NHS Isle of Wight NHS Trust NHS Solent NHS Trust

Missing & AWOL Patients Policy for Psychiatric Units & Community Teams

Solent NHS Trust policies can only be considered to be valid and up-to-date if viewed on the intranet. Please visit the intranet for the latest version.

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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Amendments Summary:

Please fill the table below:

Amend No	Issued	Page	Subject	Action Date
2.1	20/08/21	5	New wording on new template required	August 2021
2.4	20/08/21	5	References needed	August 2021
10.3.6	20/08/21	13	Add IoW policies when received from Tara Smith	August 2021
10.20	20/08/21	13	No bullets or numbering	August 2021
Appendix B	20/08/21	17	Tara Smith checking checklist against IoW, both to be combined.	August 2021

Review Log:

Include details of when the document was last reviewed:

Version Number	Review Date	Lead Name	Ratification Process	Notes
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
3	October 2021	Ben Martin-Lihou	Standard 3 year review, refresh and co-badged with IOW NHS Trust	Changes outlined above

SUMMARY OF POLICY

This policy outlines the roles and responsibilities of staff employed by both Solent NHS Trust and Isle of Wight NHS Trust, Police and Secure Ambulance staff in the event that a patient goes missing from hospital.

All patients admitted to a Solent or Isle of Wight NHS mental health inpatient bed will have a risk assessment undertaken, which includes their risk of going missing from the unit and actions to be taken that do not rely on a response from the police. The timing and scope of searches will be subject to the level of risk identified for the individual patient.

This policy equally applies to patients allocated to the community teams as inpatients.

The policy describes how searching should take place, the level of documentation required, and when the Trust's Head of Communications must be informed. The policy also describes when it is necessary to involve the police, namely if the patient's assessed risks are high and immediate, and there is threat to life; otherwise proportionate enquiries are to be made by NHS staff prior to escalating to the police.

The policy outlines the procedures to be followed when a patient has been found outside of hospital, and the roles of NHS staff, police and secure ambulance in the case of detained patient and those informally admitted to the hospital.

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1. INTRODUCTION & PURPOSE

1.1. This policy outlines procedures and considerations, and the roles, responsibilities and response of Solent NHS Trust and Isle of Wight NHS Trust staff and Police in the event of a service user going missing when admitted to a psychiatric hospital or when at home in the community.

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 applies to locum, permanent, and fixed term contract employees (including apprentices) who hold a contract of employment or engagement with the Trusts, and secondees (including students), volunteers (including Associate Hospital Managers), bank staff, Non-Executive Directors and those undertaking research working within the Trusts, in line with each Trust's Equality, Diversity and Human Rights Policy. It also applies to external contractors, agency workers, and other workers who are assigned to the Trusts.

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 proportionate and based on risk irrespective of the patient's legal status under the mental health act.

2.4. A duty of care exists to both formally detained and informal patients. Whilst the patient's 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 patient's location is known, the role of the police should, wherever possible, only be to assist a suitably qualified and experienced mental health professional in returning the patient to hospital.

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 discharged under a Community Treatment Order (CTO) and has been recalled from it but failed to arrive at the hospital as directed.

d) A conditionally discharged patient who has been recalled to hospital

2.8. 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.”*

2.9. 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) 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.

3. PROCESS/REQUIREMENTS

3.1. All patients should have a Care Programme Approach (CPA) or other preemptive risk assessment in line with the relevant Trust’s Clinical Risk Assessment and Management Policy and Procedure 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 – the 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 authorised leave or are missing from their place of residence in the community, 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 who are open to the community teams are subject to CPA, however in each instance the lead professional in any individual's care will ensure that the risk assessment is up to date and accessible.

3.4. 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.

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

3.6. All rooms / locations should be searched, including areas which are locked. No presumption should be made that locked areas are inaccessible or empty.

3.7. 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.

3.8. Known places where the patient may have gone should be explored where practicable (inpatient only), for example local shops, train stations etc. This is not an expectation of the community teams.

3.9. For patients who are living in residential or supported housing, the staff employed by that organisation should follow their own policies and procedures with regards to missing persons. The Trusts expect that organisation to report any missing persons to them, and to confirm whether they have alerted the police/others (family, 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 or Lead Professional 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. It may not always be appropriate to contact friends/relatives, depending on the patient's consent to share. There may be occasions where the risks outweigh the patient's prior consent, and a decision to breach their confidentiality needs to be made. This is to be discussed with the MDT and Team Leads, be in line with Trust policy, and the rationale to be clearly recorded in the patient's notes.

3.13. 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.

3.14. 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?

3.15. The Police may find it useful to have a copy of a photograph of the patient, and can be provided from Trust records if available, or via the patient's family.

3.16. 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.

3.17. *Mental Health Act Code 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 (see Appendix D).

3.18. 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.

3.19. 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.

3.20. 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. ROLES OF TRUST STAFF

4.1.1. The **Chief Executive** has ultimate accountability for the strategic and operational management of the organisation, including ensuring all policies are adhered to

4.1.2. The **Operational Director for Mental Health Services** has the responsibility of ensuring that this policy is cascaded down to their Service Managers as appropriate for dissemination and implementation within their inpatient environments

4.1.3. **Operational Managers** are responsible for the dissemination and implementation and monitoring of this policy in the areas that they are accountable for.

4.1.4. **Modern Matrons/Lead Nurses** are accountable for ensuring that this policy is adhered to and implemented by their staff teams. They are responsible for ensuring that staff receive appropriate training as part of their induction, support and guidance on this policy and will monitor for breaches and take action as appropriate to rectify this

4.1.5. **Relevant Trust staff** are responsible for being aware of and following the guidance within this policy at all times. They should also raise potential clinical problems that may arise from this policy with their line manager to enable a review of its contents and suitability. Line Managers and Clinical Practice Educators are also responsible for ensuring new starters to the team and Bank and Agency staff are aware of this policy.

4.1.6. The **staff member discovering that the patient is missing** must consider notifying (as appropriate), see Appendix B for checklist:

- The immediate line manager
- The Care Coordinator (if appropriate)
- The Responsible Clinician (RC, if appropriate)/Approved Clinician
- The nearest relative (para 28.20 MHA Codes of Practice)
- Any significant carers
- The Police, noting provisions within this policy
- 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)
- Person with parental responsibility (if under 18 years of age)

4.2. INFORMAL PATIENTS OR PATIENTS RECEIVING CARE IN THE COMMUNITY

4.2.1. 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.

4.2.2. If an informal patient 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.

4.2.3. A patient who lacks mental capacity in this matter may be returned to hospital in their best interests, including the use of necessary and proportionate force.

4.2.4. 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.

4.2.5. If the patient is unwilling to accept support or 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 AMHP).

4.2.6. 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.

4.3. PATIENTS DETAINED UNDER THE MENTAL HEALTH ACT 1983

4.3.1. 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

4.3.2. 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).**

4.3.3. If the patient is unwilling to return to hospital but is within a "house / flat / room / garden / garage / yard or associated outbuilding" an application under section 135(2) may be made by a member of staff of the hospital, to force entry and return the patient to hospital.

4.3.4. If the patient is located somewhere where a power of entry is required such as a building where the member of staff or Police would not have authorised access and the patient is actively self-harming or threatening / attempting suicide, attending staff to call ambulance and police.

4.3.5. 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.

4.3.6. 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.

4.4. **TRANSPORT**

4.4.1. 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 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*.

4.4.2. 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*.

4.4.3. 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.

4.4.4. 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.

4.4.5. 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.

4.4.6. 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.

4.4.7. 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 going 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 police liaison 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 Head of Quality & Professions for Mental Health Services.

8.2. 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.

8.3. The Head of Quality & Professions for Mental Health Services will be responsible for reviewing risk management and clinical governance issues.

8.4 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 Health Care Assistants (HCAs), Associate Practitioners (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*

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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
10.19. Clinical Assessment & Management of Risk Policy & Procedure
10.20. Incident Reporting, Investigation and Learning Policy

10.21. Close Supervision Policy
10.22. Mental Capacity Act Policy
10.23. Section 17 Mental Health Act Leave Policy
10.24. Supportive Observation & Engagement Policy for Mental Health Inpatients
10.25. Missing Persons Policy

11. GLOSSARY

11.1 AMH – Adult Mental Health
AMHP – Approved Mental Health Professional
APP – Authorised Professional Practice
AWOL – Absent Without Leave
CPA – Care Programme Approach
CTO – Community Treatment Order
CQC – Care Quality Commission
DoLs – Deprivation of Liberty Safeguards (to be replaced with Liberty Protection Safeguards)
ED – Emergency department
HCA – Health care Assistant
MCA – Mental Capacity Act
NHS – National Health Service
PACA – Policing and Crime Act
RC – responsible Clinician
S17 – Section 17 MHA 1983

Equality Analysis and Equality Impact Assessment

Equality Analysis is a way of considering the potential impact on different groups protected from discrimination by the Equality Act 2010. It is a legal requirement that places a duty on public sector organisations (The Public Sector Equality Duty) to integrate consideration of Equality, Diversity and Inclusion into their day-to-day business. The Equality Duty has 3 aims, it requires public bodies to have due regard to the need to:

- **eliminate unlawful discrimination**, harassment, victimisation and other conduct prohibited by the Equality Act of 2010;
- **advance equality of opportunity** between people who share a protected characteristic and people who do not;
- **foster good relations** between people who share a protected characteristic and people who do not.

Equality Impact Assessment (EIA) is a tool for examining the main functions and policies of an organisation to see whether they have the potential to affect people differently. Their purpose is to identify and address existing or potential inequalities, resulting from policy and practice development. Ideally, EIAs should cover all the strands of diversity and Inclusion. It will help us better understand its functions and the way decisions are made by:

- **considering the current situation**
- **deciding the aims and intended outcomes of a function or policy**
- **considering what evidence there is to support the decision and identifying any gaps**
- **ensuring it is an informed decision**

Equality Impact Assessment (EIA)

Step 1: Scoping and Identifying the Aims

Service Line / Department	Mental Health Services	
Title of Change:	Missing & AWOL Patients Policy for Psychiatric Units & Community Teams	
What are you completing this EIA for? (Please select):	Policy	*(If other please specify here)*
What are the main aims / objectives of the changes	Update current policy	

Step 2: Assessing the Impact

Please use the drop-down feature to detail any positive or negative impacts of this document /policy on patients in the drop-down box below. If there is no impact, please select "not applicable":

Protected Characteristic	Positive Impact(s)	Negative Impact(s)	Not applicable	Action to address negative impact: *(e.g. adjustment to the policy)*
Sex			X	
Gender reassignment			X	
Disability			X	
Age			X	
Sexual Orientation			X	

Pregnancy and maternity			X	
Marriage and civil partnership			X	
Religion or belief			X	
Race			X	

If you answer yes to any of the following, you MUST complete the evidence column explaining what information you have considered which has led you to reach this decision.

Assessment Questions	Yes / No	Please document evidence / any mitigations
In consideration of your document development, did you consult with others, for example, external organisations, service users, carers or other voluntary sector groups?)	Yes	There were no external stakeholder consultations for this policy. Consultations have taken place via the MHS Clinical Governance Group and review meeting with colleagues from Security Management, Solent/Isle of Wight inpatient leadership teams and Mental Health Act Leads. The appropriate action to take when a patient is absent from the ward/usual place of residence is determined by the needs of that individual, to show parity between different groups and fairness to all patients. Patients can share views on their experience and to help service improvements in the future.
Have you taken into consideration any regulations, professional standards?	Yes	This policy makes reference to relevant legislative frameworks, such as the Mental Health Act and Equality Act.

Step 3: Review, Risk and Action Plans

	Low	Medium	High
How would you rate the overall level of impact / risk to the organisation if no action taken?	■	☐	☐
What action needs to be taken to reduce or eliminate the negative impact?			
Who will be responsible for monitoring and regular review of the document / policy?	Ben Martin-Lihou		

Step 4: Authorisation and sign off

I am satisfied that all available evidence has been accurately assessed for any potential impact on patients and groups with protected characteristics in the scope of this project / change / policy / procedure / practice / activity. Mitigation, where appropriate has been identified and dealt with accordingly.

Equality Assessor:	Ben Martin-Lihou	*Date:*	20/08/2021

Additional guidance

Protected characteristic		Who to Consider	Example issues to consider	Further guidance
1.	**Disability**	A person has a disability if they have a physical or mental impairment which has a substantial and long term effect on that person's ability to carry out normal day today activities. Includes mobility, sight, speech and language, mental health, HIV, multiple sclerosis, cancer	• Accessibility • Communication formats (visual & auditory) • Reasonable adjustments. • Vulnerable to harassment and hate crime.	Further guidance can be sought from: Solent Disability Resource Group
2.	**Sex**	A man or woman	• Caring responsibilities • Domestic Violence • Equal pay • Under (over) representation	Further guidance can be sought from: Solent HR Team
3	**Race**	Refers to an individual or group of people defined by their race, colour, and nationality (including citizenship) ethnic or national origins.	• Communication • Language • Cultural traditions • Customs • Harassment and hate crime • "Romany Gypsies and Irish Travellers", are protected from discrimination under the 'Race' protected characteristic	Further guidance can be sought from: BAME Resource Group
4	**Age**	Refers to a person belonging to a particular age range of ages (eg, 18-30 year olds) Equality Act legislation defines age as 18 years and above	• Assumptions based on the age range • Capabilities & experience • Access to services technology skills/knowledge	Further guidance can be sought from: Solent HR Team
5	**Gender Reassignment**	" The expression of gender characteristics that are not stereotypically associated with ones sex at birth" World Professional Association Transgender Health 2011	• Tran's people should be accommodated according to their presentation, the way they dress, the name or pronouns that they currently use.	Further guidance can be sought from: Solent LGBT+ Resource Group
6	**Sexual Orientation**	Whether a person's attraction is towards their own sex, the opposite sex or both sexes.	• Lifestyle • Family • Partners • Vulnerable to harassment and hate crime	Further guidance can be sought from: Solent LGBT+ Resource Group
7	**Religion and/or belief**	Religion has the meaning usually given to it but belief includes religious and philosophical beliefs, including lack of belief (e.g Atheism). Generally, a belief should affect your life choices or the way you live for it to be included in the definition. (Excludes political beliefs)	• Disrespect and lack of awareness • Religious significance dates/events • Space for worship or reflection	Further guidance can be sought from: Solent Multi-Faith Resource Group Solent Chaplain
8	**Marriage**	Marriage has the same effect in relation to same sex couples as it has in relation to opposite sex couples under English law.	• Pensions • Childcare • Flexible working • Adoption leave	Further guidance can be sought from: Solent HR Team
9	**Pregnancy and Maternity**	Pregnancy is the condition of being pregnant or expecting a baby. Maternity refers to the period after the birth and is linked to maternity leave in the employment context. In non-work context, protection against maternity discrimination is for 26 weeks after giving birth.	• Employment rights during pregnancy and post pregnancy • Treating a woman unfavourably because she is breastfeeding • Childcare responsibilities • Flexibility	Further guidance can be sought from: Solent HR team

Appendix: B Missing Persons Checklist

Name:

NHS Number:

Date of Birth:

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:**			
Record on Trust Incident System	**Incident Number:**			
Inform Medics: RC and Duty doctor.	**RC:** **Duty Doctor:**			
Inform Care Coordinator if appropriate.				

<table>
<tr><td>Relatives / significant others</td><td colspan="2"></td><td></td><td></td></tr>
<tr><td>A&E department</td><td colspan="2"><u>Who?</u>
<u>Bleep holder?</u></td><td></td><td></td></tr>
<tr><td>Home Office
(Restricted patients)</td><td colspan="2"></td><td></td><td></td></tr>
<tr><td>Safeguarding concerns:</td><td colspan="2"><u>CHILD</u> <u>ADULT</u>

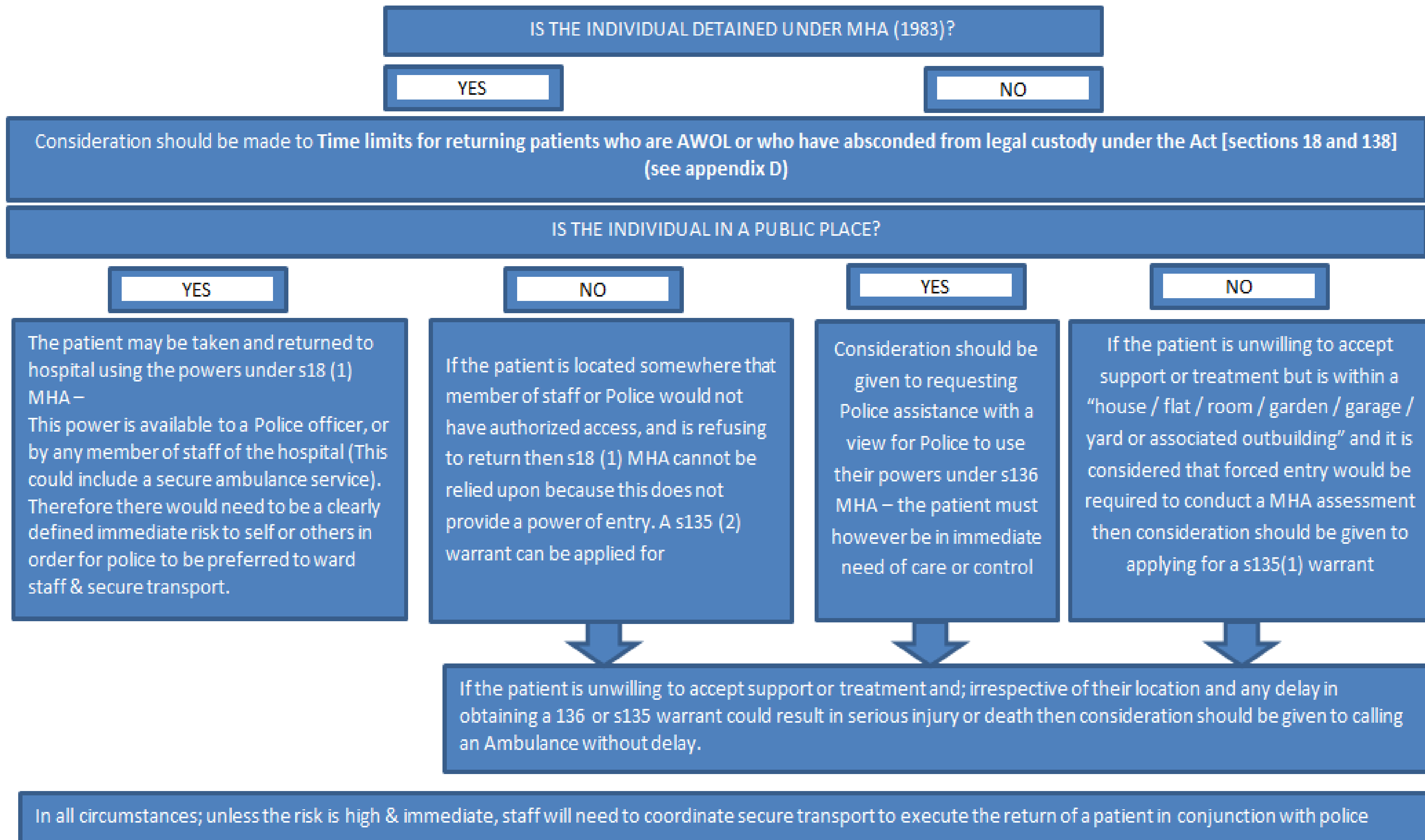
<u>Individual at Local authority notified:</u>

<u>Details:</u></td><td></td><td></td></tr>
<tr><td>Others: Social services.</td><td colspan="2"></td><td></td><td></td></tr>
<tr><td>Housing providers:</td><td colspan="2"></td><td></td><td></td></tr>
<tr><td colspan="5">For the purposes of ensuring appropriate escalation. it will be the responsibility of the person completing this form to check on the following also:</td></tr>
<tr><td>Out of Hours:

Check with Senior Nurse on site that On call Duty manager has been notified</td><td colspan="2">Senior nurse on site:

On call duty manager:</td><td></td><td></td></tr>
<tr><td>Check with Senior Nurse on Site that the On call duty consultant has been notified</td><td colspan="2">On call duty consultant:</td><td></td><td></td></tr>
<tr><td>Establish whether media coverage is considered appropriate</td><td></td><td>If so; ensure that The Trusts Head of Communications Manager is informed</td><td></td><td></td></tr>
<tr><td>All of the above documented on Electronic Patient Record</td><td colspan="2"></td><td></td><td></td></tr>
</table>

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, i.e. 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