy/procedure, document, service redesign, policy, strategy etc.)	**Title:** Missing in Patient Guideline (16yrs and above)
What is the aim, purpose and/or intended outcomes of this Activity?	The Trust has a duty of care for the safety of its patients. At the same time, patients deemed to have mental capacity have a legal right to leave the hospital unless they are detained under the Mental Health Act (MHA) 1983 or Deprivation of Liberty Safeguards. A patient who leaves the ward /department without formal discharge or prior arrangement is classified as missing. This document advises staff of action to be taken, and by whom, in the event of an inpatient being identified as missing. This guideline will enable staff to: ➢ Identify when a patient should be regarded as a missing patient ➢ Take the appropriate action in a timely and effective manner ➢ Reduce the possibility of any harmful outcomes to the patient

	➢ Ensure that relatives of any missing patients are informed as soon as possible and kept informed of all developments ➢ Establish the principles for the recognition and search for patients missing from the ward/hospital			
Who will be affected by the development & implementation of this activity?	√ √ √	Service User Patient Carers Visitors	√ ❑ ❑ ❑	Staff Communities Other _____
Is this:	√ Review of an existing activity ❑ New activity ❑ Planning to withdraw or reduce a service, activity or presence?			
What information and evidence have you reviewed to help inform this assessment? (Please name sources, eg demographic information for patients / services / staff groups affected, complaints etc.	Detailed within reference list of guideline			
Summary of engagement or consultation undertaken (e.g. who and how have you engaged with, or why do you believe this is not required)	Detailed within Consultation			
Summary of relevant findings	Policy reviewed and updated to reflect learning from incidents and relevant changes to process /procedure			

Section 3

Please consider the potential impact of this activity (during development & implementation) on each of the equality groups outlined below. **Please tick one or more impact box below for each Equality Group and explain your rationale**. Please note it is possible for the potential impact to be both positive and negative within the same equality group and this should be recorded. Remember to consider the impact on e.g. staff, public, patients, carers etc. in these equality groups.

Equality Group	Potential positive impact	Potential neutral impact	Potential negative impact	Please explain your reasons for any potential positive, neutral or negative impact identified
Age		x		Age applicable to clearly defined in law – 16yrs and above
Disability		x		Specific NHSE guidance for patients with a Learning Disability incorporated into the MCA Policy as best practice guidance. Staff are directed to the MCA Policy within the guideline.
Gender Reassignment		x		Policy applicable to all irrespective of gender reassignment. Process to be undertaken is person centred
Marriage & Civil Partnerships		x		Policy applicable to all post 16yrs. Decision making process clearly laid out
Pregnancy & Maternity		x		Policy applicable to all post 16yrs. Foetus remains classed as a limb of the mother until birth. Special considerations detailed within checklist.
Race including Traveling Communities		x		Policy applicable to all post 16yrs
Religion & Belief		x		Policy applicable to all post 16yrs. Right to make what others may deem an unwise decision and

Equality Group	Potential positive impact	Potential neutral impact	Potential negative impact	Please explain your reasons for any potential positive, neutral or negative impact identified
				exclusions clearly articulated within the legal frameworks.
Sex		x		Policy applicable to all post 16yrs
Sexual Orientation		x		Policy applicable to all post 16yrs
Other Vulnerable and Disadvantaged Groups (e.g. carers; care leavers; homeless; Social/Economic deprivation, travelling communities etc.)		x		Process for 16-17 years clearly defined within the Policy and supporting legal frameworks. Legal advice and support available. Where required, best interest guidance is provided to guide practice and conform to legal requirements. Deprivation of Liberty incorporated into Policy.
Health Inequalities (any preventable, unfair & unjust differences in health status between groups, populations or individuals that arise from the unequal distribution of social, environmental & economic conditions within societies)		x		Policy applicable to all persons 16yrs and above.

Section 4

What actions will you take to mitigate any potential negative impacts?	Risk identified	Actions required to reduce / eliminate negative impact	Who will lead on the action?	Timeframe
		.		
How will you monitor these actions?				
When will you review this EIA? (e.g in a service redesign, this EIA should be revisited regularly throughout the design & implementation)				

Section 5 - Please read and agree to the following Equality Statement

1. Equality Statement

1.1. All public bodies have a statutory duty under the Equality Act 2010 to set out arrangements to assess and consult on how their policies and functions impact on the 9 protected characteristics: Age; Disability; Gender Reassignment; Marriage & Civil Partnership; Pregnancy & Maternity; Race; Religion & Belief; Sex; Sexual Orientation

1.2. Our Organisations will challenge discrimination, promote equality, respect human rights, and aims to design and implement services, policies and measures that meet the diverse needs of our service, and population, ensuring that none are placed at a disadvantage over others.

1.3. All staff are expected to deliver services and provide services and care in a manner which respects the individuality of service users, patients, carer's etc, and as such treat them and members of the workforce respectfully, paying due regard to the 9 protected characteristics.

Signature of person completing EIA	D Narburgh E King
Date signed	12.06.2025
Comments:	
Signature of person the Leader Person for this activity	
Date signed	
Comments:	

Supporting Document 2 – Financial Impact Assessment

To be completed by the key document author and included when the document is submitted to the appropriate committee for consideration and approval.

ID	Financial Impact:	Yes/No
1.	Does the implementation of this document require any additional Capital resources	No
2.	Does the implementation of this document require additional revenue	No
3.	Does the implementation of this document require additional manpower	No
4.	Does the implementation of this document release any manpower costs through a change in practice	No
5.	Are there additional staff training costs associated with implementing this document which cannot be delivered through current training programmes or allocated training times for staff	No
Other comments:		
[Insert comments here]		