Missing & AWOL Patients Policy for Psychiatric Units & Community Teams

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Purpose of Agreement	The purpose of this policy is to provide an agreed and consistent approach in; • Reducing the risk of patients going missing • Responding when patients are missing
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1	October 2018	Richard Sneade	Policy Steering Group, Assurance Committee	New Policy
2	August 2021	Ben Martin-Lihou	Policy Steering Group – Chair's action approved extension request by 1 month	To allow sufficient time to review policy

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Missing & AWOL Patients Policy for Psychiatric Units & Community Teams

1. INTRODUCTION & PURPOSE

1.1 This policy outlines procedures and considerations, and the roles, responsibilities and response of Trust staff & Police in the event of a service user going missing.

1.2 The policy is intended to provide staff with the knowledge and understanding of safe practice and the roles and responsibilities of each agency involved.

1.3 This policy aims to increase the knowledge base of staff responding to missing persons, by providing clear guidance to staff regarding expected actions which will minimise such incidents.

2. SCOPE & DEFINITIONS

2.1 This policy covers all service users in receipt of Mental Health Services from the Trust, whether they are within inpatient services both detained & informal, receiving support from community teams or within residential services within the Trust.

2.2 This Policy only refers to missing service users – prevention, immediate actions, reporting, "Retaking" and powers to remove the patient back to the hospital.

2.3 The response to any Absent without Leave (AWOL) or 'missing' incident should always be always be proportionate and based on risk irrespective of the patients legal status under the mental health act.

2.4 A duty of care exists to both formally detained and informal patients. Whilst the patients status under the MHA will affect what legal powers can be used in their return, "the difference between the two categories of psychiatric patient should not be exaggerated" and these differences "would have been one of form not substance".

2.5 *AWOL but not missing.* There are some situations where a person that is an AWOL patient for the NHS will not be considered missing by the police. For example, a patient is afforded s17 leave but has failed to return, a telephone call confirms the patient is at their home address or other leave location – ostensibly safe and well – then they are AWOL from the hospital without being a missing person.

2.6 *Mental Health Codes of Practice para 28.14* The Police should be asked to assist in returning a patient only if necessary. If the patients 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.

2.7 *AWOL.* There are a number of situations where, for these purposes, a patient is to be considered AWOL under the MHA.

- **a)** A person who is detained as an inpatient (under Part II of the Act) has left without s17 leave.
- **b)** A patient who has been quite properly allowed authorised leave under s17 MHA and who fails to return to the location at the appointed time.
- **c)** A patient who has previously been in hospital, but has been released under a Community Treatment Order (CTO) and has been recalled from it, but failed to turn up at the hospital as directed.
- **d)** A conditionally discharged patient who has been recalled to hospital

2.7.1 The Police definition of a missing person is taken from the College of Policing Missing Approved Professional Practice and is: "*Anyone whose whereabouts cannot be established will be considered as missing until located, and their well-being or otherwise confirmed."*

2.7.2 All reports of missing people reported to the Police will sit within a continuum of risk from 'no apparent risk' though to high-risk cases that require immediate, intensive action;

a) ***No Apparent Risk (NAR)*** – Actions to locate the subject and/or gather further information should be agreed with the informant and a latest review time set to reassess the risk. If the potential enquiries do not require a policing power (such as phone calls, address checks, CCTV, bus, train or taxi companies) then the emphasis will be for the person reporting to conduct these enquiries – this will be discussed and confirmed with the person reporting.

b) ***Low Risk*** - The risk of harm to the subject or the public is assessed as possible but minimal. Police will carry out proportionate enquiries to ensure that the individual has not come to harm. As above, who completes these actions will be agreed with the informant.

c) ***Medium Risk*** - The risk of harm to the subject or the public is assessed as likely but not serious. This category requires an active and measured response by the police and other agencies in order to trace the missing person and support the person reporting. Actions to trace the missing person may be conducted by either the person reporting or the Police; this will be agreed at the first point of contact or shortly after.

d) ***High Risk*** - The risk of serious harm to the subject or the public is assessed as very likely. This category almost always requires the immediate deployment of police resources – action may be delayed in exceptional circumstances, such as searching water or forested areas during hours of darkness. A member of the senior management team (see 2.8.2.e) must be involved in the examination of initial lines of enquiry and approval of appropriate staffing levels. Police officers may be diverted from other emergency calls and potentially brought in from other areas. Consideration will be given to deploying specialist resources such as Police Search Advisors (PolSA), dog section and air support and volunteer agencies such as Hampshire Search and Rescue (HANSAR) or Fire Service.

e) ***"Senior*** **Management Team " -** In the context of an inpatient setting: this pertains to a minimum of the band 7 practitioner (or their nominated cover) that has direct accountability for the operational day to day running of the setting from which the individual has gone missing. In their absence the Band 8 responsible for the service in question would be sought. Out of hours this responsibility is delegated to an Out of Hours on call duty manager. The senior manager or out of hours on call manger will delegate and / or escalate as appropriate and in line with the protocols set out in this policy . In a community setting the senior manager is the Band 7 of the team to which the individual has been referred, accepted and is "open" to the team. The on call duty manger has responsibility for all adult mental health services out of hours ; however given the scope and hours worked by those in the community it would be on rare occasions that the On Call Duty manager would be involved

3. PROCESS / REQUIREMENTS

3.1 All patients should have a Care Program Approach (CPA) or other preemptive risk assessment in line with AMH004 Clinical Risk Assessment and Management Policy and Procedure AMH clearly recorded in the appropriate Trust system for recording clinical information. This assessment should identify whether there is an active risk that the patient will knowingly and overtly attempt to leave the clinical area or passive risk that the patient may be confused or disorientated and may wander out of the clinical area. The risk assessment should be updated whenever the risks change.

3.2 The level of risk assessment will clearly vary from patient to patient and from service to service – they key is that staff will have actively considered the possibility of the patient leaving the clinical area without the knowledge of the staff, or having failed to return from authorized leave, and that there will be a plan in place should this happen that does not solely rely on a Police response.

3.3 Not all individuals being cared for in the community are subject to CPA , however in each instance the lead professional in any individuals care will ensure that the CPA risk assessment is up to date and accessible.

3.4 Consideration should be given in respect to positive risk where appropriate, balancing the severity of the current risk with the potential for invasive action to increase future risk or risky behaviors in line with the patients preemptive plans / CPA.

3.5 In the event of a patient going missing or if it is unclear whether they are missing an immediate and thorough search of the ward area and common areas in buildings should be undertaken, where appropriate with the assistance of security staff.

3.6 The timing and scope of the searches undertaken should be appropriate to the level of risk identified.

3.7 All rooms / locations should be searched, including areas which are locked. No presumption should be made that locked areas are inaccessible or empty. (For patients missing from a care environment formal and informal).

3.8 The person coordinating the search must maintain a written record of actions taken and the decision making process. This would be documented in the individuals case notes .

3.9 Known places where the patient may have gone should be explored where practicable, for example local shops, train stations etc.

3.10 The Trusts Head of Communications Manager must be alerted where there is a significant concern for the missing individual and communication with Police / other agencies is being considered. The responsible Clinician however , is the individual that is responsible for deciding whether media coverage is necessary

3.11 Where the risks are not considered to be immediate or life threatening then proportionate enquiries are to be conducted in order to locate the person prior to reporting the person as missing to the Police. These may include telephone enquiries with friends / relatives, checking local shops, transport links, and their home address or addresses they are known to go to when these are local - and document these.

3.12 Where these initial enquiries have proved negative and there is still a concern for that person then further consideration is to be given to reporting the person as missing to the Police and what actions the Police should take.

3.13 When reporting to the Police it is important that as much of the following information is to hand as possible as these questions are to guide their own risk assessment and proportionate response. This is in addition to the person's Name, Date of Birth, and Description etc.

1) What is the specific concern that has caused you to call the police?
2) How many times have they been missing in the past?
3) What has been done so far to trace this individual?
4) What medication does the person need? What happens if they do not get their medication?
5) Are they likely to come to any harm?
6) Are they likely to be the victim of a crime?
7) Are they likely to self-harm or to attempt suicide?
8) Do they pose a danger to other people?
9) Is this significantly out of character (has there been a recent change in the persons behaviour)
10) Is there any other information relevant to their absence?

3.14 The Police will also require a single point of contact, this would usually be the reporting person, but in any event it needs to be someone who knows the patient and the circumstance of their missing episode well. The responsibility of this single point of contact is likely to be handed over as shifts finish and the oncoming shift commences but will always be the nurse in charge of the shift. dependent on the circumstances it may be necessary for the individual that initially reported or identified that the individual was missing to make themselves available to Police even after they have gone off duty.

3.15 *Mental Health Codes of Practice para 28.17* – Whenever the Police are asked for help in returning a missing patient; they must be informed of the time limit for taking them into custody.

3.16 A Mutually agreed plan of Action will be agreed with Police at the first point of contact or shortly after. These will identify actions expected of the Police, and actions expected of staff. These actions should be realistic, proportionate and with an agreed time frame appropriate to the level of risk.

3.17 Staff should continue to make efforts to contact the missing person by phone, address checks or other reasonable and proportionate searches and enquiries throughout the missing episode unless otherwise agreed with the Police.

3.18 The Police should be updated if any further information comes to light, contact is made with the missing person, or if the missing person is found or returns. This should be done without delay.

4. ROLES & RESPONSIBILITIES

4.1 The staff member discovering that the patient is missing must consider notifying (as appropriate), see appendix for checklist:

- The immediate line manager
- The Care Coordinator (if appropriate)
- The Responsible Clinician (RC)
- The nearest relative (para 28.20 MHA Codes of Practice)
- Any significant carers

- The Police (after actions in 5.11, or if high risk skip to 5.13)
- Safeguarding Teams (both Trust and Local Authority) if a person subject to DOLs has gone missing
- CQC (in the case of a secure patent)
- Ministry of Justice (in the case of forensic section patients and Specialized services where applicable)
- NHS England (for Specialized Services)
- Person with parental responsibility (if under 18 years of age)

4.1.1 INFORMAL PATIENTS OR PATIENTS RECEIVING CARE IN THE COMMUNITY

4.1.1 If the missing person returns to the clinical area, or to their home, it is important that the Police are informed without delay, and that the patient's records are updated accordingly.

4.1.2 If an informal patient or a patient receiving care in the community is located by staff outside of the hospital then staff must first consider what action is required, if any, this will almost certainly be guided by how the patient is presenting, risk assessment and what support they may require.

4.1.3 If the patient is unwilling to accept support or treatment but is in immediate "need of care and control" and is not within a "house / flat / room / garden / garage / yard or associated outbuilding" then consideration should be given to requesting Police assistance with a view for Police to use their powers under s136 MHA.

4.1.4 If the patient is unwilling to accept support of treatment but is within a "house / flat / room / garden / garage / yard or associated outbuilding" and is deemed that they require a MHA assessment then consideration should be given to referring the patient for a MHA assessment. (the decision to apply for a s135(1) warrant lies with the AMPHP).

4.1.5 If the patient is unwilling to accept support or treatment and; is in a "house / flat / room / garden / garage / yard or associated outbuilding" and; the patient is actively self-harming or threatening / attempting suicide and; the delay in obtaining a s135 warrant could result in serious injury or death then consideration should be given to calling Ambulance without delay. If immediate entry is required due to immediate risk then the police should be contacted**.**

4.2 PATIENTS DETAINED UNDER THE MENTAL HEALTH ACT 1983

4.2.1 For patients detained under Mental Health Act 1983; refer to Appendix D for guidance on the Time limits for returning patients who are AWOL or who have absconded from legal custody under the Act [sections 18 and 138]

4.2.2 If the patient is located by staff or Police somewhere where a power of entry is not required, then the patient may be taken and returned to hospital using the powers under s18(1) MHA – this power is available to a Police officer, an AMHP, or by any member of staff of the hospital, or by anyone authorised in writing by the manager of the hospital (This could include a secure ambulance service).

4.2.3 If the patient is located somewhere where a power of entry is required such a building where the member of staff or Police would not have authorized access and; the patient is actively self-harming or threatening / attempting suicide. Call an ambulance and police.

4.2.4 Section 139 MHA allows the use of force when retaking a patient using Section 18 so long as the act was not done in bad faith or without reasonable care.

4.2.5 If the patient absconded whilst detained under s136 (whether in the community, from the ambulance or from the hospital) then s138 is the power used to retake them.

4.3 TRANSPORT

4.3.1 Patients should always be transported in the manner most likely to preserve their dignity and privacy, consistent with managing any risk to their health and health and safety of both the patient and others. Those arranging transport should always consider the *Equality Act 2010*, and the *Health and Safety at Work Act 1974.*

4.3.2 S135 (1&2) MHA - When taking the person to a place of safety on a section 135 warrant, the AMHP, hospital managers or the local authority (as appropriate) should ensure that an ambulance or other transport is available to take the person to the place of safety or to the place where they ought to be, in accordance with a locally agreed policy on the transport of patients under the Act – *Para 16.16 MH Codes of Practice.*

4.3.3 S136 MHA - People taken to a health-based place of safety should be transported there by an ambulance or other health transport arranged by the police who should, in the case of section 136, also escort them in order to facilitate hand-over to healthcare staff. – *Para 16.41 MH Codes of Practice.* When secure transport is used the handover to healthcare staff will take place on scene to the Secure Ambulance Provider in line with the local s136 Policy.

4.3.4 If a detained patient is located out of area and is taken to a local hospital, then transfer between hospitals should be arranged between the two hospitals involved using an appropriate vehicle, for patients in the country of Hampshire this would usually be facilitated by a Secure Ambulance Provider. This will never be a Police vehicle.

4.3.5 For Patients that have been re-taken under S18(1) MHA then an ambulance or secure ambulance should be used where possible. If risks are low, the patient is located close to the hospital, and there would be a delay in sourcing more appropriate transport, the person re-taking may choose an alternative. It must be in the patient's best interest not to wait.

4.3.6 In the case of people voluntarily returning to hospital, consideration should be given to what the patients' needs may be, and is their presentation likely to change during transport.

4.3.7 Police will not routinely transport patients back to hospital if they are attending voluntarily, however there may be exceptions to this, for example if the Police locate the missing person close to the hospital then it may not be in the patients best interest to wait for more appropriate transport. This will be assessed on an individual risk basis.

5. DEBRIEF AND LEARNING FROM INCIDENTS

5.1 Following the service user/patient's return to hospital or home a debriefing with the service user/patient and discussion related to the service user/patient missing or not returning from leave should take place. This meeting will assist the team to understand the service user/patients rationale for missing, to share information as to the whereabouts of the service user/patient whilst absent, contact they may have had with family or friends and may provide helpful information for any future episodes and should feed into pre-emptive plans around the patient.

5.2 The Police may also wish to speak to the patient upon return, or as soon as practicable after. The College of Policing refer to this as a return interview, which seeks to identify information that may help prevent further episodes or provide valuable information should that person go missing again.

5.3 In line with the *Mental Health Codes of Practice para 28.22* and the *College of Policing APP for Missing*, each missing episode will be reviewed in conjunction with the Police and discussed with ward managers at regular "Missing & AWOL review meetings", these are usually conducted monthly and seek to identify the causality of each episode and implement organisation learning where required. In high risk cases, or where there could be serious failings by any agency involved these may be debriefed sooner as required.

6. TRAINING

6.1 All staff are required to ensure they know the correct procedure – this will be undertaken as part of induction and updated as appropriate through local training timetables. To be undertaken as a minimum of annually whether or not there have been any significant changes to policy or procedure.

7. EQUALITY IMPACT ASSESSMENT AND MENTAL CAPACITY

7.1 The Equality Impact Assessment and Mental Capacity Act Assessment identified that this policy is unlikely to lead to discrimination against any particular group and that it takes the situations of service users who lack capacity to make decisions into account. The Impact Assessment can be seen in Appendix A.

8. SUCCESS CRITERIA / MONITORING EFFECTIVENESS

8.1 The responsibility for monitoring this policy will be vested in the Professional Lead and the Quality and Standards Team.

8.2 Each service provider must have an audit programme in place to ensure compliance with this policy.

8.3 The effectiveness of this policy will be reviewed by the Mental Health Act Scrutiny Committee and will be discussed prior to the stipulated review timeframe at the Mental Health Act Monitoring Meeting. Details of these discussions will be documented in the minutes.

8.4 The quality and Standards team for Adult Mental Health will be responsible for reviewing risk management and clinical governance issues.

8.5 The policy will be assessed by the Policy Steering Group who will review the policy and any updates being presented to the Group to ensure that they conform to Trust procedures and format. This Group will determine subsequent ratifying groups that the policy should be presented to.

9. REVIEW

9.1 This document may be reviewed at any time at the request of either staff side or management, but will automatically be reviewed 3 years from initial approval and thereafter on a triennial basis unless organisational changes, legislation, guidance or non-compliance prompt an earlier review.'

10. REFERENCES AND LINKS TO OTHER DOCUMENTS

10.1 *Duty of Care.*

10.1.1 The law imposes a duty of care on practitioners, whether they are HCAs, APs, students, registered nurses, doctors or others.

10.1.2 Health care professionals have a clinical responsibility for all patients in their care. This responsibility will never be displaced by the presence of a police officer, and cannot be passed to the Police when reporting a missing person because a police officer is not a health care professional (unless the circumstances in OSMAN are met (4.2.1 b)

10.2 *Human Rights Act Considerations.*

10.2.1 Article 2 – Protection of the Right to life.

a) What this means to the NHS*; Rabone & Anor v Pennine Care NHS Foundation Trust [2012]* – where the state owed a duty to take reasonable steps to protect the person's life because the person was under the State's control or care and the State knew (or ought to have known) there was a real and immediate risk to the person's life. This would include voluntary psychiatric patients as well as detained patients.

b) What this means to Police; *Osman v UK [1998]* – The Police owe a duty of care when someone is in Police custody, and/or the conditions set out by Osman are met where the Police "knew or ought to have known at the time of the existence of a real and immediate risk to the life of an identified individual or individuals from the criminal acts of a third party and that they failed to take measures within the scope of their powers which, judged reasonably, might have been expected to avoid that risk."

10.2.2 Article 8 - Right to respect a private life and family life. This gives everyone the right to respect to a private and family life. This is especially relevant when sharing information. Article 8 is not an absolute right – public authorities are permitted to interfere when it is lawful and proportionate to do so.

a) What this means for the NHS; In terms of missing people the reporter will need to balance the subjects right to privacy and the necessity of sharing the information in conjunction with the Data Protection Act and the Common Law duty of Confidentiality.

b) What this means to Police; this is especially relevant in missing person investigations. When investigating the disappearance, intrusion into the life of the missing person or his or her family will be taken into account. Such intrusion should be proportionate. It is particularly pertinent where an individual disappears deliberately; the right to do so will be respected, but it will be balanced with the rights of the family and the wider community. – National Centre for Policing Excellence.

10.3 Right to make unwise decisions.

10.3.1 *Section 1(2) Mental Capacity Act* – A person must be assumed to have capacity unless it is established that he lacks capacity.
Section 1(4) Mental Capacity Act – A person is not to be treated as unable to make a decision merely because he makes an unwise decision.

10.3.2 A lack of proportionate action in some circumstances may incur liability to those charged with a person's care, this could be the trust as a whole, the hospital manager, or an individual member of staff.

10.3.3 *Section 44 Mental Capacity Act* makes it an offence if a person ("S1") has the care of a person ("P1") who lacks capacity, or whom S1 reasonably believes to lack capacity, ill-treats or wilfully neglects P1. Wilful neglect could be "allowing" a person to become missing when reasonable steps could have been taken to prevent it. For wilful neglect *could* be true if there was a deliberate decision not to follow someone who they believed could come to harm if they become a missing person.

10.3.4 *Section 20 Criminal Justice and Courts Act 2015* makes it an offence for an individual who has the care of another individual by virtue of being a care worker to ill-treat or willfully neglect that individual.

10.3.5 *Section 21 Criminal Justice and Courts Act 2015* makes it an offence for a care provider; if an individual who has the care of another individual by virtue of being part of the care provider's arrangements ill-treats of willfully neglects that individual or; the care provider's activities are managed or organized in a way which amounts to a gross breach of a duty of care owed by the care provider to the individual who is ill-treated or willfully neglected and; in the absence of the breach, the ill-treatment or willful neglect would not have occurred or would be less likely to occur. This would need to be taken into consideration when considering any 'lone working' directives or any directive not to follow a vulnerable person who it was believed could come to harm if they became a missing person.

10.4 Mental Health Act 1983 (as amended by PACA 2017)
10.5 Mental Health Act Codes of Practice
10.6 Mental Capacity Act 2005
10.7 Human Rights Act 1998
10.8 Data Protection Act 2018
10.9 Criminal Justice & Courts Act 2015
10.10 College of Policing – Missing APP
10.11 *Rabone & Anor v Pennine Care NHS Foundation Trust 2012*
10.12 *Osman v UK 1998*
10.13 *Powell v UK 2000*
10.14 *R (on the application of Munjaz) v Mersey Care NHS Trust 2003*

Solent NHS Trust

10.15 Mental Health Act Policy
10.16 Section 17 Leave Policy
10.17 Deprivation of Liberty Safeguards and Mental Capacity Act Policy
10.18 Lone Working Policy

Southern Health Foundation Trust

10.19 SH NCP 16 – Policy for managing Incidents and Serious Incidents
10.20 SH NCP 17 – Procedure for Reporting and Managing Incidents
10.21 SH NCP 25 – Risk Management Strategy and Policy
10.22 SH CP 51 – Policy for the use of Leave under Section 17

10.23 SH CP 97 – Clinical Disengagement / Did Not Attend Policy
10.24 SH CP 37 – Observation and Engagement Policy.

11. GLOSSARY

11.1 AMH – Adult Mental Health
11.2 AMHP – Approved Mental Health Practitioner
11.3 APP – Authorised Professional Practice
11.4 AWOL – Absent Without Leave
11.5 CPA – Care Programme Approach
11.6 CTO – Community Treatment Order
11.7 CQC – Care Quality Commission
11.8 DoLs – Deprivation of Liberty Safeguards
11.9 ED - Emergency department
11.10 HCA – Health care Assistant
11.11 MCA – Mental Capacity Act
11.12 NHS – National Health Service
11.13 PACA – Policing and Crime Act
11.14 RC – responsible Clinician
11.15 S17 – Section 17 MHA 198

Appendix: A Equality Impact Assessment

Step 1 – Scoping; identify the policies aims	Answer		
1. What are the main aims and objectives of the document?	To support save management of missing persons and AWOL by clarifying the procedure to be followed and roles and responsibilities of staff involved.		
2. Who will be affected by it?	Potentially all patients admitted to or cared for by the clinical areas covered by the policy.		
3. What are the existing performance indicators/measures for this? What are the outcomes you want to achieve?	This is a policy review of current practice. There have been no significant changes as practice is currently in line with this policy.		
4. What information do you already have on the equality impact of this document?	There has been some research carried out in relation to client going AWOL, the flow chart has incorporated elements of this that have been suggested to have an effect in reducing this. The policy primarily covers what to do in the event of a missing person / AWOL and the actions are compliant with mental health code of practice and that practice of our partners, e.g. police.		
5. Are there demographic changes or trends locally to be considered?	N/A		
6. What other information do you need?	NONE		
Step 2 - Assessing the Impact; consider the data and research	Yes	No	Answer (Evidence)
1. Could the document unlawfully discriminate against any group?		X	By having this clear operational policy and ensuring the guidance and practice laid out within it is applied to all patients at all times, it ensures that no group could be unlawfully treated favourably or unfavourably compared to another
2. Can any group benefit or be excluded?		X	As above

3. Can any group be denied fair & equal access to, or, treatment as a result of this document?		X	As above
4. Can this actively promote good relations with and between different groups?	X		It can show parity between different groups and fairness to all
5. Have you carried out any consultation internally/externally with relevant individual groups?	X		All relevant staff have been consulted several times. This has included; • Nursing Staff • Auxiliary Staff • Allied Health Professionals
6. Have you used a variety of different methods of consultation/involvement?	X		Different methods of consultation have included: • Emails • Discussion in various meetings
7. Mental Capacity Act implications		X	
8. Will this document require a decision to be made by or about a service user? (Refer to the Mental Capacity Act document for further information)	X		MCA taken into account in the policy and supports the decision making identified within this policy to ensure patients' needs are represented and met
<u>External considerations</u>			
8. What external factors have been considered in the development of this policy?			Changes in police legislation increase in Operational scope of Solent AMH to include 136 suites.
9. Are there any external implications in relation to this policy?			Greater cohesion and collaboration across Solent NHS Trust; The police and Southern Health Foundation Trust
10. Which external groups may be affected positively or adversely as a consequence of this policy being implemented?			All individuals within the jurisdiction and catchment of Hampshire constabulary can expect the same safeguards and be subject to as similar a process as is practicable outside of local procedures.

If there is no negative impact – end the Impact Assessment here.

Step 3 - Recommendations and Action Plans	Answer
1. Is the impact low, medium or high?	Low
2. What action/modification needs to be taken to minimise or eliminate the negative impact?	Ensuring that this policy is followed at all times by staff will eliminate the potential for negative impacts.
3. Are there likely to be different outcomes with any modifications? Explain these?	
Step 4- Implementation, Monitoring and Review	Answer
1. What are the implementation and monitoring arrangements, including timescales?	Once ratified by Solent NHS Trust, this policy shall be disseminated via the trust intranet. In addition senior clinical staff in affected services will be informed that the policy is operational. Monitoring arrangements are documented within the main body of the text.
2. Who within the Department/Team will be responsible for monitoring and regular review of the document?	Support in this process and comments for amendments will be received from significant groups and committees which include, the AMH Essential Standards Group, the Acute Services Operational Meeting, the Acute Care Forum and the Mental Health Act Scrutiny Committee
Step 5 - Publishing the Results	Answer
How will the results of this assessment be published and where? (It is essential that there is documented evidence of why decisions were made).	Attached to this policy and published as such on the intranet

****Retain a copy and also include as an appendix to the document****

Appendix: B Missing Persons Checklist

Name:

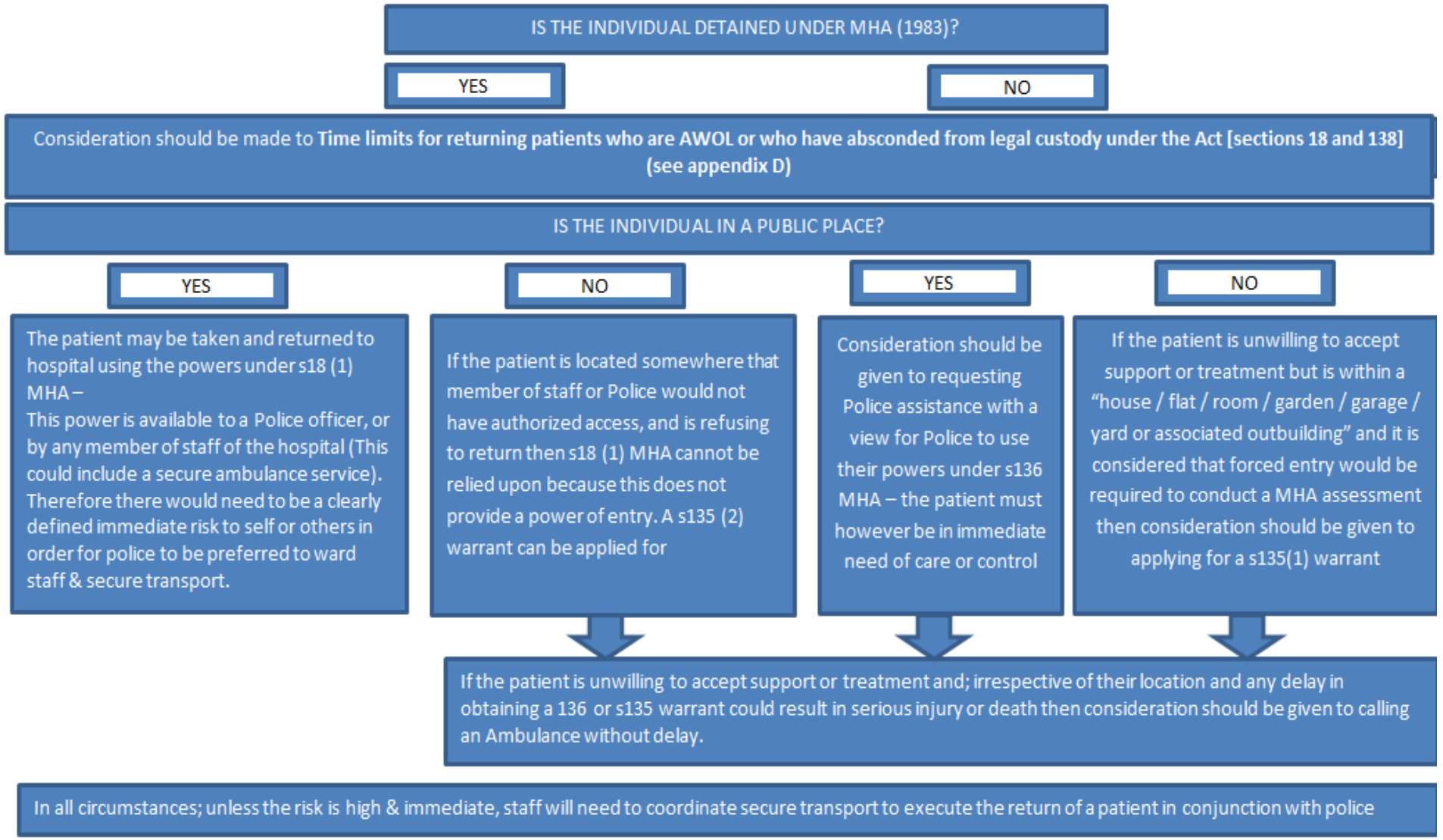
NHS Number:

D.o.B

When was the individual last seen? **Where were they expected to be at the point at which they were noticed missing?** **What time where they noticed to be missing?**				
Action	**Comments**		**Signed**	**Time**
Ward Searched				
Hospital searched		If found here refer to appendix C for guidance on powers to return.		
Phone patients mobile:				
Check with supported accommodation providers	**Who?**	If found here refer to appendix C for guidance on powers to return.		
Check with family members or friends (provided consent has been given or if risk sufficient)	**Who?**	If found here refer to appendix C for guidance on powers to return.		
Inform ward manager / senior nurse on site:	**Who?**			
Local area searched if appropriate		If found here refer to appendix C for guidance on powers to return.		
Review CCTV if necessary				
Notify police	**Name of person taking call + Collar number?** **Incident number :** **Comments on mutually agreed plan:**			

Solent Adverse event form number	**AER:**		
Inform Medics; RC and Duty doctor.	**RC:** **Duty Doctor:**		
Inform Care Coordinator if appropriate.			
Relatives / significant others			
A&E department	**Who?** **Bleep holder?**		
Home Office (Restricted patients)			
Safeguarding concerns:	**CHILD** **ADULT** **Individual at Local authority notified :** **Details:**		
Others: Social services.			
Housing providers:			
For the purposes of ensuring appropriate escalation . it will be the responsibility of the person completing this form to check on the following also:			
Out of Hours: Check with Senior Nurse on site that On call Duty manager has been notified	Senior nurse on site: On call duty manager :		
Check with Senior Nurse on Site that the On call duty consultant has been notified	On call duty consultant :		
Establish whether media coverage is considered appropriate		If so; ensure that The Trusts Head of Communications Manager is informed	
All of the above documented on Systm 1			

Appendix C: Missing & AWOL Patients Policy for Psychiatric Units & Community Teams



Appendix: D:

Time limits for returning patients who are AWOL or who have absconded from legal custody under the Act [sections 18 and 138]

The time limits for returning patients who go AWOL or otherwise abscond in England or Wales are summarised below:

Where the police are asked for help in returning a patient, they must be informed of the time limit for taking them into custody. They should also be told immediately if a patient is found or returned.

A patient who, at the time of absconding, was (or is treated as):	**May not be returned after:**
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 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 who, at the time of absconding, was (or is treated as):	May not be returned after:
Detained on the basis of an application for admission for treatment under section 3	The later of: six months starting with the day the patient went absent, or the date on which the authority under which they were detained at the time they went absent is due to expire (ignoring any possibility of it being renewed or replaced by a different authority and any extension allowed because of the patient's absence)
Liable to be detained on the basis of an unrestricted hospital order, hospital direction or transfer direction under part 3	
A patient on a community treatment order who had been recalled to hospital	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: 24 hours from the time the patient absconded, or the period for which the patient may be detained, ie 24 hours' from the start of the patient's detention in the place of safety

A patient who, at the time of absconding, was (or is treated as):	May not be returned after:
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, 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

Retaking patients who abscond to Scotland , Northern Ireland , the Isle of Man or The Channel Islands

A Person (other than one subject to guardianship) who could be taken into custody in England and Wales may be taken into custody and returned by:		In accordance with
Scotland	• A Scottish constable • A mental Health officer as defined in the Mental Health (care and treatment) (Scotland) Act 2003 • A member of any hospital in Scotland • Anyone authorised by the patients responsible Clinician (or equivalent)	The Mental Health (Absconding patients from other jurisdictions) (Scotland) regulations 2008
Northern Ireland	• A constable or officer of the Police Service of Northern Ireland • A Northern Ireland Approved Social Worker • Anyone who could do so in England and Wales	Section 88
IoM / Channel Islands	• Anyone authorised under local legislation	The applicable legislation

Patients who abscond overseas

The Act does not permit patients to be retaken outside of the UK, The Isle of Man or the Channel Islands.

In certain Cases under the Extradition Act 2003 patients who are convicted offenders or accused of a crime may be extradited back to England; if the necessary warrants have been issued