Pennine Care
NHS Foundation Trust

DOCUMENT CONTROL	
Title:	**Patients Absent Without Leave Policy (AWOL)**
Version:	**8**
Reference Number:	**MHL001**

Scope:

This policy applies to all staff employed by or seconded to Pennine Care NHS Foundation Trust including temporary, bank or agency staff.

Purpose:

The purpose of this document is to:

- Identify when a patient should be regarded as missing or AWOL
- Ensure the actions required are clear and can be completed in an effective and timely manner
- Minimise the risks to patients and others including the risk of disruption to their treatment and care plan
- Ensure everyone involved in the patients care is informed as necessary
- Provide information on preventative measures that can be applied
- Guide staff in the reporting and monitoring procedure for AWOL's across the Trust
- Ensure lessons learned from monitoring AWOL's is communicated locally

Requirement for Policy

Mental Health Legislation, Mental Health Act Code of Practice (2015)

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Supersedes:

Version 7

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- Transferred onto new Trust template and moved to MHL policy Set (Was CL006)
- Appendices designed as TAD and hyperlinked to policy

Owner:

Mental Health Law Manager – Mia Majid

Individual(s) & group(s) involved in the Development:	
This document has been developed in collaboration with the following interested parties: • Mental Health Law Scrutiny Group • Acute care Forum • Local Borough wide forums	
Individual(s) & group(s) involved in the Consultation:	
The document has been circulated for consultation and comments have been taken into consideration and the document amended accordingly: • Mental Health Law Scrutiny Group • Acute care Forum • Local Borough wide forums	
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Other Trust documentation to which this guideline relates (and when appropriate should be read in conjunction with):	
CL005	Observation Policy and Engagement Policy
MHL002	Section 17 (Leave of Absence) Policy
CL003	Care Programme Approach Policy
CL031	Section 135 Mental Health Act 1983 - Warrant to Search & Remove Patients
CL061	Admission Entry and Exit Policy for Mental Health Wards
CL032	Management of CTO and SCT
CL019	Clinical Risk Assessment and Management Policy
CL087	Victim Policy
CL035	Search Policy
	Including any relevant local protocols or procedures i.e. informing A&E's
Policy Associated Documents:	
TAD_MHL001_01	Missing Persons Form
TAD_MHL001_02	Missing Persons Form – LSU/PICU/STEP DOWN
TAD_MHL001_03	RHSD Specialised Commissioning Team Paperwork
TAD_MHL001_04	CQC Statutory Notification Form
TAD_MHL001_05	AWOL Patient Flowchart (Acute Care Forum)
Other external documentation/resources to which this guideline relates:	
CQC Regulations **This guideline supports the following CQC regulations:**	

Contents Page

i. Guiding Principles

It is essential that all those undertaking the functions under the Mental Health Act 1983 (MHA) understand the five sets of overarching principles which should always be considered when making decisions in relation to care, support or treatment provided under the Act.

The five overarching principles are:

- **Least restrictive option and maximising independence**

Where it is possible to treat a patient safely and lawfully without detaining them under the Act, the patient should not be detained. Wherever possible a patient's independence should be encouraged and supported with a focus on promoting recovery wherever possible.

- **Empowerment and involvement**

Patients should be fully involved in decisions about care, support and treatment. The views of families, carers and others, if appropriate, should be fully considered when taking decisions. Where decisions are taken which are contradictory to views expressed, professionals should explain the reasons for this.

- **Respect and dignity**

Patients, their families and carers should be treated with respect and dignity and listened to by professionals.

- **Purpose and effectiveness**

Decisions about care and treatment should be appropriate to the patient, with clear therapeutic aims, promote recovery and should be performed to current national guidelines and/or current, available best practice guidelines.

- **Efficiency and equity**

Providers, commissioners and other relevant organisations should work together to ensure that the quality of commissioning and provision of mental healthcare services are of high quality and are given equal priority to physical health and social care services. All relevant services should work together to facilitate timely, safe and supportive discharge from detention.

Staff must apply all the principles to all decisions. All decisions must be lawful and informed by good professional practice. Lawfulness necessarily includes compliance with the Human Rights Act 1998 (HRA) and Equality Act 2010. All five sets of principles are of equal importance, and should inform any decision made under the Act. The weight given to each principle in reaching a particular decision will need to be balanced in different ways according to the circumstances and nature of each particular decision.

Any decision to depart from the directions of the policy and the Code of Practice must be justified and documented accordingly in the patient's case notes. Staff should be aware that there is a statutory duty for these reasons to be cogent and appropriate in individual circumstances.

1. INTRODUCTION

The Trust is committed to ensuring the safety and well-being of patients. The Trust recognises its obligations under the duty of care and the Mental Health Act 1983 (MHA) with respect to in-patients who have absconded or have otherwise been found to be absent from hospital without explanation.

Episodes of unexplained or unauthorised absence from care and treatment may serve to disrupt recovery and prevention of such episodes is considered an integral component of risk management plans for all patients.

The Trust is also committed to improving the patients experience and communicating with patients and those involved in their care to reduce incidences of absence without leave and establish individual prevention strategies wherever possible to minimise risk to patients and others.

2. PURPOSE

The aim of this policy is to:

- Identify when a patient should be regarded as missing or AWOL
- Ensure the actions required are clear and can be completed in an effective and timely manner
- Minimise the risks to patients and others including the risk of disruption to their treatment and care plan
- Ensure everyone involved in the patients care is informed as necessary
- Provide information on preventative measures that can be applied
- Guide staff in the reporting and monitoring procedure for AWOL's across the Trust
- Ensure lessons learned from monitoring AWOL's is communicated locally

3. RESPONSIBILITIES, ACCOUNTABILITIES AND DUTIES

The **Medical Director** is responsible for ensuring the requirements of this policy are adhered to via the Mental Health Law Scrutiny Group.

Divisional Governance Managers are responsible for escalating issues to the Mental Health Law Scrutiny Group for investigation and monitoring the use of this policy in the Divisions.

Lead Managers, Team Supervisors, Health and Social Care Staff are responsible for the implementation of the policy and in particular, for the recognition and management of AWOL patients and the required processes as laid out within this policy.

It is the responsibility of **all health and social care staff** to ensure they are familiar with their individual responsibilities within this policy. Staff also have a duty to record attempted

AWOLs and report any AWOLs or concerns regarding an AWOL patient or the process to the rest of the care team or their line managers for further investigation.

To support staff who are applying this policy the Trust will make sure the management of patients AWOL is covered within the Trust training program on Mental Health Law and that any learning requirements identified through the monitoring of this policy are included in future training programs. This will be the responsibility of the Organisational Learning and Development department and the Mental Health Law Manager (MHL Manager).

The application of the AWOL process is, in the case of inpatients, the responsibility of the **nurse in charge of the ward / bleepholder** where the patient is currently admitted to. The nurse in charge of the ward / bleepholder where a patient has been recalled to will also be responsible in the case of patients who are AWOL following recall from their Community Treatment Order. If the patient has not been recalled to a particular ward then the Bleep Holder will be responsible for ensuring the AWOL policy is adhered to.

The **Mental Health Law Administrators (MHLAs)** are responsible for ensuring the AWOL forms completed by staff are collated, scrutinised and stored on patient's medical files and MHA files. MHLAs are also responsible for submitting appropriate AWOL forms to the Care Quality Commission when required. Notification to the CQC is only required for low secure settings within Rehabilitation and High Support Directorate.

The **MHL Manager** has a responsibility for ensuring the AWOL policy is updated, monitored, and compliant with legislation and overseeing the submission process to the Care Quality Commission.

All staff have a responsibility to follow Trust policies and escalate any issues with the practical application of policies.

4. DEFINITIONS

'The AWOL patient'

- This term is used in connection with patients who are liable to be detained under the MHA and who absent themselves from hospital without authorised leave granted under section 17 or are subject to a Community Treatment Order (CTO) and have failed to attend hospital when recalled. A patient would also be considered AWOL if they failed to return within the time limits allowed for authorised section 17 leave.
- Section 18 of the MHA allows for the return of patients who are absent from hospital without leave or are absent without permission from an address at which they have been required to live, either by the conditions of their leave of absence or by their guardian.
- An AWOL patient may be taken into custody and returned to hospital (or the place where he/she is required to live) by an Approved Mental Health Professional (AMHP),

any officer of the staff of the hospital (usually nursing staff), any police officer or any other person authorised in writing by the Hospital Managers.[1]

- **Absent without explanation' or 'missing' patient**
  This term is used in connection with informal patients (who are not liable to be detained under the MHA who leave the unit (inpatient or day services) unexpectedly, without explanation or prior notice and should be considered 'absent' or 'missing'.
  By definition, patients who are not detained cannot technically be 'AWOL'. Therefore, the terms 'leaving without explanation', 'absent' or 'missing' are used to define these situations (leaving without explanation may be distinct from '*discharge from hospital against medical advice*' as the patient would in this case be providing the hospital with notice of his/her intention to leave).
  The Department of Health's definition of a missing person is of 'a patient absent from a ward or unit without the staff being aware of their whereabouts'. The term 'hospital' also covers other mental healthcare settings, including those in the community.

- **Leave**
  Patients detained under the MHA can be granted leave by their responsible clinician using section 17 of the Act. The section 17 policy sets out the conditions and requirements for staff working with patients who have been granted leave.

Staff roles

- **Responsible Clinician**

  Approved Clinician **/** Registered Medical Practitioner in charge of the patient's treatment.

- **Nurse in Charge**

  Senior nurse in charge of the management and application of the AWOL process. This may also be referred to as bleepholder, ward manager, nurse on block. Please note the Missing Persons form may be amended in local areas to reflect the local term for this role.

5. RISK ASSESSMENT

In line with the Trust Risk Assessment policy all patients must have comprehensive/up to date risk assessments completed and these should be clearly communicated with other members of the clinical team.

Risk assessments must include consideration of the risk of AWOL for all patients and in addition it will be necessary for it to be clearly recorded and addressed for patients who have absconded in the past.

[1] Mental Health Act Code of Practice - paragraph 28.4

Risk assessments must also be updated following any attempt to abscond. This should be informed by discussion with the patient and the individual facts of the actual attempt to abscond.

The following bullet points are taken direct from the Mental Ill Health, Mental Incapacity & Learning Disabilities Policy & Procedure Greater Manchester Police May 2014. This is to understand how the police will interpret the reporting of AWOL from Trust staff.

- An absence of a patient will be categorised as a temporary absence **by the police if the circumstances indicate:**
  - The patient has deliberately or carelessly absented themselves;
  - The patient will either return of their accord, go home or go to the home of a friend or relative; **and**
  - There is no apparent imminent risk of them suffering or causing significant harm (to self or others).

  The decision would be based on the clinical team / care coordinators knowledge of the patient and their current risk assessment. The police advise that the patient should not be reported missing to them at this time.
- The staff of the Trust remain responsible for managing the absence and for keeping the absence under continuous review. A temporary absence can be re-categorised as missing if the level of risk increases due to a change of circumstances and the police need to be informed.
- If the police are contacted they will want to look at each case on its own merits and they will want to identify:
  - If the person is potentially incapable of looking after themselves, i.e. at risk of accidental harm or neglect.
  - If the person is at risk of causing deliberate harm to him or herself; and
  - If the person is potentially at risk from others. (Although not clarified in the police policy this would include risk to others).
- The police should always be informed immediately if a patient is missing who is:
  - Considered to be particularly vulnerable
  - Considered to be dangerous and/or
  - Subject to restrictions under part 3 of the Act (restricted patients)[2]
- Once a Missing /AWOL person is reported to the police and the patient returns/conveyed to the ward the police should be informed of the circumstances of their return, their current mental state / wellbeing, and the informant will be asked if there are any other issues of concern for the police. The open missing person report will then be updated by divisional officers with the information provided by the

[2] 28.15 Code of Practice 2015

informant and the report closed. On return, the patient's observation levels should be reassessed.

6. TIMESCALES FOR THE RETURN OF AWOL (DETAINED) PATIENTS

Detained patients who are AWOL may be taken into custody and returned by an AMHP, any member of the hospital staff, any police officer, or anyone authorised in writing by the hospital managers.[3]

A person is considered AWOL in various circumstances, in particular when they:

- have left the hospital in which they are detained without leave being agreed (under section 17 of the Act) by their responsible clinician
- have failed to return to the hospital at the time required to do so under the conditions of leave under section 17
- are absent without permission from a place where they are required to reside as a condition of leave under section 17
- have failed to return to the hospital if their leave under section 17 has been revoked
- are patients on a CTO who have failed to attend hospital when recalled
- are CTO patients who have absconded from hospital after being recalled there
- are conditionally discharged restricted patients whom the Secretary of State for Justice has recalled to hospital
- are guardianship patients who are absent without permission from the place where they are required to live by their guardian.[4]

A patient who has been required to reside in another hospital on leave of absence can be re-taken by any member of that hospital's staff or any other person as authorised by that hospital's managers.[5]

If the absconding patient is initially taken to another hospital, for example if the patient is out of area, that hospital may, with the written authorisation of the managers of the detaining authority, detain the patient while arrangements are made for their return.

Patients detained under Sections 2, 4, 5(2), 5(4), 135, 136 may be retaken up to the end of the period of detention. The expiry date of the order must be communicated to the police at the time of reporting.

Patients detained under Section 3, 37 or CTO (or received into guardianship under Section 7[6]) can be taken into custody at any time up to six months from the date on which (s)he absconded or, if later, the end of the existing authority for detention.

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[3] Mental Health Act Code of Practice – paragraph 28.4
[4] Mental Health Act Code of Practice – paragraph 28.3
[5] Mental Health Act Code of Practice - paragraph 28.5
[6] Local Social Services Authorities should have their own AWOL policy concerning Guardianship Patients Mental Health Act 1983 Code of Practice paragraph 28.13

Sections 21, 21A and 21B of the Mental Health Act stipulate special provisions to AWOL patients and the action to be taken upon the return of the patient to hospital, allowing for the detention order to be extended if necessary and to enable the responsible clinician to examine the patient and decide whether the detention order is to be renewed. It is important to notify your local MHL Office immediately of all AWOLs as part of the procedure contained within TAD_MHL001_01 especially where the patients section has expired or is due to expire whilst the patient remains AWOL so that the necessary actions can be taken within statutory timescales.
Patients subject to restriction orders (under Section 41 or 49) may be returned at any time.

7. PROCEDURE FOR DETAINED PATIENTS WHO ABSENT THEMSELVES

7.1 Specific Procedure for Patients Absenting Themselves from Inpatient Setting

If any member of staff discovers or is informed that a detained patient appears to be AWOL, they will immediately inform the nurse in charge.

Unless informed reliably that the patient has left the ward, the nurse in charge must organise a thorough and systematic search of the ward and adjoining departments. This would include a search of the patient's area to see if they have taken their belongings with them.

If appropriate, other patients on the ward should be asked whether they are aware of the person's whereabouts, when they last saw the patient and if anything was said to indicate where she or he may have gone.

If the patient is not found the nurse in charge should organise as many staff as possible to search:

- The grounds
- Surrounding area[7]

On site security officers should be used to search the hospital grounds. A full description and photograph of the patient (if available) should be given to Security to enable them to do this.

If the patient is not found then the nurse in charge should assess whether there are real and immediate risks and contact the responsible clinician (or deputy on-call if out of hours).

The individual care plan for the patient should be considered. If the MDT including consultant has considered and documented a 'grace period' of x number of hours before there are any concerns this plan should be considered by the nurse in charge before taking any further actions. If the patient has displayed any increased risks to themselves or

[7] This is the grounds immediately around the unit in question to confirm the person is indeed off the unit and its grounds, Staff may consider checking known places where patients can avoid detection on the grounds but this should be a minimum of two staff or it would count as a lone working situation. The decision will be the nurse in charge and should be taken following a risk assessment.

others prior to going missing then that care plan MUST be reviewed and a course of action agreed.

The on-call manager should only be informed out of hours if there is a real and immediate risk identified by the nurse in charge.

Once the clinical processes have been carried out the completion of the missing persons form (TAD_MHL001_01) is required[8]. In addition the RHSD areas will need to complete their Specialised Commissioning Team paperwork and send to RHSD Governance (TAD_MHL001_02).

When contacting the police a formally detained patient should be reported to the police as an 'absconder', the section information and expiry date of the order must be communicated.

This approach was considered in D.C.D v South Tyneside Healthcare NHS Trust[9] where the hospital adopted a policy of considerable latitude as to how to react to an absconsion. Due to the number of repeated AWOLs by the patient in this particular case, the staff would communicate with her family and gave the patient a chance to return to the hospital of her own accord. It seemed the judge did not feel that the reporting of the AWOL any sooner to the police in this particular case and under the particular circumstances of the situation would have changed the outcome. Having reviewed the Trust's policy at the time the judge stated that this seemed to be a sensible policy as avoided calling for police assistance when this was not necessary.

It is important to note that any patient management/contingency/care plan/risk assessment documentation MUST be robust as this would be used as evidence in the event of an untoward incident.

7.2 Specific Procedure for Patients Not Returning from Section 17 Leave

Where the patient does not return from leave the AWOL process must be commenced at the time the patient was due to return. The law is clear on the fact that if the patient has not returned by the end of the period covered by their Section 17 form then they become subject to Section 18 and therefore AWOL. Care plan and risk assessment documentation must be consulted before informing the police.

The nurse in charge should be informed and initial attempts to contact the patient should be made by telephone and at the place the patient was on leave to if relevant.

7.3 Specific Procedure for CTO Patients who have not returned following recall

The bleepholder / Nurse in charge where the ward/responsible hospital has been identified on the statutory recall notice (Form CTO3) must liaise with the responsible clinician and care coordinator where appropriate to ascertain the last known whereabouts of the patient

[8] All the boxes do not need to be completed. They should only be completed if needed and based on the risk assessment of that individual being AWOL.
[9] [2003] EWCA Civ 878

and the length of time since the patient was last seen. The AWOL procedure below must then be applied.

7.4 MHA related steps

Although the circumstances of each individual case will need to be considered, patient confidentiality will not usually be a barrier to providing basic information about a patient's absence to people (such as those the patient normally lives with or is likely to contact – who may be able to help with finding the patient).[10]

When deciding whether to contact the nearest relative (NR) of a patient you must consider whether the patient has previously objected to you providing the NR with information and whether informing the NR may;

- put the patient at risk of physical harm or financial or other exploitation
- cause the patient emotional distress or lead to a deterioration in their mental health or
- have any other detrimental effect on their health or wellbeing and if so whether the advantages to the patient and the public interest of the disclosure outweigh the disadvantages to the patient in the light of all the circumstances of the case.[11]

If contact with the patient is not made, the nurse in charge should (providing the provisions above regarding confidentiality have been considered) contact the NR or other significant contacts and inform them of the patient's absence and agree with them a course of action if the patient contacts them.

Attempts should be made to contact the patient by phone. A delegated member of staff should try and contact the patient by contacting:

- Mobile phone
- Home
- Relatives
- Friends
- Other significant places or contacts

If phone contact is made with the patient staff should try and persuade them to return to hospital.

If the patient refuses to return then staff should try and ascertain the patient's whereabouts.

Once the local searches and contact calls have been made:

The police should be notified immediately where the patient is:

- Considered vulnerable
- Considered a risk to self or others
- Subject to restrictions under Part III of the Mental Health Act 1983

[10] Mental Health Act 1983 Code of Practice – paragraph 28.19
[11] Mental Health Act 1983 Code of Practice – paragraph 4.36

- There may be other cases where, although the help of the police is not needed, a patient's history makes it desirable to inform the police that they AWOL in the area.[12]

Where there is a possibility of risk to another person the team must decide who would be responsible for informing that person (usually it would be the nurse in charge) or whether the police should be asked to contact them dependent upon the level of assessed risk.

The nurse in charge will consult the patient's care plan, risk assessment and other records for information (where it exists) regarding contingencies already planned in the event of the patient leaving unexpectedly. The nurse in charge must implement the contingency care plan if there is one.

When informing the police the nurse in charge should provide them with information regarding:

- Their direct contact details
- What has already been done to locate the patient
- Circumstances of absence
- A full description of the patient (photograph to be provided if available)
- Diagnosed condition
- Social history (for example friends, family, other contacts including addresses and contact details if known)
- Medication – date and time next due, whether they are carrying medications and effects of not having that medication including approximately when those effects will emerge
- Section details – type, start time, expiry date other relevant information / advice regarding powers
- Care history and risk assessment including details of any 'grace period' already given
- History of attempted suicide or self-harm (type of attempts)
- Whether MAPPA are involved
- Any contingencies

If police are contacted and requested to be involved in the return of the patient the nurse in charge must ensure they are aware of the time limit for retaking the patient into custody. (For details/clarification on expiry of section dates seek advice from MHL Office if unclear).

In the case of a restricted patient the nurse is responsible for ensuring that the Ministry of Justice (MoJ) caseworker is contacted immediately they become aware that the patient is AWOL. They must also ensure that the RC is contacted as a detailed report will need to be completed by the RC within a week of the AWOL. This report will need to be sent to the case worker at the MoJ.

Any decision to release information to the press is the responsibility of the police. However, the police have agreed to work jointly with the Trust's Communications Manager to agree the appropriate details for inclusion in any press release. The level of detail for disclosure will be initially agreed by the RC (or deputy) and relevant Service Director (or

[12] Mental Health Act 1983 Code of Practice – paragraph 28.16

deputy) and the Communications Manager will gain authorisation from an Executive Director to release this information.

If the patient is not found (within the previously agreed time limits); the nurse in charge should ensure the following people are notified by the next working day:

- The In-patient Services Manager/Modern Matron
- The patient's Care Co-ordinator
- Mental Health Law Office
- Divisional Governance Manager / Team - **RHSD only**

From discussions with the above people and consultation with the patients care plan and risk assessment, the level of urgency regarding the return of the patient should be established and an action plan should be agreed to ascertain the whereabouts of the patient, make contact with the patient and return them to hospital. If the police are involved at this state they must be made aware of the action plan

Once the whereabouts of the patient is established, the nurse in charge should make arrangements for the patient to be returned to the ward. If any of the RAVE [13] risks are present, arrangements should be made for the police to return them to the ward as soon as possible. If the patient is felt to be at no immediate risk, consideration should be given to consulting with the RC/Police/Care Coordinator/AMHP and/or relevant others as to the safest method of contact, re-assessment and conveyance.

The police should only be asked to assist if absolutely necessary. If the patient's location is known the role of attending police should only be to assist a suitably qualified and experienced mental health professional in returning the patient to hospital[14] where the RAVE risks apply.

Patients should always be returned in the manner, which is most likely to preserve their dignity and privacy consistent with managing any risk to their health and safety or to other people[15].

The responsibility for the safe return and the transport arrangements for the detained patient rest with the detaining hospital. A detained patient may be taken into custody and returned to hospital by an AMHP, any officer of the staff of the hospital, any police officer or any person authorised in writing by the Hospital Managers[16].

Depending upon the location of the patient and the patient's willingness to return to hospital, it may be necessary to consider the use of Sections 135(2)[17] of the Mental Health Act 1983 to enter private premises and 'retake' the AWOL patient.

The nurse in charge should ensure that the incident is recorded as follows:

- Incident form completed

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[13] Resistance, Aggression, Violence, Escape
[14] Mental Health Act 1983 Code of Practice paragraph 28.14
[15] Mental Health Act 1983 Code of Practice paragraph 17.3
[16] Mental Health Act 1983 Code of Practice paragraph 28.6
[17] See Pennine Care Policy on Use of Section 135

- Missing persons form completed
- Entry made in the nursing notes
- CQC form completed if patient on low secure unit (includes PICU) the
- MHL Office will assist with this requirement where agreement has taken place.

7.5 Steps to take when a detained patient has left the jurisdiction of England/Wales

There is provision for the retaking of patients who abscond to Scotland, Northern Ireland, the Isle of Man or the Channel Islands; the precise detail of the arrangements varies according to the jurisdiction. Timescales will need to be taken into account as to whether the authority exists. Please check with your local MHL Office.[18]

7.6 Patients detained under an urgent/ standard authorisation as per the Deprivation of Liberty Safeguards (DoLS)

If a person is under an urgent authorisation or standard authorisation there is no specific legal authority under the Mental Capacity Act to return the patient to the hospital they are detained to if the patient refuses/objects or resists. This would need to be discussed with the clinician in charge of the person's care and treatment as in these circumstances it may be necessary for clinical staff to make urgent arrangements under section 135(1) to undertake a MHA assessment or for police to consider their powers under section 136 where applicable and appropriate.

If the urgent authorisation has already expired and the Trust is waiting for assessments for a standard authorisation to be authorised the patient should be treated as a 'missing person' and apply the relevant part of this policy/procedure, taking into account patients vulnerability and risk to self and others.

8. PROCEDURE FOR INFORMAL PATIENTS WHO ABSENT THEMSELVES

If a member of staff discovers or is informed that an informal patient appears to have left without explanation or appears to be absent or missing they will immediately inform the nurse in charge;

The nurse in charge will consult the patient's care plan, risk assessment and other records for information (where it exists) regarding contingencies already planned in the event of the patient leaving unexpectedly. The nurse in charge must implement the contingency care plan if there is one.

If there is no contingency care plan the following procedures should be followed and clearly documented.

The nurse in charge should consult with other nurses and assess the patient's last reported/recorded mental state and level of risk (ensuring that the consultant is informed of the situation).

[18] Reference Guide Mental Health Act 2015 11.14 – 11.25

Where the risk (to self or others) has been assessed as high (as agreed between the nurse in charge and the Consultant or doctor-on-call), and there is concern regarding the safety of the patient or the public, the police should be informed. The police do not have powers to return informal patients, although if the risks are such then 135(1) or s136 should be considered by the clinical care team / police where applicable and appropriate.

If the outcome of that assessment is that the patient should ideally return to the ward the following procedures should be implemented:

The nurse in charge should delegate staff and where necessary contact other departments to organise a thorough search of: -

- The ward
- Other wards/departments
- The hospital grounds

If the patient is not found then a delegated member of staff should try and contact the patient by telephone:

- Mobile
- Home

If contact with the patient is not made the nurse in charge should contact the Next of Kin/Carer/Nearest Relative[19] and inform them of the patient's absence and agree with them a course of action if the patient contacts them.

If contact is made with the patient staff should try and persuade them to return to hospital.

If the patient refuses to return then staff should try and ascertain the patient's whereabouts.

If contact with the patient is not made or the patient refuses to return to hospital the consultant should be informed to assess whether the use of the Mental Health Act should be considered.

The nurse in charge should ensure that the incident is reported and recorded as follows;

- Incident form completed
- Missing Persons Form completed
- Entry made in the nursing notes

If the patient declines to return to the in-patient unit for an urgent re-assessment and the patient is not considered liable to be detained under the Mental Health Act 1983 the patient can be considered to have discharged his or herself against medical advice. If however the consultant is in agreement the patient should be discharged then this may be recorded as discharge in the patient's absence. The clinical team would then need to decide if any community follow up is required on the basis of their clinical knowledge of the patient. In some cases an urgent community assessment will be appropriate; in others it may be appropriate to discharge the patient back to their GP with no follow up. The

[19] Taking into consideration the Trust's confidentiality policy

consultant must ensure a suitable entry is made in the medical records to explain the outcome, along with any necessary further action.

9. PROCEDURE WHEN A PATIENT ABSCONDS WHILST UNDER STAFF ESCORT

If a patient attempts to abscond during a period of escorted leave then staff may only attempt to prevent the absconsion if it is safe to do so. They should be guided by their personal safety in the first instance particularly where there is only one staff member present. This would be covered by the Lone Working Policy.

In the case of detained patients where the patient can be safely prevented from absconding either via verbal discussion or physical restraint then the staff member is protected by the authority of Section 138 – Retaking of patients escaping from custody and Section 139 – Protection for acts done in pursuance of the MHA. These provide the necessary powers for nursing staff to do all that is reasonable to prevent a patient from absconding.

Where the patient successfully absconds then the staff member should contact the unit if able (mobile phone or other available telephone) and carry out a search of the local area if safe to do so.

Once notified the nurse in charge should ensure the requirements of the AWOL procedure outlined in this policy are carried out in the normal way.

10. PROCEDURE TO BE UNDERTAKEN WHEN A PATIENT RETURNS TO THE WARD

The nurse in charge of the ward accepting the patient should ascertain the patient's immediate mental and physical health status and needs. The nurse should also establish whether a search of the patient is necessary[20].

The nurse in charge will notify the following of the patient's safe return:

- The patient's RC (or deputy) so that a decision can be made as to whether a medical examination of the patient needs to be undertaken;
- The Service Manager/Modern Matron;
- The Bleep-Holder;
- The Nearest Relative, Next of Kin, Carer; (if notified of the absence);
- The police service (if notified of the absence);
- The Mental Health Law Office (or by next working day);
- Ministry of Justice;
- Divisional Governance Manager **RHSD only**;

[20] Refer to Search Policy for process

- Secure Commissioners **RHSD only**.

The nurse in charge will record the following information in the nursing record:

- Date and time of return;
- Where the patient was found (plus an account of the patients whereabouts during the absence);
- Details of police involvement (i.e. ID number of the police officer(s)); officers or log number if police informed for information purposes only.
- Mental state of the patient on return;
- Physical state of the patient on return;
- Details of any untoward incident that occurred during the patients period of absence without leave;
- An assessment of "triggers" or reasons for going AWOL.
- Completion of the AWOL form at part 2 ensuring for detained patients this is sent to the MHL Office.

The nurse in charge will arrange for a full re-assessment (including updating the care plan and reviewing the risk assessment) of the patient by the multidisciplinary team with the addition (or revision) of a contingency plan for further episodes of absence without leave.

If the patient is detained the nurse in charge should check whether 28 days has elapsed since they went AWOL and report this to the responsible clinician and MHL Office immediately to take actions to review the continuing detention within the statutory time frame.

At the earliest possible opportunity following return, the responsible clinician must investigate with the patient the reasons for the absconscion and document this discussion in the medical records. This should include consideration of the risk assessments, care plan and observation levels as necessary.

Where a patient has gone AWOL previously, it may be useful for the patient's care plan to include specific actions which experience suggests should be taken if that patient were to go missing again.[21]

11. ATTEMPTS TO ABSCOND

When an inpatient attempts to abscond, nursing staff should record this in their nursing records and discuss the reasons for the attempt with the patient as soon as practicable. The responsible clinician should be informed of the attempt and asked to consider the patients risk assessment, care plan and observation levels if necessary. A record of this consideration should be made in the patients nursing and medical records.

Where restraint has been necessary to prevent the patient leaving the ward then an incident form must also be completed.

[21] Mental Health Act Code of Practice 28.23

12. REPORTING INCIDENTS

It is a requirement of this policy that all AWOL's are reported via the Trust incident reporting system. The Nurse in Charge must ensure this is completed and refer to the Incident Policy for additional information or guidance if required.

13. LEARNING LESSONS

Where incidents have been reported the Trust's monitoring arrangements detailed in the following section will allow for lessons to be learned from the AWOL's occurring across the Trust. Action plans developed for incidents and audits will include and promote how the Trust learns from issues with the AWOL procedure.

Local areas should identify how lessons can be learned either for individual patients during the team discussions following their return or on a wider basis through escalation to the Divisional Integrated Governance Groups. Any general improvements made should be shared with the MHL Manager to ensure this is embedded into the policy review and promoted through the Trustwide groups. This could for example include environmental changes or employment of the prevention strategies outlined in this policy. It is the responsibility of the Governance Manager to ensure this is flagged with the MHL Manager.

14. AWOL PREVENTION

Staff working with patients should be promoting prevention strategies to reduce the incidences of AWOL. These strategies will vary across the different services and local protocols may be adopted through the Acute Care Steering Groups and Forums / Mental Health Law Forums highlighting additional requirements within services but as a minimum ward managers should ensure:

- Clinical staff are identifying and discussing risk of AWOL at the time of admission to the ward and documenting this in the patients care plan and risk assessment.
- Staff are familiar with the Entrance and Exit procedure on the ward and discussing this with patients routinely
- Staff are allocated to patients at the start of every shift
- Risks and management plans are updated and discussed with patients
- Staff working on the ward understand that all 1:1 interactions need to be clearly documented using the Trust documentation

Medical staff also need to ensure that they are documenting information relating to risk of AWOL in the patients notes and that these risks are clearly communicated with nursing staff regarding the levels of observation required and any changes to the risk assessments made following an AWOL or attempted AWOL.

As stated above different strategies will need to be adopted in different service areas.

15. EQUALITY IMPACT ANALYSIS

As part of its development, this document was analysed to consider / challenge and address any detrimental impact the policy may have on individuals and or groups protected by the Equality Act 2010. This analysis has been undertaken and recorded using the Trust's analysis tool, and appropriate measures will be taken to remove barriers and advance equality of opportunity in the delivery of this policy / procedure

16. FREEDOM OF INFORMATION EXEMPTION ASSESSMENT

Under the Freedom of Information Act (2000) we are obliged to publish our policies on the Trust's website, unless an exemption from disclosure applies. As part of its development, this policy was assessed to establish if it was suitable for publication under this legislation. The assessment aims to establish if disclosure of the policy could cause prejudice or harm to the Trust, or its staff, patients, or partners. This assessment has been undertaken using the Trust's Freedom of Information Exemption Guide, and will be reviewed upon each policy review.

17. INFORMATION GOVERNANCE ASSESSMENT

This Policy has been analysed to ensure it is compliant with relevant information law and standards as in place at the time of approval, and are consistent with the Trust's interpretation and implementation of information governance components such as data protection, confidentiality, consent, information risk, and records management.

Compliance will be reviewed against any changes to legislation / standards or at the next review of this document.

18. SAFEGUARDING

All staff have a responsibility to promote the welfare of any child, young person or vulnerable adult they come into come into contact with and in cases where there are safeguarding concerns, to act upon them and protect the individual from harm.

All staff should refer any safeguarding issues to their manager and escalate accordingly in line with the Trust Safeguarding Families Policy and Local Safeguarding Children/Adult Board processes.

19. MONITORING

Assurance will be offered that this policy is being applied via routes outlined in the below Monitoring Table

	Minimum Requirement	Process/Method	Frequency	Responsibility for Action Plan	Monitoring Action Plan
Trust Board & Quality Group	Number of AWOL's	Quality Account	Monthly	Medical Director	Medical Director
Risk Department	Details of AWOL's	Incident reporting	Daily	Risk Manager	Risk Manager
Quality Group	Number of AWOL's	Dashboard	Specialist Services Division – QGAC Monthly	Governance Manager	Governance Manager
MHLSG	Issues with process	Serious Untoward Incident Forms	Ongoing	MH Law Manager	MH Law Manager
Trust ACF	Issues with AWOL's	Incident Forms	Ongoing	ACF lead	ACF lead

The Mental Health Law Manager receives Serious Untoward Incident Reports or Actions Plans related to AWOL's.

As part of the review, monitoring and audit of incidents Divisional Governance Managers and the Mental Health Law Scrutiny Group will consider how any learning requirements will be addressed with staff. This includes incorporation of the AWOL policy and process in to the MHL Training provided across the Trust.

Any issues or learning outcomes raised will be sent to the Trustwide Acute Care Forum for discussion.

The effective application of this policy / guideline, including adherence to any standards identified within will be subject to monitoring using an appropriate methodology and design, such as clinical audit.

Monitoring will take place on a biannual basis and will be reportable to the Quality Group via the Clinical Effectiveness and Quality Improvement Team.

20. REVIEW

This policy / guideline will be reviewed three-yearly unless there is a need to do so prior to this; e.g. change in national guidance.

21. REFERENCES

In developing and reviewing this policy the following documents were referred to and considered:

- Mental Health Act
- Human Rights Act
- Mental Ill Health, Mental Incapacity & Learning Disabilities Policy & Procedure Greater Manchester Police May 2014
- The Anti-Absconding Workbook, Bowers et al (2003), City University London
- Safer Wards for Acute Psychiatry, A Review of the Available Evidence, Marshall et al (2004), National Patient Safety Agency

- Missing Patients Toolkit, NHS Yorkshire & NPSA (2007)
- Runaway Patients, Report to the GNC Trust, Bowers et al (1998), City University London
- GUIDANCE ON THE MANAGEMENT RECORDING AND INVESTIGATION OF MISSING PERSONS 2005 Produced Produced on behalf of the Association of Chief Police Officers by the National Centre for Policing Excellence
- Transcript of decision Savage v South Essex Partnership NHS Foundation Trust [2010] EWHC 865 (QB)
- Guidance on Responding to People with Mental Ill Health or Learning Disabilities (2010), National Policing Improvement Agency
- Department of Health. (2001). Safety First Five-Year Report of the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness. London: Department of Health. Available at: www.dh.gov.uk
- University of Manchester. (2006). Avoidable Deaths Five year report of the national confidential inquiry into suicide and homicide by people with mental illness. Manchester: University of Manchester. Available at: www.medicine.manchester.ac.uk University of Manchester. (2009). National Confidential Inquiry into Suicide and Homicide by People with Mental Illness: Annual report: England and Wales. Manchester: University of Manchester. Available at: www.medicine.manchester.ac.uk