Sheffield Health and Social Care NHS Foundation Trust

Policy:

Missing Absent Without Leave and Missing Patients OPS 002

Executive or Associate Director lead	Executive Director of Operations
Policy author/ lead	Senior Nurse, In Patient Directorate
Feedback on implementation to	In-Patient Directorate Senior Management Team, Nurse Leadership Group

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Target audience	All Staff working in bed based services in SHSC

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Policy Version and advice on document history, availability and storage

This is version 3 of this policy. This new policy has been developed to comply with the Mental Health Act 1983 Code of Practice (2015).

This policy will be available to all staff via the Sheffield Health & Social Care NHS Foundation Trust Intranet and on the Trust's website. Word and PDF copies of the current and the previous version of this policy are available via the Director of Corporate Governance.

Reviewed and up dated January 2019 by Kim Parker – Clinical Nurse Manager and Naomi Hebblewhite – Senior Operational Manager
Additional paragraph outlining the responsibilities for transporting AWOL patients/service users who have been detained by the Police Out of Area.

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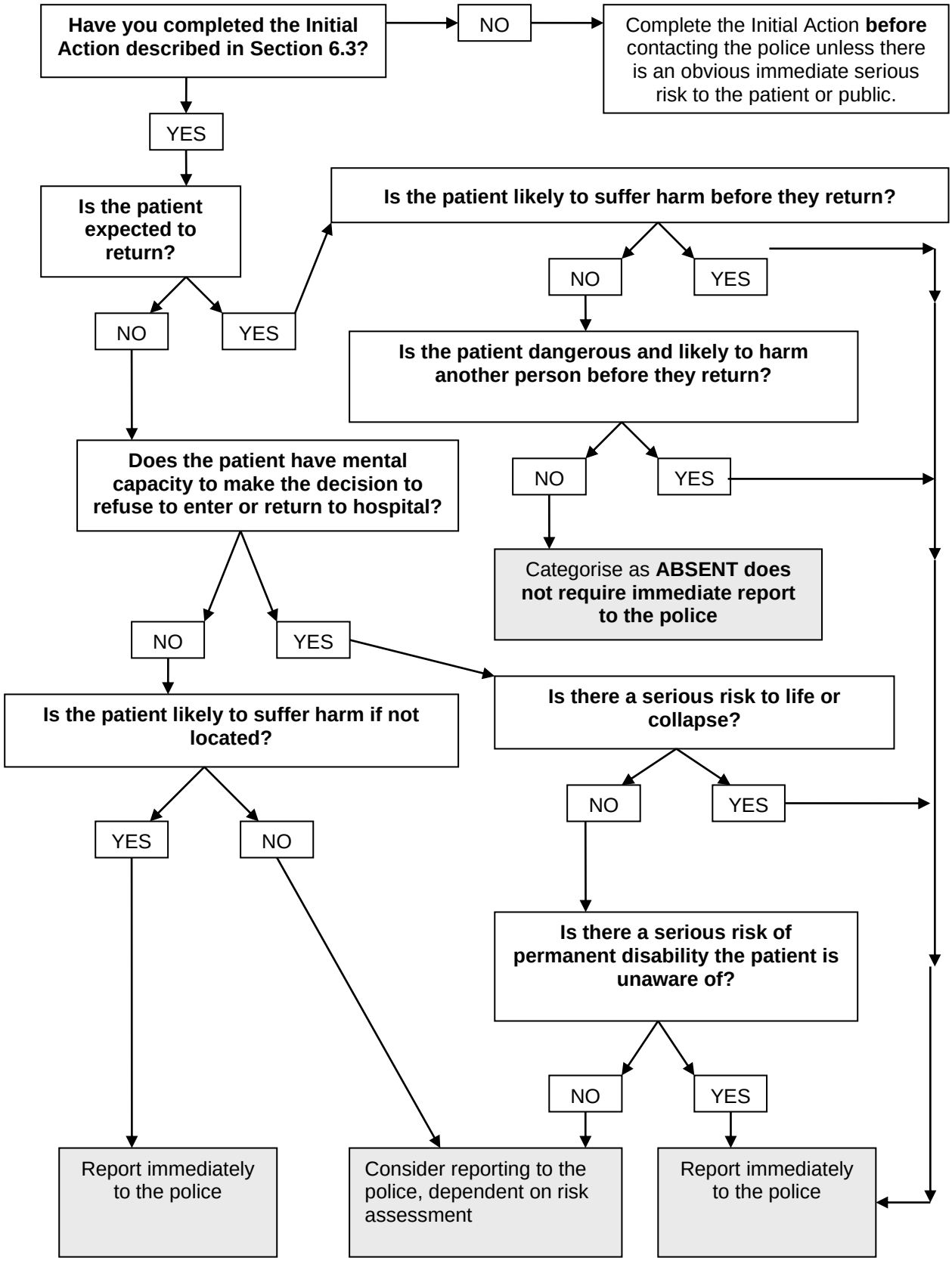
Categorisation of Absence Flow Chart



1. Introduction

This policy and procedure has been jointly developed between Sheffield Health and Social care NHS Foundation Trust (SHSC) and South Yorkshire Police (SYP). It provides a consistent template for responding to service users or inpatients whose absence is unplanned and therefore identified as absent without leave and those whose whereabouts are not known and therefore missing. It applies to all SHSC service users/patients of inpatient services, irrespective of the service they are using.

SYP will determine which category a SHSC service user falls into for the purpose of this policy.

The purpose of this policy is to ensure a safe and consistent response from staff when patients become absent, meaning they are correctly classified as such and categorised according to the risk of harm they may present to either themselves or others. The policy will outline and support a joint approach with other key services such as the local Police forces and other local partners to ensure consistency of descriptive terms and joint responsibilities for maintaining a person's safety should they go missing. This policy does not apply to patients who receive their care at home in community settings eg CERT who are absent from where they are expected to be. In this situation the DRAM, Collaborative Care Plan and Care Programme Approach will determine next steps.

Its purpose is to minimise the risk posed by the absence of the service user, whether to others or the person themselves.

This policy aims to outline the expectations placed upon staff delivering this duty of care and provide guidance on good practice that reduce the potential for a patient to go absent without leave and missing from a ward/unit**.**

In recognising that service users/patients may go absent without leave despite good practice, this policy provides guidance on the measures and actions to be taken by staff to assist with the service user/ patients' safe and timely location and return to a ward or area providing care.

All members of staff have an important role to play in the effective implementation of this policy and should ensure that they are familiar with the guidance outlined.

Although the policy and attached protocol is the product of joint agency development, it nevertheless remains a Trust document, and as such meets the normal standards for approval and use.

2. Scope

This policy applies to all bed based services within the Trust.

The policy addresses the needs of all inpatients, or those in community/residential bed based services , who are absent without leave, whether they are:

- Informal (i.e. not detained under statutory provisions),
- Subject to deprivation of liberty safeguards (DOLS), or

- Subject to detention or compulsion the under Mental Health Act, including section 5 holding powers .

Informal patients do not require 'leave' to be granted formally, but their absence from the ward or care area may give cause for concern and this policy applies equally in those circumstances.

The Trust has a duty and responsibility to ensure that care and treatment is delivered in a safe environment to service users entrusted to our care. In discharging this duty of care the Trust and its staff have a responsibility to ensure that the presence and wellbeing of its service users are managed, planned and known at all times.

This policy does not cover in detail how to proceed in relation to a Service user living in their own home (when their own home is not an SHSC service) who appears to have gone missing. In this situation the DRAM, Collaborative Care Plan and Care Programme Approach will determine next steps.

3. Definitions

For the purpose of this policy framework the following definitions are used:

South Yorkshire Police (these two definitions are irrespective of the relative Mental Health Act status of the patient)***:***

Missing Person: A patient will be considered missing when their whereabouts cannot be established and where the circumstances are out of character or the context suggests the person may be a subject of crime or at risk of harm to themselves or another.

Absent: A patient will be considered as absent if they are not at a place where they are expected or required to be.

Sheffield Health and Social Care:

Service User or Patient: a person who is in receipt of care or treatment from SHSC in any of the care areas covered

Missing patient: a person who has been receiving care or treatment in an SHSC ward/care area, or STH who has left the area in an unplanned way, ie without going through normal leave or discharge processes. NB - SHSC policy does not differentiate between those ***whose whereabouts is unknown and those whose whereabouts is known, but the procedure is different when the service user's location is known.***

Ward/Unit: Is used to apply to any ward/care area where SHSC is involved directly with the provision of staffing to provide care and treatment

Person in Charge /Senior Nurse: Person-in-charge of the ward/unit at the time of the incident.

Informal Patients: Patients who are not legally detained in hospital have the right to leave at any time. They cannot be required to ask permission to do so, but may be asked to inform staff when they wish to leave the ward. (MHA Code of Practice 2015: 27.38)

NB – there is an operational duty to preserve life where there is a 'real and immediate' risk of suicide in informal patients, see Rabone v Pennine Care Trust.

Formal Patients: A service user/patient detained under a section of the Mental Health Act 1983 or subject to compulsion. Needs to say the same as introduction, including MCA things

S17 Leave: Leave from hospital granted under the Mental Health Act to a patient who has been detained under the Act

Escape: A service user/ patient leave's a locked setting by breaching the physical security measures of the building or perimeter

Abscond: A patient leaves the ward/care area without notification (if informal) or agreement (and Section 17 if detained pursuant to the MHA) or has parted from their escort while away from the ward.

Failure to return: A patient fails to return from a notified or agreed period away from the ward/care area.

Responsible Clinician: The member of the clinical team (most often but not always a Doctor) who is in overall charge of a person's care and treatment when detained under the Mental Health Act.

Approved Mental Health Practitioner: A person authorised to carry out an assessment make an application for detention under the Act.

Care Programme Approach: The agreed process in Mental Health services for the assessment, care planning and review for and with service users

Acronyms used in this policy

CERT	Community Enhanced Rehabilitation Team
DRAM	Detailed Risk Assessment and Management Plan
MHA	Mental Health Act 1983 (as amended in 2008)
CoP	The Code of Practice (most recent edition April 2015) for the above Act
AMHP	Approved Mental Health Professional

4. Purpose

The purpose of this policy is to ensure a safe and consistent response from staff when patients become absent, meaning they are correctly classified as such and categorised according to the risk of harm they may present to either themselves or others. The policy will outline and support a joint approach with other key services such as the local Police forces and other local partners to ensure consistency of descriptive terms and joint responsibilities for maintaining a person's safety should they go missing. This policy does not apply to patients who receive their care at home in community settings e.g. CERT who are absent from where they are expected to be. In this situation the DRAM, Collaborative Care Plan and Care Programme Approach will determine next steps.

5. Duties

The Chief Executive is responsible for ensuring that the systems on which the Board relies to govern the organisation are effective. The Statement of Internal Control is signed annually indicating that systems of governance, including risk management are properly controlled. The Trust's Chief Executive through the Executive Director of Operations is responsible for keeping the policy updated and available for staff.

The Executive Director: Chief Operations Officer/ Chief Nurse has lead responsibility for policy adherence in the Trust and will ensure that the policy is reviewed and updated accordingly through the Trust's governance processes.

The Executive Director: Chief Operations Officer/ Chief Nurse is responsible for ensuring that all Clinical and Service Directors implement and adhere to this policy within their individual remits.

Service Directors are responsible for ensuring that all managers in their areas are aware of the policy, understand the requirements and support its implementation.

The Executive Medical Director, through the Medical Directors, is responsible for ensuring that medical staff adhere to the policy

Service Managers/Head of Department/ Team Leader will ensure all staff (including new starters, including volunteers, agency staff and contractors) are aware of the policy and the risks associated, and ensure that the control measures are in place to manage those risks.

Ward/ Team Managers are responsible for ensuring that the policy is fully implemented within the ward/ team environment. They must ensure that the policy is readily available to all staff at all times regularly updated.

All Health Care Professionals are responsible for ensuring that their practice reflects the standards identified within the policy.

Staff have a duty to assess risk to service users (DRAM) and to act in accordance with these procedures and guidelines. All ward staff will use the policy and procedures and be aware of their roles and responsibilities.

6. Process

6.1 General Principles

This policy and its procedures will ensure that all initiatives, actions, are in accordance with relevant statute law and best practice.

The maintenance of service user/ patient safety is based on adequate risk assessment, planned interventions, and regular review of these.

This is supported by clear reporting mechanisms and planned responses which require:

- A risk assessment of the likelihood a person may leave the ward/care area without notifying staff or without MHA s17 leave or other agreed arrangements completed as part of the standard risk assessment process
- Clarity regarding when a person should be regarded as absent.
- Clear categorisation of the risk, which will determine the urgency and effectiveness of the joint response
- Ensuring relatives are informed of absent or missing persons as soon as possible and then kept up to date with all developments
- On return, acting to reduce the risk of future unplanned absence through review of the reasons the person went missing and ensuring care planning is modified appropriately to reduce further risk.

Channels of communication between the Trust, local providers of healthcare and the relevant Police Departments must be established for every incident and maintained in order to facilitate the partnership approach. This will continue until such time that the person is returned to the care environment.

This document is compliant with the Human Rights Act 1998, the Mental Capacity Act 2005, DoLS (2008), the Care Programme Approach and all other legal requirements

This policy should therefore always be considered in conjunction with the following:-

- The Mental Health Act (MHA) 1983 (as amended by the Mental Health Act (2007)
- The Mental Health Act Code of Practice (2015)
- The Mental Capacity Act (2005)
- The Mental Capacity Act Code of Practice 2007
- Deprivation of Liberty Safeguards Code of Practice (2008)
- European Convention on Human Rights (ECHR) Articles 5 & 8, (1950)

With regard to Article 8, confidentiality should always be maintained but may be overridden where the opinion of the MDT deems this necessary when:

- It is in the patients best interests
- For the protection of others
- To ensure accurate and full interdisciplinary and service communication

6.2 Good Practice on admission – to be followed for all service users/patients

6.2.1 Initial Risk Assessment

This will form part of the initial clinical assessment and will assist the person in charge of the ward/ department or unit to categorise the absence in the event that the patient goes absent without leave. It will include information on:

- Previous history of absconding or going missing
- Identifying what may trigger the patient to leave on an unplanned basis or abscond/not return from planned leave. This should include consideration of any factors that may arise from one or more of the protected characteristics.
- The current level of the service user/ patient's awareness, confusion, stability, disorientation
- Whether the service user/ patient is unsettled, distressed or showing any signs they will leave on an unplanned basis or abscond or not return from planned leave.
- Whether the service user/ patient is unhappy with their present environment and care
- The vulnerability of the service user/ patient and the risk of harm to him/ her if he/she is absent from the care area on an unplanned basis or absconds or fails to return from planned leave; the risk of harm the service user/ patient poses to individuals, specific groups or the wider public if he/she is absent
- Consideration of any external influences which may result in a service user/ patient's removal without consent by others and the likelihood of the service user/ patient being harboured by family or friends
- If the service user/ patient is a young person or vulnerable person, the likelihood of the service user/ patient being harboured by a potential abuser
- Medical issues such as diabetes, epilepsy, heart conditions, medication required or consequences of not taking medication in a timely manner.

6.2.2 Care Planning

Based on the initial risk assessment, the Collaborative Care Planning process should be developed, with the service user/patient where possible and consider:

- Informal service user/ patients should be encouraged to inform staff before they leave the ward/department/unit. They cannot be required to ask permission but may be asked to inform staff when they wish to leave. (CoP 27.38). Staff have an operational duty to assess the risk posed.
- Detained service user/patients require Section 17 MHA to be authorised by the Responsible Clinician before leave can take place. Staff are require to check that authorisation is in place and consult the necessary risk assessment.
- Service user/patient specific guidance on the action to be taken if service user/ patient goes absent from the care area on an unplanned basis or absconds or fails to return from planned leave;
- The views of relatives/carers (if appropriate to obtain) on the service user/ patient's needs and their views of the action that needs to be taken if the person is absent from the care area on an unplanned basis or absconds or fails to return from planned leave;
- Where risk is identified and care plans developed these should be reviewed at appropriate intervals by ward teams ensuring these are up-to-date and reflect the care needs for the individual

- Where the service user/patient has dementia the ward/unit may use the Herbert Protocol (Appendix H). Such services e.g. in the Specialist Directorate, may consider filling out the form in conjunction with the care setting/ family and retain in the event of the service user/patient going absent from the care area on an unplanned basis or absconds or fails to return from planned leave;
- This will ensure that the right information is readily available for the police so that the search can be targeted appropriately in the event the service user/patient going absent from the care area on an unplanned basis or absconds or fails to return from planned leave;
- This will also support and inform future risk management plans.

6.2.3 Effective Admission Arrangements

A positive admission experience is considered essential for promoting engagement and collaboration, alongside reducing dissatisfaction, which may decrease the potential for absconding (Safewards, 2015). It is recognised that the environment of a ward/unit has an impact on the level of patient's feelings of safety, confidence and satisfaction in relation to their stay as an inpatient.

Examples of good practice in relation to issues surrounding absconding and or missing patients include:

- Service User/Patient involvement in and awareness of initial assessments following admission.
- Awareness and involvement in developing a Collaborative Care Plan, supported by comprehensive ward information. This may take account specifically of a range of factors that fall within the range of protected characteristics.
- Awareness of ward procedures regarding ward rounds, multi-disciplinary team (MDT) meetings, discharge meetings, care programme approach etc.
- Awareness of the opportunities to meet and plan regular time with their named nurse, their ward Doctor or their Consultant.
- Awareness of their status under the Mental Health Act, with clear and regular information provided about this and information in respect of authorised leave.
- Awareness of their medication and issues relating to it.
- Awareness of available services to support them in terms of advice and advocacy.
- Staff awareness of a service user/patient's advance statement where one exists
- Consideration of the person's mental capacity/capacity assessment. However, circumstances appertaining to a person's level of understanding/capacity may influence the degree of involvement of the patient.
- Provision of facilities to enable and support patient Eliminating Mixed Sex Environment Principles and ensure privacy and dignity
- Appropriate therapeutic activities and engagement opportunities
- Appropriate and timely use of the RESPECT, Aggression and Violence; Respectful Response and Reduction Policy.

6.2.4 Specific Preventative Measures

Will include:

- Identifying the potential opportunities to leave the care area on an unplanned basis or to abscond or to fail to return from planned leave;
- Considering security measures and environmental factors;
- Ensuring knowledge of the whereabouts of the service user/ patient as required by the patient observation policy (much of the nursing activity is concerned with the observation of the mental state of the service user/ patient and this will be supported by active observation and engagement with the service user/ patient, their family and/or carer);
- The use of formal observations where assessment reveals specific risks exist
- In mental health units it may be necessary to use physical interventions to prevent the patient leaving on an unplanned basis. This should however be within the appropriate legal framework and clinically justified and proportionate to the risk presented.

6.2.5 Photographs of Service Users/Patients

As part of the admission protocol for Inpatient Wards, all service users will be expected to have an up to date digital photograph taken.

The person's capacity to consent to having their photograph taken should be assessed by the admitting nurse i.e. that the person understands that they are being asked to have their photograph taken, that they can remember that information and weigh up the information to make a decision and then communicate their decision by talking, using sign language or by any other means.

If a person who is a voluntary patient refuses to have a photograph taken but has capacity to consent then the MDT should make a decision about the safe management of that individual.

If a person is admitted under section of the Mental Health Act refuses to have a photograph but has capacity to consent then the MDT must take into account the refusal of a photograph with regard to future s17 leave arrangements.

The photograph will be stored on a restricted access datastore. The photograph will only be shared with SYP if there are concerns about safety or risk of the service user/patient or others, in relation to being absent or missing from care. Photographs can be emailed to SYP on force.control@southyorks.pnn.police.uk Reporting staff should include in the email that the image should be deleted once the person is safety located.

On discharge from the ward, the photograph will be deleted.

Each admission to an inpatient service will require the consent process to be completed and a new photograph taken even where someone has been previously admitted and previously consented.

It is noted that some service users/ patients may refuse to have a photograph taken as part of this leave risk assessment. This should be discussed with the MDT for relevant actions and a team decision re: management of leave

Services with different levels of security e.g. Low secure, may have different arrangements for the frequency with which photographs are taken and the storage of these.

6.3 Service User/ Patient is found to be absent: Protocol

6.3.1 Reporting arrangements for all unplanned absences

Following the service user/patient being found to be absent the person in charge will contact a senior nurse or relevant medical staff. Contact will be made in order to:

- Confirm that the initial actions described above have been completed;
- discuss the level of concern;
- review the risk assessment taking into consideration the current circumstances of absence;
- Agree the preferred response, including possible action to be taken upon return.
- Consider the circumstances of absence;
- Determine, with appropriate consultation, whether it is necessary immediately to inform the police – see below
- If it is immediately necessary, the police will then determine whether the service user is absent or missing, by their definitions.

During working hours, Ward Manager/ Senior Clinical Nurse Service manager will be made aware of the situation. Out of hours, the Band 6 nurse or on-call manager will be contacted if the person is absent and there are significant concerns. The service user/patients Responsible Clinician should be informed at the earliest opportunity. (CoP 28.12)

An incident report will be completed in all cases of patients being classified as absent. Following resolution of the incident the incident report should be updated with the time of return, or other outcome, and details of the support/debrief offered.

6.3.2 Urgency of Action

Although all detained mental health patients and service users on acute wards are likely to pose a significant risk to themselves or others if they are not located, it is not always the case that the risk is so immediate and so serious that urgent police assistance is necessary.

6.4 Informing the Police

SHSC is responsible for the welfare of service users/patients in its care. SHSC is therefore primarily responsible for locating and returning the service user/patient unless the risk is ***serious and immediate***, such as when they may be a victim of serious crime; may suffer death or serious injury; or may cause death or serious injury to another person.

The Police should be informed IMMEDIATELY if

- There is an obvious immediate serious risk to the service user/ patient or the public;
- The patient is subject to restrictions under Part III of the Mental Health Act;
- The patient is subject to Bail restrictions, where they must reported to the police.
- The service user has escaped from a locked or secure environment
- The service user/patient has Ministry of Justice restrictions.

Following review of the risk, the MDT might decide to report the absence to the Police at a later time; in either event, the Police will then categorise the person according to risk as 'Absent' or 'Missing Person'.

6.4.1 Police Categorisation of Risk

South Yorkshire Police will conduct a risk assessment using the 22 risk assessment questions (see Appendix G) and jointly review the initial health categorisation and decide with the person in charge whether the absence falls within the definition of:

- Missing
- Absent

If the Police agree the absence falls within the definition of missing, the police officer in consultation with the person in charge will:

- Categorise the risk based on risk to the service use/patient and public
- Conduct appropriate enquiries.

6.4.2 Contacting the Police

A telephone call to Atlas Court will be made. Telephone 101. A Unique reference number (URN) will be provide which must be recorded on Insight and used in all communications with SYP.

SHSC staff will supply sufficient information in line with the 22 risk assessment questions (Appendix G) to enable South Yorkshire Police to undertake the required investigation in an effective manner.

The reporting person should provide a current assessment of risk to SYP as assessed by them on making the absent/missing person report. This will include information to enable the police to assess whether they may meet a level of physical threat, any medical risks as a result of medication not having been taken or other healthcare issues. This will also include providing SYP with details of the MHA status of the absent /missing service user/patient, specifically whether they are an informal service user/ patient or detained under a particular section of the Mental Health Act. For Informal service users/patients information on whether an urgent Mental Health Act assessment is to be undertaken as this information may lead to police utilising their powers under S136 Mental Health Act if they find the person in a public place. The details provided will be recorded on the Insight records.

6.4.3 Potentially Violent or Infectious Service Users/Patients:

If clinical staff have identified that the service users/patient poses a significant risk to themselves or other individuals who may be required to detain or transport that individual, this should be communicated to the police and any existing risk assessment shared. For example:

- Although it should not normally be disclosed that a service user/patient has an

infectious disease, where such a disease can be passed on via contact with bodily fluids, these risks should be shared if the service user/ patient is known to be violent, or is known to spitting or self-harm.

- It should be disclosed if a service user/patient is known to carry weapons;
- It should be disclosed if it is known that a service user/ patient has a partner who is likely to be violent if attempts are made to recover that service user/ patient.

6.4.4 Disputes over Categorisation of Absence or Risk

- Any disagreement or dispute between the Police and SHSC staff over the categorisation of absence or risk will be referred to the Senior Clinical Nurse Service Manager/ Band 6 nurse on duty/ or on-call manger and the Duty Inspector (or force incident manager if inspector unavailable). The outcome will be recorded on Insight. If resolution cannot be achieved the concern should be escalated to the relevant Assistant /Clinical Director within SHSC.

6.5 If the service user/patient is categorised by the police as 'Absent'

SHSC staff remains responsible for managing a service user/patients absence, however:

- The Police will ensure that the person who is absent is circulated on the Police National Computer so that appropriate action can be taken if that person is stopped and checked by the police.
- The Police will periodically review the risks relating to the absence with hospital staff. SHSC staff will maintain contact with SYP, a minimum of once a day.
- If after 48 hours the service user/patient has not returned the Duty Inspector will decide if the absence needs to be upgraded to a missing person. This will depend on the associated risks.

On discovering the absence:

The nurse in charge of the ward/department will be informed and will co-ordinate the response and act as a point of contact. The nurse in charge will check the DRAM/care plan to ascertain:

All reasonable steps will be taken to:

- Determine the nature and reason for absence;
- Ascertain the likely intentions of the absent service user/ patient in light of their clinical condition, recent events and precipitating factors
- Establish the likely whereabouts and well-being of the absent service user/ patient by, ringing the service user/ patient's mobile telephone number or landline.
- Where possible seek assistance from relevant agencies or family to check known addresses and places frequented (e.g. community teams, when available)

Staff will conduct all reasonable enquiries and searches that will include:

- Telephoning or sending a SMS text message (if possible) to the absent service user/ patient's mobile phone and/or home phone using the ward, (not personal) phone. ;
- Searches of the service user/patients bedroom, other rooms on ward, unit, or departments, including all locked areas;
- Initiate a ground search of the site and surrounding area and alerting any existing reception and security services if working at the time;

- Enquiries with other staff/ service users/ visitors to see if they have seen or heard anything or know the current whereabouts of the service user/patient.
- Enquiries with relatives or friends, associates and other relevant agencies
- Contact security staff where this is possible
- Arranging for the home address of the service user/ patient to be checked by ward staff, the crisis team, the community mental health team, or a relative.
- If the whereabouts are established, take all reasonable steps to return the service user to the ward/care area
- Regularly review the absence and the associated risk assessment;
- Consider other factors such as medical status, age or possible levels of disorientation that may influence risk and the response required
- May alternatively decide to seek a clinical review to formally discharge the service user/ patient where this is deemed appropriate.

A service user/patient who is initially categorised as absent might subsequently re-categorised as Missing if the level of risk increases due to a change of circumstances or because they do not return and are not located as expected.

If it is thought necessary to upgrade the category of absence to Missing, the person in charge of the ward/ department/ unit will contact the appropriate clinical manager/ on-call manager to discuss and then contact the police if they agree that the missing criteria apply.

6.6 If the Service User/Patient is categorised by the police as a 'Missing Person' SHSC will carry out all actions on discovering the absence as detailed above for an 'Absent' service user.

In addition-

The Police, in consultation with SHSC will determine necessary action, this may include using local or national or social media.

Media

The police have responsibility for considering whether to inform the media about missing service users/ patients to;

- To make the public aware that the individual is vulnerable and requires treatment;
- Warn the public should that individual pose a significant threat; and
- Appeal for the public's assistance to locate that individual.

6.7 Consultation about Publicity

The police decision to publicise will always be made in consultation with a responsible person (SHSC Assistant/Clinical Director and Communications Department) who will consult the relevant family members.

6.8 Contacting the Identified Carer, Next of Kin, Nearest Relative (as defined under the MHA 1983) or Named Contact Person

The identified carer will be informed by telephone as soon as it is clear that the service user/patient is absent unless:

- Informing the identified carer is judged by the clinical team to be counter-productive for example, by causing excessive alarm;
- It is thought more appropriate to contact them by another means e.g. community mental health team staff or police.
- There has been a prior agreement with the identified carer that they do not need to be contacted immediately.

When patients become absent consideration should always be given to contacting people who are identified as being at specific risk from individual service users/patients. Such risks, and the degree to which these are present, should be balanced against disclosure and breaching confidentiality. People known to be at risk for the service user/patient should be identified in the DRAM.

6.9 Notification of CQC re Absence without Leave form Low Secure Care

The CQC are to be notified regarding any absence without leave (AWOL) of a person who is detained, liable to be detained or subject to compulsion, under the Mental Health Act 1983 from Low Secure Service (i.e. Forest Lodge). The Statutory Notification is completed as soon as possible after the incident by the Mental Health Act administrator, who will be notified by staff from Forest Lodge.

The Ministry of Justice also needs to be informed by the Responsible Clinician, Ward Manager or nurse-in-charge of the ward when service user/patients subject to Restriction Orders are absent without leave.

6.10 Service Users /Patients Who Fail to Return

For service user/ patients detained under the Mental Health Act or subject to compulsion, please note the provision s18 to s21 of the Mental Health Act (return and readmission of service user/patients AWOL, regulations as to transfer of service user/patients, duration of authority and return before/after 28 days). See Appendices J and K.

Where the service user/ patient has been missing for a period of 48 hours an MDT review should be undertaken. This should aim to include the:

- The service user/ patient's Responsible Clinician (RC), Named Nurse, Charge Nurse/Ward Manager/Sister, Police representative, Care Co-ordinator (or appropriate community worker if appropriate or applicable.
- Service user/ Patient's General Practitioner, relative and/or carer where appropriate, or, alternatively the views and concerns of these individuals should be incorporated within the review.

This will be arranged by the Ward/Unit Manager and the aim of this review should be to:

- Review the level and grounds of concern.
- Review action taken to date and any progress made.
- Agree plan for further action and exploration.
- Agree a single point of contact.

Effective communication following this review is essential to ensure feedback is received in the future as to the possible whereabouts of the service user/ patient. This communication should cover all relevant services/individuals involved with the service user/ patient and should outline what actions individuals should take and who they should notify (clear contact points agreed within the Police, first contact

and statutory Health Services) should they have further contact with the service user/patient.

As part of this review, utilisation of broader communication within the NHS organisations within neighbouring districts or further afield should also be considered as an option if there is a present concern for the vulnerability of risks of the service user/patient and a potential that the patient has travelled outside of the locality.

6.11 Record keeping

Throughout the period that the service user/ patient is absent, staff must keep a full contemporaneous record of all circumstances, decisions, actions taken and messages received and given within the service user/ patient's health record Details of the person making the entry will be recorded and entries will be dated and timed.

DRAM/Care plans, which may include those to prevent absconding where this is identified as a specific risk or following return from a period of absence from the ward should be recorded. These should assimilate any previously known risks in respect of absconding and incorporate new information from the current episode. These should be then reviewed at appropriate intervals based on the service user/patients presentation by the MDT to reflect any on-going changes in risk or interventions

All telephone calls made to the police are to be recorded on Insight with the time and name (number) of the person spoken to.

6.12 Planning for Return

During a period of absence, clinical staff should contingency plan and make arrangements for the service user/patients return. Questions to consider:

- What is the clinical need now?
- Where is the appropriate care location for care?
- How urgent will it be to return the service user/patient?
- How will the service user/patient be transported?
- Will the service user/ patient need an escort?
- Does the risk assessment indicate that police assistance is likely to be required?
- Will it be appropriate to involve the next of kin or named contact and if so how?

6.13 When the person returns or is located

The police should be asked to assist in returning a service user/patient to hospital only if necessary. The level of risk presented will always determine the appropriate response. If the service user/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 service user/patient to hospital. (MHA CoP 28.14.

SHSC staff are responsible for arranging appropriate transport for the service user/patient to ensure their safe return to their care establishment. SYP will support staff with this if the risk assessment indicates that this is the only safe way to return the service user/patient.

If the service user/patient has returned to the ward without the assistance of the Police, the person in charge should notify the Police as soon as possible so that the search/enquiries can be discontinued. Unless there are documented exceptions, the person's relatives should also be informed of their return at this point.

If the service user/ patient has been returned by the Police, then the Police Officer should inform ward staff of any incidents or issues that they may be aware of arising during the service user/patient's absence from the ward.

Following this a review of the previous DRAM/Risk assessment should be undertaken including level of observation, with consideration being given to reassessing previous risk factors and identifying risk behaviour.

Potential measures / interventions or actions that could reduce further instances of the service user/ patient absconding should be considered and documented within their Insight notes and where appropriate, discussed and communicated with the service user/patient if possible and shared with relatives if appropriate.

6.13.1 The Return Interview and Assessment

Following a service user/ patient's return it is expected that the following should be reviewed and explored within 24 hours of return:

- Why the service user/ patient absconded or went missing from their perspective.
- Where the service user/ patient went whilst away from the ward, where they were located.
- How the service user/ patient managed and coped whilst absent from the ward.
- How the service user/ patient feels following their return to the ward, generally and with regard to being back on the ward.
- Communication to Police (if not returned by the Police) regarding where the service user/ patient was found or had been, to assist with future responses. (The Police need to be informed of the safe return of a service user/ patient and the location where found for future reference. The contact for this would be the Duty Sergeant.
- The service user/ patient will also be given the opportunity to talk to someone independent about their absence ie Advocate if required.

6.13.2 Support and Assessment Following Return

- A doctor will assess the service user/ patient if there are any causes of concern raised by the service user/ patient or staff: this may relate to physical or mental health.
- If there is any suggestion that the service user/ patient has been the victim or perpetrator of crime this should be reported at the earliest opportunity as consideration must be given to the securing of evidence for forensic examination and initiation of victim care. This will include securing clothing and delaying washing/bathing in relevant cases.
- The police will fully investigate allegations of physical or sexual abuse and take whatever steps are necessary to protect the service user/ patient from further abuse. Adult / Child Protection Procedures will be followed.
- The DRAM will be updated

6.14 If a Service User/ Patient Refuses to Return

- SHSC staff will attempt to speak to the service user/ patient or the/a responsible person at the scene on the telephone and make a note of details. SHSC staff will attempt to establish the service user/ patient's intentions and the level of concern at the time.
- Discussions will take place between the clinical team, relatives and the police to establish the next steps. They may include discharge, arranging a visit by Community Mental Team staff, or assessment for detention under the Mental Health Act (1983), or an application under deprivation of liberty safeguards (2009). All actions and decisions will be fully documented in accordance with NMC guidelines and Trust policies on record keeping.

6.15 Power of Entry to Recover

Section 135(1) of the Mental Health Act allows a Justice of the Peace to issue a warrant authorising a Police Officer to enter premises, using force if necessary, for the purpose of removing a person with a mental disorder.

A warrant can be issued in situations where there is concern about a person who is not currently liable to detention under the Mental Health Act. This section should only be considered in circumstances in which there is a high risk of a person meeting the criteria for the obtaining of a warrant i.e. they have a mental disorder and they have been or are being ill-treated, neglected or kept otherwise there under proper control, or the service user /patient is living alone and unable to care for themselves **AND,** where entry to the premises has been denied. This will only apply in a very small number of cases.

The decision to apply for a warrant must be made in the light of a full assessment of all the circumstances, bearing in mind the potential or actual risks to the service user/ patient and/or others balanced against their human rights, i.e. the application for a warrant must be a justifiable and proportionate response to the situation.

Applications for a warrant in these situations must be made by an Approved Mental Health Professional.

6.16 Patients Detained under the Mental Health Act

Section 135(2) of the Mental Health Act allows a warrant to be issued where the person is already liable to be detained (i.e. the person has been detained under the Act prior to, or during this admission) and where Mental Health professionals and Police Officers are being prevented from entering the premises where the patient is thought to be. Applications for such warrants may be made by a Police Officer, Approved Mental Health Professional or any person authorised by Hospital Managers.

It is recognised that in the interests of good practice, all agencies should work together and that each situation should be considered according to the individual circumstances. Therefore this policy deliberately does not place responsibility for obtaining a warrant under S135 (2) on any specific agency. However, where a service user/ patient is liable to be detained has absconded; all agencies have duty to be involved in agreeing upon a course of action and negotiating roles and responsibility in situations where it is deemed appropriate to invoke this section.

6.17 Guidance on Obtaining a Warrant

SHSC in patient staff have authority to obtain warrants. Guidance is available in Appendix I.

Where a warrant is obtained, although it is not a requirement for the Police Officer(s) executing it to be accompanied, it would be good practice for someone who knows the service user/patient, or if this is not possible, another suitable representative from the Trust to be present.

In these circumstances the warrant authorises a Police Officer to enter the premises to remove a person to a place of safety which should in the first instance be either the ward on which they are currently a patient or the S136 suite as a place of safety for that locality; negotiation should take place between those executing/obtaining the warrant and person in charge/ senior manager to agree on the appropriate place of safety prior to the execution of the warrant.

6.18 Service Users/Patients who go missing regularly

Where on-going and repeat absconding by a service user/ patient is a concern, due to risk factors, a meeting will be held to discuss preventative action and the appropriate combined response to future incidents and confirm:

- The known opinions and views of the service user/patient leading to them absconding.
- The range and level of concern/risk posed by the service user/ patient repeatedly absconding,
- Interventions and options to be explored to reduce the levels of repeat absconding.
- A considered MDT opinion as to a general categorisation of risk to assist with future reporting.
- Consideration should be given to involving an appropriate Police Officer in reviews. This should be initiated by the respective senior clinician from the area in which the service user/patient is missing.

A clear management and response plan should be formulated with service user/ patient involvement where appropriate, which should consider specific interventions to reduce the potential of further absconding, or alternatively interventions to reduce the likelihood of further incidents of absconding, or alternatively grounds for flexibility with regard to on-going reporting of future incidents of absconding.

To assist the Police in their on-going support of the service in responding to service user/patients who repeatedly abscond, consideration should be given to approaching members of the patient's family with regard to the provision of photographs to aid the Police in identifying the patient (if the a photograph was not taken on admission).

Details of the names, addresses, and telephone numbers of where the patient was located should be obtained and recorded in the patients notes for future reference.

6.19 Transportation of SHSC AWOL patients detained by police Out of Area from the hospital from which they are absent

Where a service user/patient is absent or missing and has been detained by Police Out of Area, the responsibility for returning the service user/ patient lies with hospital from which they are absent.

When making arrangements for the return of service users/patients temporarily held in police custody, police transport would not normally be appropriate. Decisions about the type of transport to be used should be taken in the same way as for service users/patients being detained in hospital for the first time.

Discussion about the safety and risk of transporting the individual should occur between the Duty Sergeant and relevant Ward Manager. Out of hours this will be the Flow Coordinator and/or Senior Manager on call

6.20 Procedure for discharging patients in their absence

On rare occasions, despite on-going efforts, it may remain the case that the whereabouts of a patient remains unknown, or that it has not been possible to re-establish contact with the patient concerned. Discussion should take place between all appropriate members of the Care Team and where appropriate, a service user/ patient may be discharged in their absence. The rationale should be clearly recorded in the service user/ patient Insight notes.

7. Dissemination, storage and archiving (Control)

Dissemination – To be disseminated via all Directorates that operate bed based services. Reference to the new policy to be included in the next available Communications Digest

Storage – Trust Intranet or central storage for all Trust Policies within one week of ratification. This policy should be filed under both Missing Patients and Absent without Leave

The previous policy will be removed from the Trust intranet by the Clinical Governance team. Team managers are responsible for ensuring that it is also removed from any policy and procedure manuals or files stored in their offices and destroyed. Archiving - The Clinical Governance team will keep a paper and an electronic version of the previous policy for archive purposes. Please contact them if a copy is needed.

8. Training and other resource implications

All ward staff will have learning about the policy and categories through Team Meetings and Supervision sessions.

Other staff, such as those based in the community are to be aware of and know how to access the policy.

It is intended that the Absent/Missing Persons form for reporting to the Police will be entered onto Insight in the future. Until that time, a paper copy should be completed whenever appropriate.

9. Audit, monitoring and review

NHSLA Risk Management Standards - Monitoring Compliance Template						
Minimum Requirement	Process for Monitoring	Responsible Individual/ group/ committee	Frequency of Monitoring	Review of Results process (e.g. who does this?)	Responsible Individual/group/ committee for action plan development	Responsible Individual/group/ committee for action plan monitoring and implementation
Appraisals/ Supervision	Review	Line managers	Annual	Line managers/ Appraisees	Line managers/ Appraisees	Line managers
Review of Safeguard system re absence incidents	Review	Risk Management Department/ Ward/Team Managers	Annual	Directorate Governance Groups	Directorate Governance Groups	Directorate Governance Groups
Review of Safeguard system re absence incidents	Review	Risk Management Department/ Ward/Team Managers	Annual	Directorate Governance Groups	Directorate Governance Groups	Directorate Governance Groups
Review of Safeguard system re absence incidents	Review	Risk Management Department/ Ward/Team Managers	Annual	Directorate Governance Groups	Directorate Governance Groups	Directorate Governance Groups

Statistics on all incidents reported (including absent or missing persons) will be provided to Executive Directors and Clinical/Service Directors on a quarterly basis for analysis and discussion at Governance Committees.

Also absent /missing persons data, and exceptional reporting, will be shared/discussed at the Police Liaison meetings.

This policy should be reviewed with SYP at least annually to reflect the changing nature of liaison work with SYP, or earlier if issues become apparent, arising from service concerns, or on-going monitoring.

10. Implementation plan

Implementation date will be September 2016.

- The implementation will be through the following identified lead for each Directorate: Community – Service Director
- Acute and Inpatients – Assistant Service Director
- Specialist – Assistant Clinical Director
- Substance Misuse – Assistant Clinical Director
- Learning Disabilities – Assistant Clinical Director

The main areas to focus for implementation are:
- Revised definitions
- New Reporting Form to be devised
- Flowchart to aid decision making
- Availability of forms in each worksite
- Access to a copy of this policy on each worksite.

Other actions:
Inform and agree implementation date with Police – Police Liaison (Assistant Service Director).

11. Links to other policies, standards and legislation (associated documents)

Trust Policies about the Mental Health Act
Care Programme Approach
Incident Reporting & Investigation
Prevention and Management of Violence & Aggression
Security Policy
Consent Policy (in relation to photographs)
Managing Access and Exit / Locked door Policy
Risk management (DRAM)
Mental Health Act – Section 17 – Authorisation of Leave Policy
Mental Capacity Act Guidance for Information
Mental Capacity Act Deprivation of Liberty Safeguards
Photographs of Patients
Aggression and Violence: Respectful Response and Reduction.
Mental Health Act Section 17 Authorisation of Leave.
Guidance for AMHPS Section 135.

12. Contact details

Police Liaison

Title	***Name***	***Phone***	***Email***
Deputy Chief Executive	Clive Clarke	18758	Clive.Clarke@shsc.nhs.uk
Service Director – In-Patients	Richard Bulmer	16384	Richard.Bulmer@shsc.nhs.uk
Senior Nurse – In-Patients	Kim Parker	63306	Kim.Parker@shsc.nhs.uk

13. References

South Yorkshire Police Mental Health Toolkit 2018: Operational and tactical guidance for Police Officers and staff when dealing with someone who has mental ill health

Police and Criminal Evidence Act (1984)

Mental Health Act 1983 (as amended 2007)

Code of Practice to the Mental Health Act (2015) (https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/435512/MHA_Code_of_Practice.PDF)

Human Rights Act 1998 http://www.opsi.gov.uk/ACTS/acts1998/ukpga_19980042_en_1

Rabone v Pennine https://www.supremecourt.uk/cases/docs/uksc-2010-0140-judgment.pdf

Mental Capacity Act (2005)

MCA Code of Practice (2015)

Safewards (2015); http://www.safewards.net/

Department of Health (2015) Reference Guide to the Mental Health Act 1983. The Stationery Office; London. Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/417412/Reference_Guide.pdf. Last accessed on 20.09.2016.

Appendix A – Version Control and Amendment Log

Version No.	Type of Change	Date	Description of change(s)
V1 D0.1	Draft policy creation	July 2016	New policy to comply with the Mental Health Act 1983 Code of Practice, 2015
V1 D0.2	Updated following consultation	August 2016	Updated following consultation. See Appendix E.
V1 D0.3	Formatted for compliance with Policy on Policies	Sept 2016	Formatting. Appendices checked and updated.
V1 D0.4	Updated following verification at the Mental Health Act Group	Sept 2016	Draft updated. New appendices J and K added, plus minor corrections.

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Appendix B – Dissemination Record

Version	Date on website (intranet and internet)	Date of "all SHSC staff" email	Any other promotion/ dissemination (include dates)
1	*Sept 2016*	*Sept 2007*	

Appendix C – Stage One Equality Impact Assessment Form

Equality Impact Assessment Process for Policies Developed Under the Policy on Policies

Stage 1 – Complete draft policy

Stage 2 – **Relevance** - Is the policy potentially relevant to equality i.e. will this policy potentially impact on staff, patients or the public? If **NO** – No further action required – please sign and date the following statement. If **YES –** proceed to stage 3

This policy does not impact on staff, patients or the public (insert name and date)

Stage 3 – **Policy Screening** - Public authorities are legally required to have 'due regard' to eliminating discrimination , advancing equal opportunity and fostering good relations , in relation to people who share certain 'protected characteristics' and those that do not. The following table should be used to consider this and inform changes to the policy (indicate yes/no/ don't know and note reasons). Please see the SHSC Guidance on equality impact assessment for examples and detailed advice this can be found at http://www.shsc.nhs.uk/about-us/equality--human-rights

	Does any aspect of this policy actually or potentially discriminate against this group?	**Can equality of opportunity for this group be improved through this policy or changes to this policy?**	**Can this policy be amended so that it works to enhance relations between people in this group and people not in this group?**
AGE	**No**		
DISABILITY	**Yes This policy will impact on service users with mental health problems as it relates to the legal framework for detention under the Mental Health Act**	**This Policy has been redrafted in line with the most recent Code of Practice. Its aim is to keep people safe within the statutory framework of the Mental Health Act**	
GENDER REASSIGNMENT	**No**		
PREGNANCY AND MATERNITY	**No**		
RACE	**National figures suggest that BME men are disproportionally detained under 136. This is monitored in Sheffield through the 136 group.**	**The policy itself does not discriminate**	
RELIGION OR BELIEF	**No**		
SEX	**No**		
SEXUAL ORIENTATION	**No**		

Stage 4 – **Policy Revision** - Make amendments to the policy or identify any remedial action required (action should be noted in the policy implementation plan section)
Please delete as appropriate: Policy Amended / Action Identified / no changes made.

Impact Assessment Completed by (insert name and date)	Kim Parker 26 08 16

Appendix D - Human Rights Act Assessment Form and Flowchart

You need to be confident that no aspect of this policy breaches a person's Human Rights. You can assume that if a policy is directly based on a law or national policy it will not therefore breach Human Rights.

If the policy or any procedures in the policy, are based on a local decision which impact on individuals, then you will need to make sure their human rights are not breached. To do this, you will need to refer to the more detailed guidance that is available on the SHSC web site
http://www.justice.gov.uk/downloads/human-rights/act-studyguide.pdf
(relevant sections numbers are referenced in grey boxes on diagram) and work through the flow chart on the next page.

1. **Is your policy based on and in line with the current law (including case law) or policy?**

☒ **Yes.**

2. **On completion of flow diagram – is further action needed?**

☒ **No, no further action needed.**

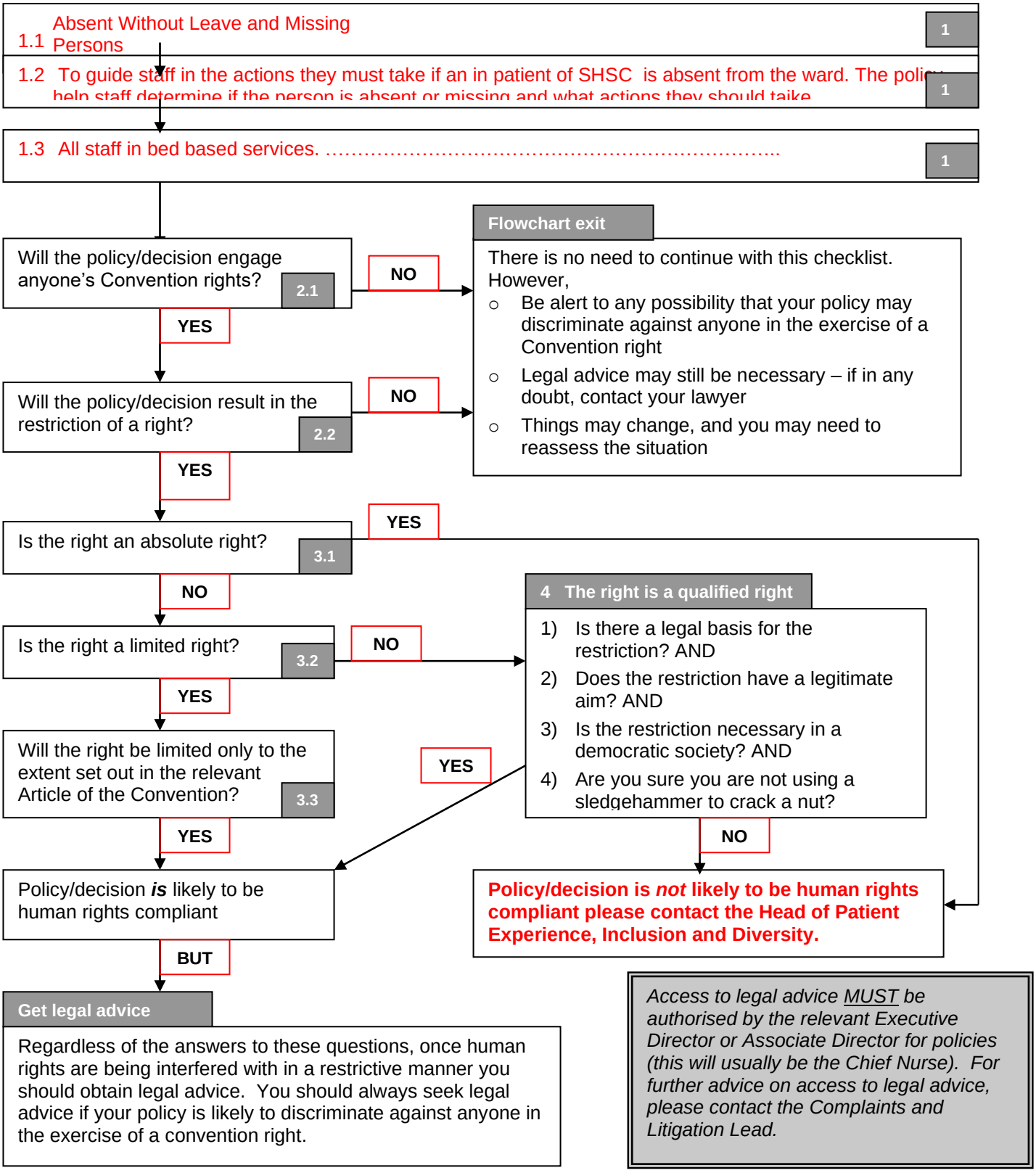
3. **Complete the table below to provide details of the actions required**

Action required	By what date	Responsible Person

Human Rights Assessment Flow Chart

Complete text answers in boxes 1.1 – 1.3 and highlight your path through the flowchart by filling the YES/NO boxes red (do this by clicking on the YES/NO text boxes and then from the Format menu on the toolbar, choose 'Format Text Box' and choose red from the Fill colour option).

Once the flowchart is completed, return to the previous page to complete the Human Rights Act Assessment Form.



Appendix E – Development, Consultation and Verification

Kim Parker (Senior Nurse), wrote the policy with support from Anne Cook (Clinical Nurse Manager).

The policy was sent to the following groups for consultation.

- **The Service User Safety Group** Request from Toby Morgan Service User Governor to amend ' Mentally Disordered persons' to 'person with a mental disorder'.
- **All In Patient Senior Staff** Shirley Lawson, queried the use of the term 'escape' and suggested reference to staff not using their own phone to text absent service users.
- **SHSC Nurse Leaders** Eva Rix advised on correct terminology for clinical governance.
- **South Yorkshire Police**. Requested clarity of service user rights regarding taking photographs.
- **The Joint Police Liaison Meeting.** Julia Walsh stated that a warrant under 135(1) must be from an AMHP
- Dates for consultation 21st July to 12th August 2016

The draft policy was verified by the Mental Health Act Group (with minor corrections and the addition of appendices J and K) on 16 September 2016, prior to being sent for ratification by the Executive Directors Group.

Appendix F – Policies Checklist

Please use this as a checklist for policy completion. The style and format of policies should follow the Policy template which can be downloaded on the intranet (also shown at Appendix G within the Policy).

1. Cover sheet ☒

All policies must have a cover sheet which includes:

- The Trust name and logo ☒
- The title of the policy (in large font size as detailed in the template) ☒
- Executive or Associate Director lead for the policy ☒
- The policy author and lead ☒
- The implementation lead (to receive feedback on the implementation) ☒
- Date of initial draft policy ☒
- Date of consultation ☒
- Date of verification ☒
- Date of ratification ☒
- Date of issue ☒
- Ratifying body ☒
- Date for review ☒
- Target audience ☒
- Document type ☒
- Document status ☒
- Keywords ☒
- Policy version and advice on availability and storage ☒

2. Contents page ☒

3. Flowchart ☒

4. Introduction ☒

5. Scope ☒

6. Definitions ☒

7. Purpose ☒

8. Duties ☒

9. Process ☒

10. Dissemination, storage and archiving (control) ☒

11. Training and other resource implications ☒

12. Audit, monitoring and review ☒

This section should describe how the implementation and impact of the policy will be monitored and audited and when it will be reviewed. It should include timescales and frequency of audits. It must include the monitoring template as shown in the policy template (example below).

Monitoring Compliance Template						
Minimum Require-ment	Process for Monitoring	Responsible Individual/ group/ committee	Frequency of Monitoring	Review of Results process (e.g. who does this?)	Responsible Individual/group/ committee for action plan development	Responsible Individual/group/ committee for action plan monitoring and implementation
A) Describe which aspect this is monitoring?	e.g. Review, audit	e.g. Education & Training Steering Group	e.g. Annual	e.g. Quality Assurance Committee	e.g. Education & Training Steering Group	e.g. Quality Assurance Committee

13. Implementation plan ☒

14. Links to other policies (associated documents) ☒

15. Contact details ☒

16. References ☒

17. Version control and amendment log (Appendix A) ☒

18. Dissemination Record (Appendix B) ☒

19. Equality Impact Assessment Form (Appendix C) ☒

20. Human Rights Act Assessment Checklist (Appendix D) ☒

21. Policy development and consultation process (Appendix E) ☒

22. Policy Checklist (Appendix F) ☒

Appendix G: 22 Risk Assessment Questions

South Yorkshire Police will ask these questions every time an absent/missing person call is made. Please ensure you can answer these questions as fully as possible.

1. Has this person been previously missing/absent
2. What is the specific concern that has caused you to call the Police?
3. Is this behaviour out of character?
4. Is this person vulnerable for any reason? (i.e. any physical illness, disability or mental health problems)
5. Does this person require any essential medication / medical treatment?
6. Does the person pose a risk to themselves or others?
7. Is there any history of self-harm or suicide?
8. Is the person suspected to be the victim of any kind of crime, including any violent or racist crime, bullying or harassment?
9. Are they currently known to the sexual exploitation service?
10. (Under 18's only) Are they on the child protection register?
11. Is the person a victim or perpetrator of domestic abuse, or involved in any other family or relationship conflict?
12. Does the person take drugs or alcohol?
13. What was the person intending to do when last seen? (e.g. going to the shops pr catching a bus; and did they fail to complete their intentions?
14. Belief that the person may not have the physical ability to interact safely with others or an unknown environment?
15. Do they have school, college, university, employment or financial problems?
16. Do they have a mobile phone? (Add number/Service provider)
17. Do they use social network sites?
18. Do they have access to transport?
19. Have they access to money/bank account? (If so, what are the bank details?)
20. Are there any indications that preparations have been made for them to leave, including taking any belongings or luggage with them, and have they taken their passport?
21. What has been done so far to trace the individuals?
22. Is there any other information relevant to their absence? (e.g. power of arrest associated with mental health order)

Appendix H: The Herbert Protocol

This is a risk reduction tool for people and their families living with dementia.

What is this for?
This form is designed to make sure that, if someone goes missing, the police can get access to important information about that person as soon as possible. If a relative cannot be found, then this is a deeply distressing and upsetting time for their family and friends. Being asked by a police officer to remember all sorts of information can add to this stress, and these forms are designed to remove some of that worry.

When should I complete the form?
As soon as possible. The form can be completed at your leisure, with no time pressure or urgency. That said, the sooner it is complete , the quicker the information can be used if it is needed.

How much detail is needed?
The police officer just needs an overview of the required information so don't worry about too much detail. If you are writing the information by hand, please try to make sure that it is clear and easy to read.

What should I do when I find out that my relative / friend is missing?
You should ring 999 immediately. The sooner the police know that someone is missing, the sooner officers can start looking for them.

What will the police need to know?
When you speak to the police operator, tell them who is missing and that they have dementia. The operator will ask you several questions but this will not delay the police's response – there are systems in place to allow them to talk to you at the same time that officers are deployed to come and help you find your relative/friend.
Some of the questions that you may be asked are:
• When and where was the person last seen? Be as specific as you can.
• What were they wearing? The operator will ask for a description of the clothes the person was last seen wearing, and anything they might be carrying, such as a bag or walking stick etc.
If you have the information sheet with you, tell the police operator. An officer will come to meet you to collect the form. If you don't have it with you, don't worry, the officer may simply ask you more questions. The information will be used to coordinate the search for your loved one. You may be feeling upset and worried for their safety. This is completely natural, and police officers will make sure that you are supported throughout the process.

Vulnerable Person Profile

Fill in these sections and keep it in a safe place, where it can easily be located if the person it refers to goes missing. You may want to make several copies, which can be kept safe by neighbours or relatives.

The checklists below are indicative – do not worry if you do not have or cannot get all of the information it asks for- some of it will not apply to everyone.

Name of Vulnerable person:	**Date of Birth**

Medical Information	
- *Current Diagnosis?* - *Medical Conditions?* - *Any particular fears or phobias (such as fear of water / heights etc)?* - *How easily can the person walk? How far could they get before becoming tired? Do they need a stick or other aid? Can they move between furniture without help?* - *How may they react to being upset or scared?* - *If they don't have their medicine – are there any short term risks?*	
Places or addresses of note	
- *Previous home address?* - *Childhood address?* - *Family addresses?* - *Places of interest or significance – could be old school, a favourite walk or place to visit, a cemetery, former place of work or a childhood home*	

Jobs, Interests and Hobbies	
- *Where did / do they work? Most recent AND historic* - *Favourite pub / club / sports ground / allotment etc* - *Favourite outdoor activities? Bowling? Cricket? Fishing? Library? Cinema?* - *Regular holiday destinations* - *Any particular or special interests?*	
Weekly habits	
- *Which shops are used?* - *Favourite cafe?* - *GP / Nurse / Clinic / Group* - *Church/ Mosque / Synagogue / Temple?* - *Houses / friends to visit (now and historic)* - *Chemists?* - *Hospital?*	
- *Bus Pass?* - *Access to money – cash card, cheque book, cash usually carried* - *Mobile phone? Number?* - *Local transport – nearest bus stop: to where?* - *Nearest train station?* - *Car? Able to drive? Previously*	
Anything else?	

Do you have a recent photograph? Is it readily available, and a good likeness?

Photo

Appendix I: Obtaining a Warrant SOP

Inpatient Wards

STANDARD OPERATING PROCEDURE (SOP)

Obtaining Warrants to Search for and Remove Patients/ Service Users

All In-patient Wards, Sheffield Health and Social Care Trust

Purpose

- The warrant to search for and remove patient/ service users gives a police officer the right to enter any premises specified in the warrant, by force if necessary, and remove the patient/ service user.
- The purpose of this warrant is to return the patient/ service user to where they ought to be. The police officer may (but does not have to) be accompanied by a doctor or any person authorised to retake the patient/ service user, or both.
- This SOP is to ensure that S135 (2) warrants are obtained correctly in line with MHA Code of Practice.
- To ensure that warrants to search for and remove patient/ service users are obtained in a safe and consistent manner.
- To provide a robust audit trail for warrants to search for and remove patient/ service users.

Scope

This procedure covers all aspects of obtaining S135 sub section 2 warrants to search for and remove patient/ service users and the management of warrants in the inpatient/ service user areas of SHSC Trust.

This SOP will include guidance on:

- When can a warrant to search for and remove patient/ service users be issued?
- The process for obtaining a warrant under S135 (2)
- Responsibilities
- Training and education

When can a warrant to search for and remove patients/ service users be issued?

- A warrant can be issued in situations where the person is already liable to be detained under the Mental Health Act and where admission to the premises where the patient/ service user is thought to be has been refused or that a refusal of admission is apprehended.
- It also applies to patient/ service users subject to a Guardianship order. It gives authority to return the patient/ service user to the place where they are required to reside as defined in the Guardianship order.
- It can apply to patient/ service users under a Community Treatment Order (CTO) when the patient/ service user has not returned to hospital following recall by the Responsible Clinician, or their whereabouts are known but access to the patient/ service user cannot be obtained.
- Magistrates can issue a warrant to allow the police to enter premises and remove people who are liable to be taken or returned to hospital or any other place, or to be taken into custody, under the Act because, for example, they have gone absent without leave.
- A magistrate may issue a warrant if satisfied on the basis of the information provided by that person, on oath, that: there is reasonable cause to believe that the patient/ service

user in question is to be found on premises within the magistrate's area, and admission to the premises has been refused or is expected to be refused.
- Warrants may be sought where a patient/ service user already liable to detention, is either thought to be or known to be in premises other than the hospital or required place of residence for Guardianship or CTO patient/ service users and where access to the premises has been refused, or that a refusal is apprehended.
- S135 (2) can be used in cases where in-patient/ service users have absconded or refused to return from leave and in cases where a person subject to Guardianship or CTO has absconded from the place where they are required to reside.

The process of obtaining a warrant

- The person requesting a warrant to search for and remove patient/ service users should discuss the need for a warrant with the other parties, including carers, who are involved in the assessment.
- Contact is then made with the Listings Officer at the Magistrates Court - 0114-2760760, Castle Street, Sheffield S3 8LU, to register the need for a warrant under S135 of the Mental Health Act, giving the name of the person who will attend court. A warrant application form is required. They will then advise a time to attend court – e.g. 9 – 10 before court sittings start, but can be done later in the day.
- The person requesting a warrant must prepare a brief statement covering the cause for concern and any relevant history and details of any attempts made to see the patient/ service user which can be present in court or use as a guide to a verbal account.
- Be clear what the grounds for your application are prepare your evidence to support this.
- On arrival at the Magistrates Court go to the General Office – Tel: 2521873 on the 3rd Floor, where a member of staff will type the details of your request onto a warrant application. The Court charges a fee (£18.00) for the processing and issue of the warrant (Magistrates Courts Fees Order 2010 – Statutory Instruments No. 19170). You must sign the 'Court Fee Undertaking Form' which court staff are advised to send to: The Finance Department, Level 8, East Wing, Moorfoot, Sheffield S1 4PL. You do not have to pay at the time for this service. If invoices are received on worksites, they should be forwarded to the above address. You will be sent to one of the courts where the clerk will give the 'draft' warrant to the justice of peace.
- The applicant will have to swear or a firm – that the information given is correct. You will be asked to present your case in brief.
- If the warrant is granted the person requesting a warrant must return to the General Office where the signed warrant is issued and recorded onto the Court system.
- A copy of the warrant should be kept on the patient/ service user's case file and scanned onto electronic records and the original returned to the Magistrates Court after execution or after one month if it is not used, in order that the court record system is updated.

Responsibilities

- Applications can be made by any constable, any AMHP, any person authorised by hospital managers (or any person authorised by the Guardian or local authority where the person is subject to Guardianship).
- It is advisable for the most appropriate person involved with the patient/ service user to take responsibility for obtaining a warrant under s135 (2). It is unlikely to be the AMHP in cases where the patient/ service user has absconded from hospital.

- The following are authorised (s18) to retake patient/ service users – a constable, any officer on the staff of the hospital, any AMHP or any person authorised by the hospital managers.
- Any authorised person will require identification – professional ID and, if not an AMHP, written confirmation from hospital managers (this is delegated to Team Managers).
- If the detained person is subject to Guardianship however, it would be appropriate for the Guardian or person authorised by them to prepare the material for the justice of the peace and to accompany the police officer when returning the person to their designated place of residence. Where there is a CTO, the care coordinator may be the best person to prepare the report.
- Although there is no requisite for the police officer to be accompanied when executing the warrant, it is good practice for someone who knows the patient/ service user to be present.
- For patient/ service users on CTOs, it is good practice for a member of the MDT responsible for the patient/ service user's care to accompany the police officer
- Action under this sub-section only rarely requires the involvement of an AMHP.

Review

- In 6 months or after any significant incident review.

Training/Education

- All staff to receive copy of SOP

Approved by: Lorena Cain, Assistant Clinical Director, Acute - Inpatient Acute Services

Dated: 26 September 2016

Appendix J - Summary of time limits for returning patients who are absent without leave or otherwise liable to be retaken (S18)

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.
Detained on the basis of an application for admission for treatment under section 3. Liable to be detained on the basis of an unrestricted hospital order, hospital direction or transfer direction under part 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).
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).

A patient who, at the time of absconding, was (or is treated as):	May not be returned after:
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. Subject to a guardianship order under part 3.	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).
Detained in a place of safety under section 135 or 136.	The earlier of: 72 hours from the time the patient absconded, or the period for which the patient may be detained, ie 72 hours' from the start of the patient's detention in the place of safety.
Subject to a remand under section 35 or 36 or an interim hospital order under section 38.	No time limit is specified. The patient may be arrested by any police officer (or other constable), and when arrested must be brought before the court that made the remand or interim hospital order as soon as practicable.
Being conveyed in England or Wales en route to Scotland, Northern Ireland, the Isle of Man or any of the Channel Islands, in accordance with a transfer warrant.	The period during which the patient could be retaken if no transfer was being attempted. This is because, until the transfer is complete, they remain subject to detention or guardianship in England.
Being conveyed in England or Wales en route from detention in Scotland, 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. **(See note on next page)**

Source: Department of Health (2015) Reference Guide to the Mental Health Act 1983. Figure 44, page 123. The Stationery Office; London. Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/417412/Reference_Guide.pdf. Last accessed on 20.09.2016.

Note: The table does not include the provisions of s21 (extends authority to detain/CTO when AWOL at end of or in last week of detention/CTO), s21A (procedure if AWOL patient returns or is returned within 28 days), or s21B (procedure if AWOL patient returns or is returned after 28 days).

See additional guidance extracted from the Mental Health Act Reference Guide, 2015 in Appendix K.

Appendix K - Additional guidance: Extract from the Mental Health Act Reference Guide, 2015 (paragraph numbers reflect that document)

Patients absent without leave as deadline for renewal report approaches [section 21 and 21A and regulation 26]

25.36 Special arrangements apply if patients are AWOL at any point during the week which ends on the day that their current period of detention is due to expire, and a renewal report has yet to be made.

25.37 If patients have not been taken into custody, or do not come voluntarily, to the hospital or place where they are required to reside before the end of the period during which they can be taken into custody under section 18 (as described in paragraph 25.23), their period of detention expires, and no renewal report can be made.

25.38 If they are taken into custody under section 18, or come voluntarily to the relevant hospital or place, during the period allowed by that section, the period of detention is treated as not expiring until the end of the week starting with the day the patient arrives back at the hospital or other place, as the case may be.

25.39 Responsible clinicians therefore have a week from the day of the patient's return to examine the patient and send the report to renew the authority for detention to the hospital managers. So, if the patient returns on Monday, the responsible clinician has until the end of the following Sunday to submit the report.

25.40 If patients are taken into custody, or come voluntarily to the relevant hospital or place, within the 28 days starting with the day they went AWOL (ie before the end of 28 January if they went absent on 1 January), the renewal report is to be made under section 20 in the normal way. Any such report would therefore have to be agreed by a second professional – see paragraph 25.32.

25.41 If patients are taken into custody, or come voluntarily to the relevant hospital or place, after more than 28 days, it is not normally necessary to make a report under section 20. That is because the patient's detention has anyway to be confirmed by a report under section 21B, and that report can also serve as a renewal report in place of a report under section 20 (see paragraph 25.42 to 25.49).

Example – return from AWOL within 28 days
Mr G and Miss Q were both detained under section 3 on 1 January. Their current period of detention is therefore due to expire at the end of 30 June.

They both went absent on 27 June before their responsible clinicians, who had left it very late, were able finally to decide whether they should make renewal reports.

Mr G is found and returned to the hospital on Friday 28 June. The deadline for making the renewal report is extended for one week from his return, to the end of Thursday 4 July. If his responsible clinician sends a renewal report on form H5 to the managers before then, Mr G's period of detention will be renewed until 31 December.

Miss Q decides to come back to the hospital herself, but not until Wednesday 24 July.
The deadline in her case is therefore extended for one week from her return, to the end of Tuesday 30 July. If a report is made by then, her detention will be renewed until 31 December as well.

Confirmation of detention of patients who have been absent without leave for more than 28 days [section 21B and regulations 14 and 26]

25.42 Where part 2 patients or unrestricted part 3 patients are taken into custody, or come voluntarily to the relevant hospital or other place, after being AWOL for more than 28 days, their responsible clinician must examine them and, if appropriate, submit a report using form H6 to the hospital managers confirming that the criteria for continued detention are met. This must be done however long remains until the patient's detention next needs to be renewed.

25.43 The criteria for continued detention are the same as the criteria for renewing detention (described at paragraph 25.31).

25.44 Unless such a report is submitted to the managers, the patient's detention expires automatically at the end of the week starting with the day on which the patient arrives at the relevant hospital or place, as the case may be. So if the patient arrives on Monday, the report must be submitted by the end of the following Sunday.

25.45 Responsible clinicians must submit a report during this period, if they think that the criteria are met. But they must first consult one or more other people who have been professionally concerned with the patient's treatment and an AMHP acting on behalf of a local authority. There is no requirement in this case to obtain a statement of agreement from a second professional from a different profession.

25.46 The managers must record their receipt of the report in part 2 of the same form H6.

25.47 A report made under this procedure will renew the patient's detention if it would already have expired if the patient had not gone AWOL, or if it would expire on the day the report is submitted (see paragraph 25.50).

25.48 In addition, if the patient's detention is due to expire in the period of two months starting with the day on which the report is submitted to the managers, the responsible clinician may, but need not, indicate on the form that it is to act as any renewal report which would otherwise have to be made under section 20 during that period.

25.49 Unless the managers decide to discharge the patient, they should arrange for the patient and, where relevant, the nearest relative to be informed of any report under section 21B in the same way as if it were a report under section 20 itself (see paragraph 25.34). They must also take whatever steps are reasonably practicable to arrange for the person they think is the nearest relative to be informed, unless the patient has requested otherwise, or does not have a nearest relative.

Patients who return from absence without leave and whose detention would otherwise have expired [section 21A and 21B and regulation 26]

25.50 In some cases, the responsible clinician's report under section 20 or 21B renewing the detention of a patient who has been AWOL will be made on or after the day the old period of detention was originally due to expire. If so, that report is treated as having retrospectively renewed the detention from the end of the old period of detention in the normal way.

25.51 In the rare circumstances where the patient's detention would otherwise have expired has expired twice since they went AWOL, the responsible clinician's report under section 21B is treated as having renewed the detention on both occasions.

25.52 If a patient's detention is renewed retrospectively, either once or twice in this way, the hospital managers must take whatever steps are reasonably practicable to arrange for the patient to be told about the renewal. They must also take such steps to arrange for the person they think is the nearest relative to be informed, unless the patient has requested otherwise, or does not have a nearest relative.

25.53 The patient must be told of the retrospective renewal both orally and in writing. Information given to nearest relatives must be in writing, but may be communicated by electronic means (eg email) if the nearest relative agrees.

Patients who are imprisoned etc [section 22 read with sections 18, 21 and 21A]

25.54 Special rules apply to patients detained on the basis of an application for admission for treatment under section 3 and unrestricted part 3 patients, if they are imprisoned, remanded or otherwise detained in custody by any court in the UK while liable to be detained in hospital.

25.55 Such patients automatically cease to be liable to be detained on the basis of the relevant application, order or direction if they remain in custody for longer than six months in total. Until then, they remain formally liable to be detained in hospital, unless discharged in the interim.

25.56 If they are released during that six month period, they are treated as if they had gone AWOL from the hospital on the day of their release, except that they may be retaken only during the 28 days starting with that day.

25.57 Because they are treated as AWOL, if the authority for their detention would otherwise have expired, or is about to expire, it will not in fact expire until the end of the week starting with the day of the patient's return to hospital, provided that the patient is taken into custody or returns during the 28 day period allowed (see paragraph 25.38).

25.58 As a result, if the patient's current period of detention is otherwise due to expire, responsible clinicians will always have at least a week in which to examine the patient and submit a report renewing the patient's detention under section 20 (see paragraph 25.30 onward). Because patients cease to be liable to detention if they have not returned to hospital within the permitted 28 days, it will never be necessary to make a report confirming their

detention under section 21B.

Example – return from AWOL after more than 28 days

Mrs J was also detained under section 3 on 1 January 2016 and her current period of detention is therefore due to expire at the end of six months on 30 June 2016.

Mrs J went absent on 24 June before her responsible clinician had examined her to decide whether to make a report under section 20 renewing her detention from 1 July for a further six months.

Mrs J is found some distance away and taken into custody on Sunday 9 October. She is brought back to the hospital on Monday 10 October.

Because she has been absent for more than 28 days, her responsible clinician must confirm her detention by making a report on form H6 under section 21B. Unless this is done before the end of Sunday 16 October, she will no longer be detained.

Having examined Mrs J, the responsible clinician makes the report on Tuesday 15 November, confirming that she meets the criteria for continuing detention. Because her last period of detention expired while she was absent, this report automatically renews her detention retrospectively from 1 July 2016, which means her detention is now due to expire on 31 December 2016.

Because that is less than two months away, the responsible clinician has the option of indicating on the form H6 that it is also to serve as a report renewing Mrs J's detention again from 1 January 2017.

The responsible clinician decides to do that. Mrs J's detention is therefore renewed for one year from 1 January 2017 without the responsible clinician needing to make a separate report on form H5 under section 20.

Source: Department of Health (2015) Reference Guide to the Mental Health Act 1983. The Stationery Office; London. Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/417412/Reference_Guide.pdf. Last accessed on 20.09.2016.