Worcestershire Acute Hospitals NHS Trust

Missing in Patient Guideline

Department/ Service:	Corporate
Originator:	Head of Safeguarding Facilities Manager
Accountable Director:	Chief Nursing Officer
Approved by:	Chief Nursing Officer (Executive Lead, Safeguarding)
Approved by Medicines Safety Committee: *(When medicines are included in the document)*	N/A
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Target Organisation(s):	Worcestershire Acute Hospitals NHS Trust
Target Departments:	Trustwide
Target Staff Categories:	All Clinical Staff

The Missing in-Patient guidance is currently subject to a process of full review.

This **holding guidance** should be used until the fully revised guideline is in place.

Staff should always refer to the Trust Key Documents page for the most current guidance.

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 Policy revision.	Deborah Narburgh Emma King

Introduction

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

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
- Under the age of 18yrs
- Clinical condition poses a threat to patient safety

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.

Police response to 'Missing'

Going missing should be treated as an indicator that the individual may be at risk of harm.

The safeguarding of vulnerable people is paramount and a missing person report should be recognised as an opportunity to identify and address risks.

The reasons for a person deciding to go missing may be complex and linked to a variety of individual, social or family issues.

(Missing persons | College of Policing)

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.

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

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. 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 providers care environment.

Responsibility & Duties

Refer to Appendices

Incident Reporting Process

Refer to Appendices

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**

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 decision to stand down will be made 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 we 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,**		

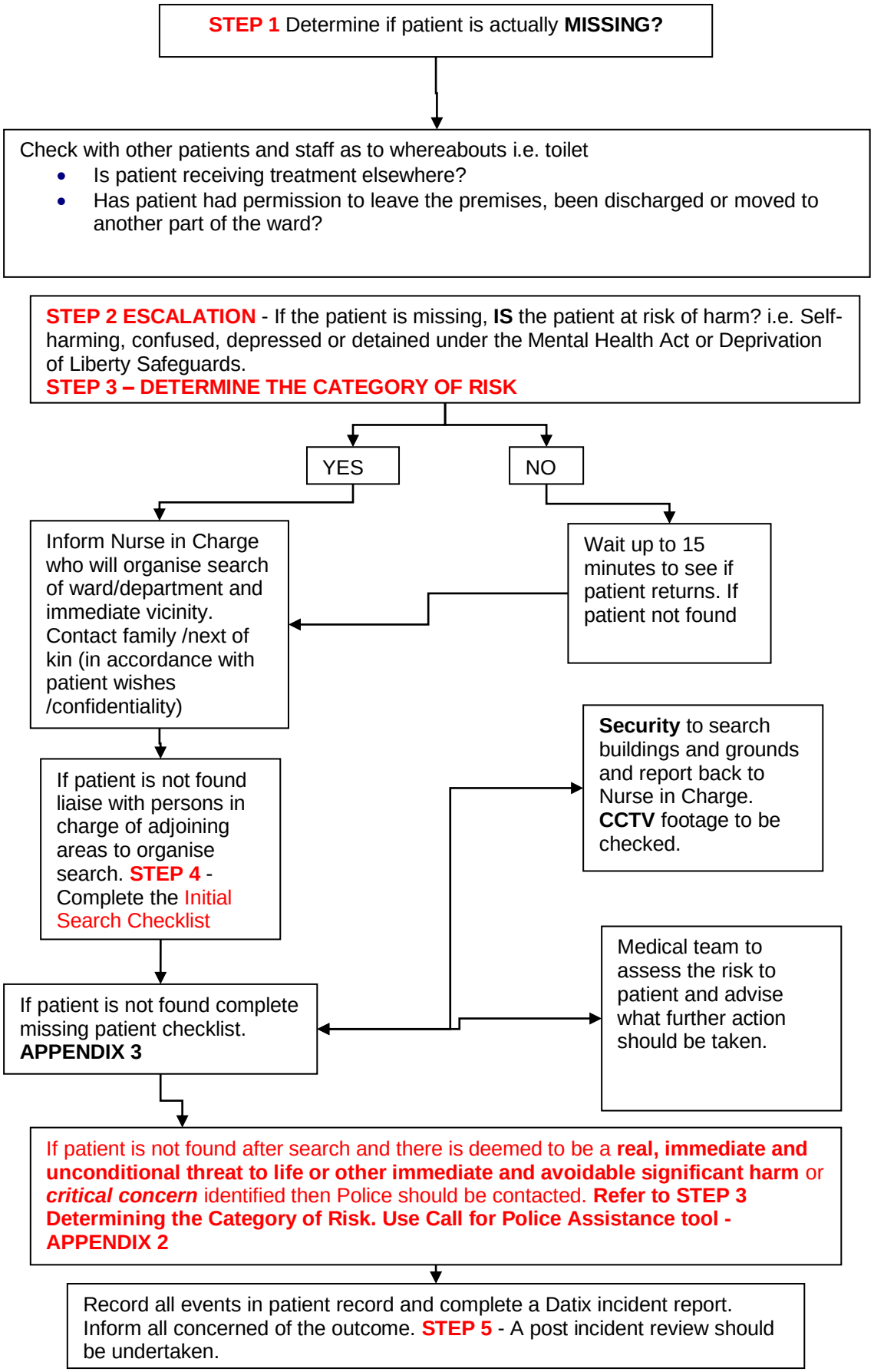
ensure you advise Police		
CSM to check clinical systems to see if there are Alerts recorded - to inform the risk assessment?		
Matron to inform the Medical team (see escalation)		
CSM/NiC to complete Missing inpatient checklist – **Appendix 3**		
NiC of ward to complete Datix incident report form		
Patient Found:		
CSM calls search off		
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.


STEP 1 Determine if patient is actually MISSING?
Check with other patients and staff as to whereabouts i.e. toilet
Is patient receiving treatment elsewhere?
Has patient had permission to leave the premises, been discharged or moved to another part of the ward?
STEP 2 ESCALATION - If the patient is missing, IS the patient at risk of harm? i.e. Self-harming, confused, depressed or detained under the Mental Health Act or Deprivation of Liberty Safeguards.
STEP 3 – DETERMINE THE CATEGORY OF RISK
YES
NO
Inform Nurse in Charge who will organise search of ward/department and immediate vicinity. Contact family /next of kin (in accordance with patient wishes /confidentiality)
Wait up to 15 minutes to see if patient returns. If patient not found
If patient is not found liaise with persons in charge of adjoining areas to organise search. STEP 4 - Complete the Initial Search Checklist
Security to search buildings and grounds and report back to Nurse in Charge. CCTV footage to be checked.
If patient is not found complete missing patient checklist. APPENDIX 3
Medical team to assess the risk to patient and advise what further action should be taken.
If patient is not found after search and there is deemed to be a real, immediate and unconditional threat to life or other immediate and avoidable significant harm or critical concern identified then Police should be contacted. Refer to STEP 3 Determining the Category of Risk. Use Call for Police Assistance tool - APPENDIX 2
Record all events in patient record and complete a Datix incident report. Inform all concerned of the outcome. STEP 5 - A post incident review should be undertaken.

APPENDIX 2

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	Consider domestic	

	means of engagement for the victim and what is the most effective means?	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,

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?	
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?	
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?	

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