Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust

Security Management Policy, Police Liaison Practice Guidance Note **Joint Missing Persons Guidance – V03**		
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Content

Section	Description	Page No
1	Introduction	1
2	Purpose	1
3	Definition	2
4	First Steps –Information gathering	2
5	Responsibilities	8
6	Ward Team Responsibilities	8
7	Patient Health Record	9
8	Ward Staff Responsibilities	10
9	Actions to be taken in relation to in-patient	10
10	Missing and contact with Children	11
11	Grading Risks and Response	12
12	Search ward/unit	13
13	Considering others input to aid finding the Person	14
14	Working together/communication	15
15	Missing Person from another area	16
16	Managing Public Interest and Media	17
17	If the Patient is Found / Returns	17
18	Police raise concern for welfare (reported missing person)	19

19	Additional risk considerations in the community – missing people	19
20	Considerations relating to Community Treatment Orders (CTOs)	20
21	Training, Support and Prevention	20
22	Associated Documentation	22
23	References	22

Appendices – listed separate to PGN	
Document No:	**Description**
Appendix 1	Missing Person Assessment
Appendix 2	Missing Persons Form
Appendix 3	Guidance for searching ward for a missing person
Appendix 4	Missing Person Information on RiO Guidance
Appendix 5	Flowchart on Assessing and Planning for Those at Risk of Going Missing
Appendix 6	Flowchart on Missing from Inpatient wards
Appendix 7	Flowchart on Missing in the Community

1. Introduction

1.1. This Practice Guidance Note (PGN) is a mutually agreed process with Northumbria and Cumbria Police. It provides structure to health staff and Police Staff in the event of a Cumbria Northumberland, Tyne and Wear NHS Foundation Trust (the Trust / CNTW) patient being deemed a 'Missing Person'. This will cover both in-patients and community patients in receipt of CNTW care. This PGN embodies the Joint Missing Adult Protocol which has been drawn up between Northumbria Police and the Safeguarding Adults Boards. This recognises that Missing Persons is a joint responsibility and agencies maintain a duty of care to their patients/clients even once they are reported as missing.

1.2. This guidance was initially established with Northumbria Police in 2016 and piloted in one area. It has been developed further updated and now inclusive of Cumbria Police, with their input, and incorporating Police National Policy. The different terminology will be addressed, and an agreed term used throughout to ensure health staff and Police can be clear what is being discussed. The PGN has been updated to reflect the guidance in: The multi-agency-response-for-adults-missing-from-health-and-care-settings-a-national-framework-for-england (click on link to access).

1.3. This will be read in conjunction with the Missing Persons Assessment, which is the document that will be used on each ward / unit for in-patients. (See Appendix 1).

1.4. This practice guidance note is joint with Northumbria and Cumbria Police, whom henceforth shall be known as 'Police Partners or Police'.

1.5. A Missing Person reported from CNTW to Police does not discharge the duty of care. Trust staff and Police must work collaboratively to do all we can to support finding the person, and ensuring we discharge our legal and professional obligations.

1.6. Clinical teams must look to assess the risk of missing persons, and identify those at risk of going missing in services, ensuring MDT discussion and development of care plan around the risks, and agreed actions to be taken. The plan should also include the person views and wishes. (Appendix 5)

2. Purpose

2.1. The aim of this PGN is to ensure that in the event of a 'Missing Person' from Trust premises or within the community, that CNTW staff and Police Partners are aware of each other's responsibilities and actions that are to be taken. This will differ for In-patients and Community services and guidance is given within this document.

2.2. In terms of agreed terminology within this document, a missing person is referred to by Police as a 'MISPER', staff should be aware of this Police language. Health staff use terms of 'AWOL patient' or 'missing person.'

However, it has been agreed that the term used throughout this guidance is 'missing person'.

2.3. This should be read in conjunction with the Trust's Search Policy - CNTW(C) 11, CNTW (C) 03 Leave, Absent without Leave and Missing patient Policy and Police Search Guidance (Police Force internal guidance).

3. Definition

3.1 The national police definition of a Missing Person is:

"Anyone whose whereabouts cannot be established will be considered as Missing until located and their wellbeing or otherwise confirmed".

3.2 The following definition has been developed to help the professionals working with people at risk of going missing to understand when they should be taking action, which may include when they should be reporting a person as missing to the Police.

3.3 A missing person is anyone whose whereabouts can't be established and:

- The context suggests the person may be a victim of crime; or
- The person is at risk of harm to themselves or another; or
- Where there is particular concern because the circumstances are out of character, or there are ongoing concerns for their safety because of a previous pattern of going missing

3.4 All missing persons are then risk assessed in a continuum of risk from no apparent risk through to high risk, as detailed below:

- No apparent risk (Absent) There is no apparent risk of harm to the subject or public;
- Low risk- The risk of harm to the subject or public is assessed as possible but minimal;
- Medium risk- The risk of harm to the subject or public is assessed as likely but not serious;
- High risk- The risk of serious harm to the subject or public is assessed as very likely.

4 First Steps – information Gathering

4.1 The Regional Missing Adult Procedure agreed by Safeguarding Adults boards outlines that prior to making a missing report to Police, agencies who have a duty of care should make reasonable enquiries to locate the patient and confirm their safety. Where it's related to child or young person missing,

although enquiring may still be made, we have to consider more around child age and vulnerability and may be informing the Police at the earliest opportunity due to this. The critical concern threshold discussed in this document is related to adults only. Please see Appendices 6 and & 7 for flowcharts to support decision making before Police contact.

4.2 When a person has gone missing, it's important Police are to be contacted immediately if the risk of serious harm is imminent to them or others, or person is considered to be particularly vulnerable, dangerous, and/or subject to restrictions under part 3 of the Mental Health Act (restricted patients – Forensic sections), this will likely be via 999. A 999 call should also be made if a person is actively making off from escorting staff and the staff are in immediate pursuit.

4.3 In absence of the above immediate risk, CNTW services should be conducting reasonable enquiries, prior to reporting a person missing. Reasonable enquiries which would be expected would include:

- Attempts to contact the patient by telephone (mobile call and texts if possible, ensure to take off withheld number) and in person at their home address (if safe to do so). If not safe, need to have explored if we can make it safer, e.g go in two's, stay on doorstep only, but if none of this is possible due to known risk to staff visiting address this needs to be detailed to Police why.
- An initial search of the place they are being reported missing from;
- Contact with next of kin, family members or associates as to their whereabouts;
- Contact with care coordinator/lead professional for details of any other professionals involved in their care and contact with those individuals;
- For wards as detailed further in guidance, has ward been searched, grounds checked, and ensure staff have maps available of what has been done.
- If the person is subject to a court or hospital order this information should be passed to Police.
- Speak to others on and around the ward that may have seen anything, or spoken to a person before they have gone missing. This may include any staff working on the ward, and other service users if appropriate. This may include reception staff/security in main hospitals area if applicable;
- If missing from a ward, checking bedroom, any personal items – notes left, and information indicating where person may have gone or intentions;
- Checking the person's healthcare record (RIO) for any relevant information;
- Is there CCTV available or accessible that can be checked to see if the person has left the building, site, or their location can be identified?

- Prior to reporting a patient as missing to police there should be consultation with the senior clinician in the team to review all known risks and that the level of "critical concern" (defined below in 4.4) threshold has been met. See Flowcharts Appendix 5, 6 and 7.

4.4 Police should only be contacted in **first instance** where there is a "critical concern" for a person's safety. If following enquires, and the person cannot be found and there is felt there is a critical concern, a missing report should be reported to the police.

4.5 Critical concern is defined by the national multi agency response to missing guidance as:

When considering if there are critical concerns, staff should think about any recent changes in the person's mood or behaviour, or whether any event or occurrence could mean they are at serious risk of harm.

Ensure a full record of actions undertaken and enquires made are recorded within the healthcare record (RIO), including decision making and rationale around escalation to Police or not.

4.6 Once a call has been made to police via 999/101, the reporting CNTW team must ensure there is nominated point of contact for police to go to for further information to aid the missing investigation. If this is in community, there should also be a contact given that can be available when the team is not on duty – e.g. Crisis Team/On call manager.

4.7 Where Police are involved in the missing episode, it is not sufficient to simply inform the Police without some form of action having taken place, and continued joint plan. Missing Patients are owed a duty of care by all agencies involved and are a joint responsibility.

4.8 The Police control room once contacted will apply a THRIVE assessment to identify the right police response (Threat, Harm, Risk, Investigation opportunity, Vulnerability, Engagement). It is essential staff provide detailed articulate information regarding the missing persons risk to self and others, and what this means. This should include the enquires undertaken as detailed in 4.3.

4.9 CNTW staff should ensure they give as much detailed and clear information as possible, and what you have tried (i.e. ringing them, speaking to family etc.) at this stage describing the risk, and the concern, do not make statements of high/medium/low risk as views of what this mean can differ between agencies.

4.10 At this point the Police will apply their criteria and if satisfied that the criteria is met, they will record the incident and deploy a resource. Please be aware that if the level of risk does not necessitate a police response, the responsibility remains with CNTW to continue the enquiries to locate the missing person and

undertake regular risk reviews. Once staff are satisfied that the risks have reached the critical concern threshold, Police should contacted.

4.11 The questions which the call taker will likely ask to log the missing person report are:

- Name of missing person including any nicknames
- Age
- Description of person and their clothing
- Home address/Last Known Address
- Location the person is missing from (E.g. CNTW ward)
- Circumstances of going missing, when were they last seen and where
- Name, address. contact number and relationship of person making report- this should include an out of hours contact number, as previously detailed
- Any mobile phone they have- phone number
- Access to money – bank cards, and passport
- Details of any vehicle or transport used
- Any known locations where missing person frequents
- Any medication the missing person requires, frequency of taking and the effects if not taken
- Information about known risks- exploitation, previously formally assessed as lacking capacity in any areas (e.g. Finance, housing, health needs etc.)
- Information about persons the missing person may be in contact with.
- Any concerns about changes in behaviour, any patterns of known behaviour, as well as how may they react when found.
- Have there been any previous missing episodes, and where were they found, any relevant information from them?
- If someone has absconded from escorting staff, to enable identifying location to police easier, consider use of ‘What3words’ app if available.
- Has the Winnie Protocol paperwork been completed? (Northumbria protocol only). This isn’t used in CNTW currently, but family member may use.

4.12 The call taker will then ask the following questions in order to aid an initial risk assessment:

- Why are you worried about the missing person
- What has been done so far to trace the individual, if possible
- Is this missing episode out of character

- Have they been missing before and if so, where were they found
- Are there any physical or specific health needs, what is the nature of these?
- What is their mental disorder – how does this affect them, and how will this affect risk to them to others?
- Are they likely to become a victim of crime
- Are they likely to be hurt or harmed, is anyone identified a risk towards them
- Are they known to be at risk of self-harm or attempt suicide
- Could they pose a danger/risk to other people, anyone identified at risk
- Are they likely to have travelled abroad, do they have means (e.g. money/passport)
- Is there any other relevant information relating to their missing episode (any reason/purpose known for this, any other person suspected involved in facilitating missing episode etc.)
- Is there any CCTV available and can it be accessed (where applicable)

4.13 It is essential CNTW staff share/explain following where appropriate:

- Are they a detained person under the Mental Health Act, what section, and when does it expire? Ensure to explain what the section means, especially if a forensic section (see point 14.20) and therefore unusual.
- Were they on section 17 prescribed leave, has this gone past return time, or has necessary paperwork completed to rescind leave.
- Is the person on a community treatment order (CTO), and been recalled, has paperwork been served, or posted and when do they become live?
- The Police should be informed if the patient is subject to the provisions of the MHA and any applicable limitations of time to retake.
- Are they a patient in Secure Services and likely to be classed as ‘a prisoner unlawfully at large’ or subject to ministry of justice restrictions?
- Are there any concerns around any physical health conditions and risk associated to this?

4.14 Ensure clear non jargon language used to Police in reporting and when Police attend, to ensure information is accurate and understood to the Police Call Handler. Ask them to repeat information back to you if needed.

4.15 The Police will then allocate the missing incident to a response team for investigation. A risk assessment will be provided and reviewed accordingly by the supervisor (Northumbria) or Police Constable (Cumbria but confirmed by supervisor) who will decide on the response required. If CNTW staff disagree

regarding the level of risk and risk grading, this should be discussed with Police and escalated in CNTW line management, and request Police review and explain why. It is ultimately a decision for Police. Clinical Police Liaison Lead can be contacted for advice and support during working hours. Please report any disagreement of risk within CNTW, and an incident reported via the web form – Cause Group – Police and Emergency Services Activity; Primary Cause – Police/NHS Communication Breakdown or Failure. As well as ensuring good record within the progress notes. This should be a separate report to the reporting of the patient being missing.

4.16 One of the challenges around missing / AWOL patients and partnerships is that a missing patient for the NHS is not necessarily a missing person for the Police.

4.17 For example, if a quick telephone call by ward staff confirms that a patient who was prescribed Section 17 leave and who has failed to return on time is at their home address or other leave location – ostensibly safe and well – then they are AWOL from hospital without being a missing person because CNTW know their whereabouts.

4.18 The Code of Practice to the Mental Health Act (MHA) states that such a scenario is primarily an NHS responsibility. Unless of course there is known risks that render this unsafe for NHS alone to bring back the patient. This may then be done jointly, after a THRIVE assessment with Police, ambulance service or AHMP dependant on the level of risk posed.

4.19 To ensure both organisations are clear below are examples, which can cause confusion, to clarify when an individual may be classed as a missing person:

- Informal/Voluntary Patient: This is when a person admitted to hospital on a voluntary basis; are called ‘informal’. These patients are free to leave when they wish, with no legal framework around them. There may be occasions staff may have concerns, due to information or circumstances, when the person is off the ward in regards to the imminence of risk that person presents to self or others. These concerns should initially be discussed with senior staff/manager involved in their care, if not imminent, to look at a plan. They should only be reported to Police when enquiries have been exhausted to establish their whereabouts, they cannot be located and on current information they will fail to return or suffer/cause serious harm while away. If the patient is informal and it is felt that the patient does not represent a risk to themselves or others, this should be documented as such, and the situation monitored by the Nurse in Charge at ward level. The patient’s doctor should be informed at the earliest opportunity. The frequency with which the situation will be monitored will be specified in the patient’s health care record, (see CNTW(C)03 Leave, Absence Without Leave (AWOL) And Missing Patient Policy). CNTW staff should also ensure there is a plan provided to Police about actions to be taken once the missing person is located (See section 17.2)

- In any case where it is felt that there is a critical concern, the patient is dangerous or particularly vulnerable, the Police should be contacted immediately (MHA Code of Practice)

- Community Patients: If a community patient has not been seen, not attended appointments, despite attempts by staff to see the person/visit home, contact family etc, and on current information they are at immediate risk of harm to themselves or others, a concern should be raised for the person's welfare with Police. This however is a concern for Safe and Well Check request, rather than missing person. (See SM-PGN - Guidance - Working with Police & Criminal Justice System Appendix 3). If Police cannot locate them, they may then turn this to a missing person enquiry and communication with CNTW will be made to update the identified point of contact.

4.20 Patients detained under the MHA are prescribed Section 17 leave by a Responsible Clinician (RC); this is often the consultant responsible for their care. When a person fails to return on time, runs off from the escorting staff, or leaves the ward without prescribed leave, this deems the person absent without leave (AWOL) under the legislation. A Police missing report may be made, as above -reporting that they are Missing and AWOL taking into account all the information available. MHA Code of Practice (2015) states that 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
- are subject to Part 3 of the Act –restricted patients.

4.13 Under Part 3 of the MHA, often referred to as the Forensic Sections of the MHA (Sections 37/41, 47/49, 48/49 or 45a), leave will be agreed by the Ministry of Justice (Secretary of State), unless in an emergency. This is due to the person being deemed a significant/serious risk to the public, and directed by the courts to hospital instead of prison (Section 37/41) and may also be a sentenced prisoner (Section 47/49) or remanded prisoner (Section 48/49) and hospital direction / hybrid order (Section 45a). This again would be reported as a person AWOL and in some cases AWOL prisoner unlawfully at large (999 call). This must be made clear when reporting to Police.

This is not an exhaustive list but designed to give some examples.

5 Responsibilities

5.1 Doctors and Responsible Clinicians (RC) in charge of the treatment of patients (or their nominated deputy) and other health care professionals will have regard to the details in this Practice Guidance Note and highlight any issues with the operation of this document to their Line Manager. Details of specific duties are given within the guidance of this document.

6 Ward Team Responsibilities

6.1 Each ward will have a Missing Person Assessment (Appendix 1), which will include the following:

- A Site Map of the hospital they are based within, this must identify what areas are not CNTW properties also;
- A Ward Map of the full ward which can be photocopied and used for the purposes of searching;
- Details of the type of ward and patient group on the ward;
- Name and contact details for the Ward Manager, Clinical Manger and Associate Director (and their equivalent out of hours);
- Contact details for security where applicable;
- Name and contact details for Local Police Liaison Officer Link;
- Details of the exits and entrances to the ward, and any doors that may fail open, include fire doors that may not be used frequently;
- Identified vulnerabilities within the ward environment;
- Preventive features and strategies in place on the ward to prevent missing people (e.g. locked doors, locked windows, etc);
- Will include details of CCTV cameras in the area and how to access images.

6.2 The Missing Person Assessment will be developed jointly with Ward Manager and Police with support from the Clinical Police Liaison Lead within the Safer Care Group if required. They must be agreed by locality care group. The Ward manager is responsible for ensuring undertaken and kept up to date.

7 Patients Health Records

7.1 To aid in the information sharing and process for searching for in-patients who are missing. The following should be available to assist the Police. They can also be in place for community patients, particularly those deemed a higher risk:

- **A photograph -** (Only taken if the person is consenting and will need to be explained to the service user that it is for their safety and would only ever be shared in the event that they were at risk or others were at risk).(Refer to VIA-PGN-01 - Taking Patients'

Photographs within Inpatient Settings to Maintain Patient Safety). This should be kept in the RIO support file.

- **A Missing Person Form** - on patient's electronic notes (RiO) (See Appendix 2) with all details to include mobile number/s, places the person may frequent if they have been missing before, diagnosis, family members / friends, description and distinguishing features etc. This will be completed with the necessary details at point the person goes missing, and much of the information will be populated from existing information on RiO. This will only be seen in its entirety when printed off as a report format. It is found in the core documentation, Inpatient documentation Section on RiO. See Appendix 4 for RiO Guidance Information.

8 Ward Staff Responsibilities

8.1 Staff who work in identified areas of high frequency and / or at risk of missing people should be trained in search team training which includes how to search for people.

8.2 Staff when accompanying patients on ground leave should ensure they carry a trust mobile phone that is charged. If one is unavailable, it will be discussed with Ward manager about utilising own mobile for this purpose.

8.3 Staff who become aware of a patient absenting themselves from a ward or while on ground leave where it is not safe for the staff member to detain them should ensure they follow the patient at a safe distance whilst ringing 999 and reporting the situation and the location. (using what3words) The staff member should continue to follow the patient until police are at scene or police control room advice staff member to stand down, or it becomes unsafe for them to do so. If possible, extra staff should be contacted via radio/second phone to support to bring person back. Staff should ensure they are aware of their own safety and not put themselves at risk.

8.4 Staff should ensure adequate information is given to Police about the person when making the call, it should include, all details as described in section 3.4.2. As well as the following:

- Ensure search of the ward has taken place and detailed clearly on the map so this can be handed to Police on arrival – 'dated and timed'.

- Ensure the Police are aware:

  - Which areas have not been searched

  - Which areas staff have been unable to search

Follow search training guidance on ensuring a co-ordinator watches over the ward to limit movement around the ward etc.

Refer to Appendix 3 for more detail on carrying out a search for a missing person). Staff should be trained to undertake this methodical search.

9 Action to be taken in relation to In-patient areas

9.1 When it is established that a patient is missing from the ward or department, the Nurse in Charge will make an initial risk assessment.

9.2 If the patient is informal and it is felt that there is not a critical concern for the patient, this should be documented as such, and the situation monitored by the Nurse in Charge at ward level. The patient's doctor should be informed at the earliest opportunity. The frequency with which the situation will be monitored will be specified in the patient's health care record, e.g. hourly, at each handover etc.

9.3 If this initial assessment identifies any immediate risk or the patient is subject to the provisions of the Mental Health Act, then the Nurse in Charge will ensure a search is instigated as quickly as possible of all areas of the ward, adjacent ward/depts. and perimeter. A grounds visual check should be undertaken. Due to the methodical nature of searching, Police have advised CNTW staff do an initial visual search of grounds. Police will undertake a further search of any grounds if required.

9.4 If the patient has been observed leaving and it is obvious they have left the site / or absconded from community leave, then an immediate area and grounds visual check may not be necessary.

9.5 Should the search of the immediate area fail to locate the patient, the Nurse in Charge will inform the appropriate doctor that the patient is missing. A more detailed Risk Assessment should be undertaken taking account of any documented history and information available within the electronic health record (RiO).

9.6 Police should then be contacted by 101/999 or if they are classified as a 'Prisoner' or an imminent risk is apparent a 999 emergency call should be made at the earliest opportunity reporting the person missing.

9.7 The RIO health record missing persons form will be printed and be available for the officer attending.

9.8 A joint decision should then be made and an appropriate action plan formulated, which will include frequency of the searches.

9.9 Consideration should be given to notifying other wards / teams on the site to the missing person as they may have sightings / information to share of relevance. This could be done via Ward Manager/POC (Point of Contact) phoning the wards and follow up email alert.

9.10 In all cases of a missing person the Trust's Incident Policy - CNTW(O)05, the Web based Incident Reporting System should be followed.

9.11 If the Risk Assessment indicates that there are specific people in the community who may be at risk from the patient (e.g. Domestic Violence concerns, MAPPA risks or Children) then an urgent consideration should be given to their notification and protection. This information must also be given to the Police immediately, with as full details as possible.

10 Missing and in Contact with Children

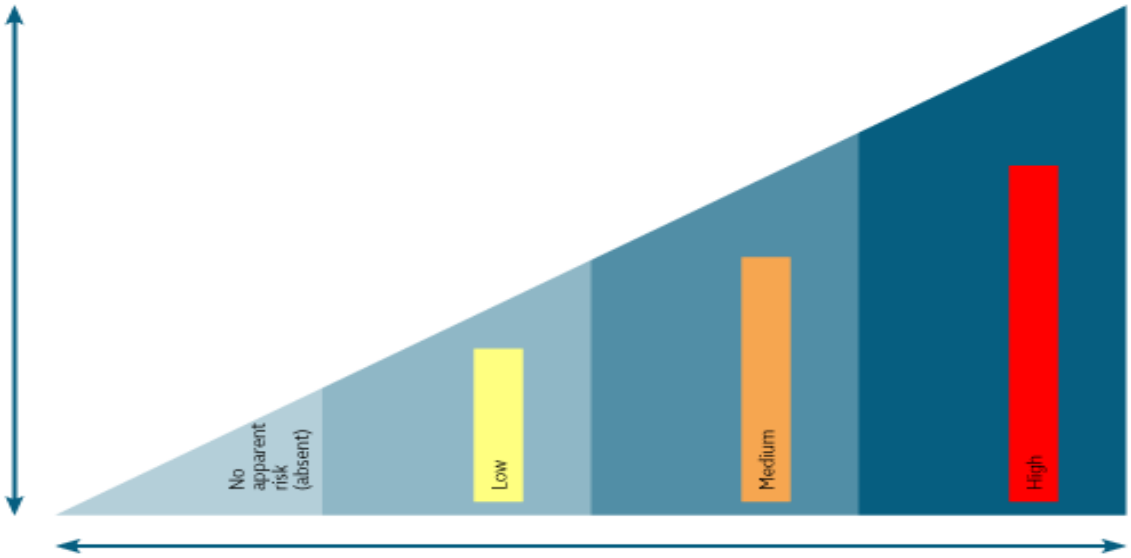
10.1 If it is known the service user is to resume contact with children while missing, this should trigger an assessment to determine whether there are actual or potential risks. This includes consideration if there are delusional beliefs involving children or risks a service user may harm a child as part of a suicide plan. The team should draw on as many sources of information as possible, including concordance with treatment.

10.2 If problems, concerns or suspicions are raised regarding a child's safety, as well as immediately making Police aware, then referral should be made to local authority children's services under local safeguarding procedures. Advice can be sought via CNTW Safeguarding and Public Protection team, or out of hours on call manager.

11 Grading Risks and Response

11.1 Police and healthcare classify risk differently, and this can be confusing to all concerned. It has been agreed with Police to assist this process, health staff will not grade the risk. Staff will give clear details about risk to self and others, the person's health condition and what this means and how it manifests.

11.2 Police would use the College of Policing Authorised Professional Practice (APP) Guidance on rating risk and managing risk of a missing person on the below continuum. They would classify risk by the graph and table below:



11.3 Police Partners use the following nationally agreed risk assessment when deciding on the investigation each Missing episode requires:

- **NO APPARENT RISK**

There is no apparent risk of harm to either the subject or the public. Actions to locate the subject and / or gather further information should be agreed with the informant and a latest review time set to reassess the risk.

- **LOW RISK**

The risk of harm to the subject or public is assessed as possible but minimal. Proportionate enquiries should be carried out to ensure that the individual has not come to harm.

- **MEDIUM RISK**

The risk of harm to the subject or public is assessed as likely but not serious. This category requires an active and measured response by the police and other agencies in order to trace the missing person and support the person reporting.

- **HIGH RISK**

The risk of serious harm to the subject or public is assessed as very likely.

11.4 This category almost always requires the immediate deployment of Police resources – action may be delayed in exceptional circumstances, such as searching water or forested areas during hours of darkness. A member of the Police senior management team must be involved in the examination of initial

lines of enquiry and approval of appropriate staffing levels. Such cases should lead to the appointment of an investigating officer (IO) and possibly and SIO, and a Police search adviser (PoISA).

11.5 There should be a press / media strategy and / or close contact with outside agencies. This will require a joined-up approach from organisation media/communication teams. See Section 13 for further details. Family support should be put in place where appropriate.

11.6 When taking a report of a missing person, Police will consider as to whether a Safeguarding Adults Concern should be raised with the appropriate Local Authority.

12 Search of Ward/Unit

12.1 The Nurse in Charge will take initial responsibility to coordinate all measures required ensuring a thorough search is then undertaken. At this stage, the Ward Manager on duty /Clinical Manager/ Associate Director (or on call equivalent) should be notified.

12.2 The Nurse in Charge will contact the relevant security (where applicable) and see if they are able to assist the Ward Manager to oversee the organisation of the ground search using the site map.

12.3 This may require the release of available staff from other departments.

12.4 The ward map should be used to record clearly areas being currently searched, areas completely searched and record the time and date this was completed. A copy of this will be given to Police on arrival at the unit. This should be undertaken in a co-ordinated, methodical manner with an overseeing co-ordinator to ensure no movement occurs throughout. Further detailed guidance is in Appendix 3.

12.5 CNTW Staff undertaking searches should have completed the Trust search training on searching for missing people and be competent to undertake the search.

12.6 Where the Trust facility is on a host site, the staff will liaise with Police and inform them which areas are not accessible or able to be searched.

12.7 Jointly with the Police, a Search Co-ordinator should be identified to support the initial search of the immediate vicinity. This person will usually be the Nurse in Charge or Ward Manager/POC.

12.8 The Search Co-ordinator will have available the relevant site map. All subsequent information should be directed through the Search Co-ordinator.

12.9 The Search Co-ordinator will act as the single point for the Police and will assist in any further information gathering that can assist in the search for the

person. Police should continue to communicate with the ward/team with updates on the missing person, at least daily.

13 Considering others input to aid finding the person

13.1 At the earliest opportunity, consideration must be given as to when the nearest relative, carer or parent should be informed. The Clinical Team will decide, in consultation with the Ward Manager / POC, who, how, and when to contact patient's relatives and carers in accordance with the Trust's Incident Policy - CNTW(O)05. This will differ depending on the individual circumstances, but must be acknowledged in the decision making, Police will contact any known family/friends as part of enquiry.

13.2 The relatives and carers may have additional information to assist with the location of the patient and may be in a position to assist in checking known locations where the patient could be. An offer of assistance by the relatives should be considered carefully in respect of the risk assessment. The Police should be involved in discussion if they are involved also. Any discussions / decisions should be fully recorded in the patient's health care record.

13.3 Other patients may have knowledge of the whereabouts of the patient and consideration should be given to asking them to provide any information that they have.

13.4 Informed by risk assessment and clinical judgement, if it is thought that the patient may no longer be in the area covered by CNTW then ensure Police are aware of the areas they have connections to, or thought to have travelled to, including outside of the UK.

14 Working Together/Communication

14.1 It is essential that all organisations work together and closely throughout. Missing people are not just a Police responsibility when they are under CNTW care also. By CNTW staff contacting Police, they are not discharging the responsibility. Missing Patients are owed a duty of care by all agencies and are a joint responsibility. Partnership working is based on respect and communication. Both parties should trust the other and share appropriate and proportionate information without unnecessary bureaucracy or delay.

14.2 It should be noted that police only have power to enter and search home addresses of an informal Missing Person to save life or limb where there are reasonable grounds to believe they are on the premises and entry is required to save life or prevent serious harm. In other circumstances, police will require a warrant under the MHA to recover the Missing Person.

14.3 The RiO Missing Person Form will be printed off and ready with photo (if available) for the Police Officer attending to aid the speedy information sharing. This will assist in the identification of the person for Police Officers and assist in commencing an earlier search and distribution of information amongst officers. Accurate recording of the patient's physical description at

the time of admission can greatly enhance the ability to locate the person where a photo is unavailable

14.4 At this stage, the CNTW Associate Director or on call equivalent should be advised of events, if they are not already involved. Police will ensure relevant escalation depending on situation and ensure correct oversight.

14.5 Section 18 MHA is the legal power to return AWOL patients (including CTO recalls) to their ward and it is not a power directed solely or even firstly at Police Officers. Where a patient who has been granted leave fails to return to hospital upon its completion, or where they fail to return if recalled from such leave when it is revoked, then they become AWOL under the MHA.

14.6 This then entitles an AMHP (Approved Mental Health Professional), anyone on the staff of the relevant hospital, a constable or anyone else authorised by the managers of the hospital, to take the patient into detention under Section 18 MHA and return them to the hospital. There is no power of entry in respect of this authority. Should entry need to be forced in order to detain someone under Section 18 who is AWOL from Section 17 Leave, then a warrant needs to be obtained under Section 135 (2) MHA via the Magistrates Court. This can be done by the Professional that knows the person best including risk involved.

14.7 Section 18 MHA is a Power of 'arrest' for the purposes of the Police and Criminal Evidence Act (PACE) 1984 and therefore reasonable force may be used under Section 117 PACE to discharge it.

14.8 It essential that there is clear communication between Police and CNTW. This should come from the CNTW team that knows the person and responsible for them wherever possible. At point of report, Police are given a point of contact (e.g. Ward number – Nurse in Charge or Community Team/Crisis Team triage nurse etc.) and they can then update them on updates or request information as required. Out of hours contact should also be provided, for community service, which may be Street Triage or Crisis Team.

14.9 Agreement on least daily frequency/updates should be agreed and facilitated.

14.10 Where a person is missing for 72 hours or more, the clinical team must consider convening a multi-agency meeting to review all known information, and co-ordinate and agree any required actions. The meeting should include the Safeguarding and Public Protection team and local Police. In Northumbria, the locality harm reduction team, and Mental health liaison teams (Cumbria /Cleveland). The decision making around these considerations must be fully recorded within the health record, and the rationale for the decision to hold or not hold a meeting recorded.

14.11 A record outlining the discussion at the meeting, information shared, and agreed actions must be recorded within the heath record, and the agreed actions sent to all involved.

15 Missing Person from another area

15.1 When a person is found by a Police Officer, who is a missing but detained patient from elsewhere in England, the Section 18 Power is only applicable to the Police. This is due to CNTW not being the relevant hospital authority, unless it is agreed the person will be admitted to one of our wards and section papers are transferred.

15.2 CNTW Street Triage or Crisis team will be contacted to support Police with this vulnerable person, and consideration given to using Trust premises to support the patient rather than a police station. This will need discussion with relevant team manager in service or POC on call senior manager out of hours, to agree plan of support and ensure care and support for person while with Police. CNTW cannot take responsibility for the person. The role is a supportive/facilitating one to Police colleagues and the service user.

15.3 CNTW will assist Police in conversing with the relevant hospital authority to make plans for the person to return or look at transfer to CNTW bed if appropriate. Bed Management would need to be consulted. This would include arranging suitable transport, or staff from the hospital traveling to pick up the person. Police transport to return them to hospital will not normally be appropriate unless risks are high. Decisions about the kind of transport to be used should be taken in the same way as for patients being detained in hospital for the first time. The decision and discussion needs to be direct with the person care team/hospital authority, who will be fully aware of the risks with the person.

15.4 Where a patient who is absent without leave from a hospital is taken into custody by Police, the managers of the hospital from which the patient is absent from are responsible for making sure that any necessary transport arrangements are put in place for the patient's return. The Police force which temporarily has custody of the patient is responsible for them in the interim, and should assist in ensuring that the patient is returned in a timely and safe manner. Police should not be used to convey AWOL patients unless risks are high. In majority of cases, ambulance services should be arranged for conveyance.

15.5 The Police will ensure the local force the person has been reported missing from, has been informed.

15.6 Safe areas can be considered in each locality area, this may be a place of safety suite, an assessment area, the Lodge at St. Nicholas Hospital etc, depending upon the needs and presentation of the person. It may be if the person is extremely aggressive and unmanageable that Police Custody is the only option, but this should be a last resort.

15.7 The role of the staff will be to liaise with the service they are from, to enable them to obtain information to sufficiently keep the person safe. This may be about urgent medical conditions etc. The staff member will offer support to the person, ensure any needs are met in relation to food and drinks and providing

with somewhere to be safe. They will offer support and advice to the officer/s detaining the person.

16 Managing Public Interest and Media

16.1 The photograph will only be released to the public with agreement from the Associate Director for the service or on call equivalent. The Associate Director, in co-operation with the Communications Department will address any publicity issues in relation to a missing patient in consultation with the clinician in charge of the patient's care and Ward Manager. The patient's relatives should, wherever possible, be involved in this decision. Reference must be made to Trust's Media Policy documents. Decisions about media strategy for a missing person should be taken between the Police officer who has command and control of the Missing enquiry and the Associate Director from CNTW.

17 If the Patient is found / returns

17.1 If the patient should be found, or returns to the ward, the Search Co-ordinator will inform the appropriate Nurse in Charge who will then inform the Doctor, Police, and relatives / carers. The Search Co-ordinator will then stand the Search Teams down. If this is a community patient, staff must notify Police the person has been located.

17.2 If an informal patient is found by Police, they have no power to return the patient to the ward. In these circumstances the police officer in charge of the case should liaise with the Nurse in Charge to determine next course of action to manage the risks the Missing Person presents. The only power available would use of Section 136, if the officer is satisfied following consultation with the ward, that the criteria was met. If this was the case, the person should be returned to the ward under Section 136 and the lawful detention passed to the nurse in charge of the ward, with full handover from the officer. The MHA assessment can then take place on the ward and the person can be lawfully held for up to 24 hours for this to take place.

17.3 Prompt notification of the Police is important so as to minimise unnecessary use of their resources. Police will actively investigate all Medium and High Risk missing person cases 24 hours a day. When a missing person returns to the ward or is seen by a professional, Police are still required to see them to conduct a prevention interview. This is a form of questions designed to establish the reasons behind the missing episode and prevent future missing reports.

17.4 Wherever possible (recognising that patients may not want to disclose to a police officer in uniform) further follow up interview with the patient should be conducted by CNTW staff, if person is willing. The questions to be asked during a prevention interview are:

- Have you come to any harm while missing (Exploitation, sexual offences, violence, self-harm- any disclosures should be reported to police via 101)

- Why did you go missing?
- What have you been doing while missing
- How did you get to your destination
- Did you travel alone or was anyone else involved in your missing episode
- How did you make arrangements to go missing
- Where have you been and who with
- How did you support yourself
- Have you used drugs, alcohol or other substances while missing
- Will you go missing again?
- What could prevent you from going missing again
- Is any signposting to other agencies or a safeguarding adults referral required.

The information obtained from a Missing patient during a missing episode should be emailed for Northumbria Police to Missingpersonmailbox@northumbria.pnn.police.uk with consent of the patient or otherwise used internally to plan to prevent future missing episodes.

17.5 If someone child or adult is having repeated missing episode, clinical team to consider multi-agency review with Police, to look at joint risk planning and any preventive actions and support that can be put in place. There should also be contact with CNTW safeguarding and Public Protection team (SAPP) around anything further required. This could be done via Trust incident report completed under missing but ticked as safeguarding for triage.

18 Police Raise Concern for Welfare (Reported Missing Person)

18.1 If Police are notified via a family member / member of public, of a missing person who is known to be in receipt of mental healthcare they must seek some advice around this via the Crisis Team / Initial Response Service / Street Triage.

18.2 Following any initial information sharing, the persons involved in their care should be notified they are currently classed as a missing person and seek if they can offer any input into the search. In these cases, the Care Co-ordinator should undertake a Risk Assessment. An Incident Report should also be completed if open to CNTW services. All professionals involved in the patients care team should be shared with police to allow them to have access to full information for investigation purposes.

18.3 If there is considered to be a risk to the patient or others, the Care Co-ordinator should consult with appropriate members of the Care Team and any relevant carers to formulate a plan of action. Clinical Teams should also consider Section 14 of this PGN, when reviewing plan.

18.4 The Clinical Manager & Associate Director should be notified at the earliest opportunity.

18.5 For CNTW raising a concern for welfare/safe and well check – please see SM – PGN – 11 - Guidance - Working with Police & Criminal Justice System Appendix 3 for guidance. Click here to access the PGN PGN 11 - Guidance - Working with Police & Criminal Justice System

18.6 Concern for welfare as mentioned in examples of section 8.2 of SM-PGN-11 Working with Police & Criminal Justice System may become a missing person enquiry. CNTW staff must be clear what they are requesting from Police at the call.

19 Additional risk considerations in community- Missing People

19.1 The Responsible Clinician (RC) should be directly involved in all clinical decision making for service users who may pose as a risk to children.

19.2 Following the initial risk assessment, due consideration should be given by clinical staff to communicating their concerns. This may include relatives, GP and voluntary groups. A Multi-Disciplinary Review may be considered.

19.3 If there are concerns regarding potential harm to a child, staff should follow clear guidelines on how to refer to local authority children's services, including accessing the pathway out of hours. Staff should also have an awareness of the role of the designated lead for child protection and the process of appropriate information sharing.

19.4 If the community patient is located in a different area and is not returning to their original address, consideration should be given by the Review Team to transferring their care.

20 Considerations relating to Community Treatment Order (CTOs)

20.1 Further considerations apply to patients missing when subject to a Community Treatment Order. A patient subject to a Community Treatment Order is considered AWOL if:

- The patient is missing and a notice of recall has been served by their Responsible Clinician;
- If they abscond from hospital within 72 hours of being recalled;
- If they fail to attend hospital when recalled.

20.2 If the patient is taken into custody under Section 18 (See Section 14.5, 14.6 and 14.7 of this PGN) or comes to the hospital voluntarily, then the 72 hour period that they can be held will start at that time. It will run for 72 hours, even

if the patient had already been detained for part of that time before they went AWOL.

20.2 If a patient has not been taken into custody, or does not attend the hospital voluntarily before the end of the period, they can be retaken then the Community Treatment Order expires and no extension report can be made.

20.3 If the patient is taken into custody under Section 18 or comes to the hospital voluntarily, after having been absent for more than 28 days then their Community Treatment Order will expire at the end of the week starting with the day of their arrival at the hospital unless it is confirmed by the Responsible Clinician.

21 Training, Support and Prevention.

21.1 Training will be delivered by Trust Search Trainers, which may include involvement of Police Search Advisors in content tor delivery, to ensure it covers all points relevant to each organisation. It is available to any ward area that requires it but should be undertaken by those in high risk and high frequency missing person areas.

21.2 In Northumbria, Police Missing Person Coordinators work in force closely with Hospital Liaison officers. Their role is around preventative problem solving for Missing persons to identify the root causes of a Missing episode and work with the Missing Person and professionals to safeguard them and prevent future missing episodes. Contact can be made with the Missing Person Coordinators through Missing Person mailbox. (Mon to Fri office hours). To discuss a current live Missing Person enquiry, contact the control room 101 and ask to speak with the Duty Response Sgt.

21.3 In Cumbria, Police there are dedicated officers that undertake missing person work and reviews, not live investigations. If a person goes missing more than 5 times in 90 days, these officers will review and if mental health related will work closely with the mental health liaison officers and CNTW services to review this.

21.4 The Wards / Teams will work closely with the Safer Care Group and Police Liaison Officers to ensure embedding of this guidance. Learning lessons will be taken to local Police and Partners Groups.

21.5 Professionals should speak to people in receipt of care who may be at risk of going missing about how that can be prevented and how they can stay safe. Processes should be put in place to allow for these discussions. This could be done at the earliest point possible, taken into account this may need revisited, as a person's mental health improves. For those identified at high risk of going missing, a care plan should be in place to consider action needed, risk managed and include service user's views.

21.6. The conversations should include:

- A discussion about when someone would be reported missing and what this will mean, including what information may need to be shared with other agencies. For example, a clear explanation of the expectations on a patient or resident in regards to where they should be at what times; what might trigger a member of staff to report them missing; what the police may then do in terms of investigation.
- Space for the person at potential risk to discuss what might trigger them to go missing, what might help to mitigate this, and any concerns about the expectations put upon them. This should be an open conversation that allows people to raise concerns about anything they may not be happy with in terms of their care or restrictive measures put in place to make them safe. It is vital that any appropriate changes raised by this conversation are actioned
- A discussion about how the person can stay safe if they do leave the health or care setting, including how they can keep staff informed of what is happening if appropriate.
- Recording relevant information about locations and activities that the person might attend or seek out if they go missing.
- Recording relevant information about who may be appropriate to contact if they do go missing.

21.7 Information from these conversations should be incorporated into people's care plans or used to support development of a Police trigger plan to be used in the event of them going missing. All information should be regularly reviewed and updated, and when appropriate, the information should be shared with other relevant agencies. These conversations should also be reviewed in a broader sense to identify any persistent reasons that people are going missing; emerging themes that may inform prevention; or necessary changes to the local protocol and response.

22 Associated Documentation

To be read in conjunction with the following:

- CNTW(C)03 – Leave, Absent without Leave and Missing Persons Policy
- CNTW(C)11 - Search Policy
- CNTW(O)05 - Incident Policy
- VIA-PGN-01 - Taking Patients' Photographs within Inpatient Settings to Maintain Patient Safety part of CNTW(O)45 Visual Imaging and Audio Recording Policy

- SM-PGN-11 - Guidance for Clinicians and Police Officers: Working with Police and Criminal Justice System part of CNTW(O)21 Security Management Policy

23 References

- The multi-agency-response-for-adults-missing-from-health-and-care-settings-a-national-framework-for-england (The multi-agency response for adults missing from health and care settings: A national framework for England - GOV.UK (www.gov.uk)

Police Partners:

- College of Policing APP (Authorised Professional Practice) March 2020 Major Investigation and Public Protection- Missing Persons