University Hospitals of Derby and Burton NHS Foundation Trust

TRUST POLICY FOR MISSING PATIENTS

Reference Number CL-RM/ 2014/ 019	**Version:** V6		**Status**	**Author:** Jane O'Daly-Miller & Katherine Golisti **Job Title:** Head of Safeguarding & Vulnerable People & Matron for Vulnerable People
Version / Amendment History	**Version**	**Date**	**Author**	**Reason**
	V1	Dec 2005	Kay Fawcett	Original Policy
	V2	Oct 2009	Em Wilkinson-Brice	Policy Reformatted to NHSLA Standard
	V3	September 2010	Gill Ogden / Bev Youson	Amendments to existing policy
	V4	September 2014	Sandra Mir	Amendments to existing policy
	V5	September 2020	Jane O'Daly-Miller/ K Golisti	Creation of overarching Trust wide policy
	V6	August 2023	Jane O'Daly-Miller	Review within timescales and incorporation of new national policy & local police policy

Intended Recipients: All wards and departments

Training and Dissemination: Dissemination via the Trust Intranet

To be read in conjunction with: Policy for Maintaining the Security of Trust Staff, patients, Visitors and Trust Premises

In consultation with and Date:

Patient Safety Committee

Safeguarding Committee

EIRA stage One Completed	**Yes**
Stage Two Completed	**N/A**
Approving Body and Date Approved	Trust Delivery Group
Date of Issue	October 2023
Review Date and Frequency	August 2026 (then every three years)

Contact for Review	Head of Safeguarding & Vulnerable People
Approving Executive Signature	 Executive Chief Nurse

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Appendices

TRUST POLICY FOR MISSING PATIENTS

1. Introduction

This policy is revised and based on the June 2023 government policy and National Partnership Agreement: Right Care, Right Person (RCRP). The Right Care, Right Person is an approach designed to ensure that people of all ages, who have health and/or social care needs, are responded to by the right person, with the right skills, training, and experience to best meet their needs.

Many people who attend and then leave Trust departments or ward areas have mental capacity and are not detained under a section of the Mental Health Act; they leave as a matter of choice and are free to do so. However, patients who leave the ward or other departments without the knowledge of staff can cause concern for their safety and some patients due to their vulnerability leave and pose a risk to themselves or to others.

It is of vital importance that staff adopt a preventive approach to risk of leaving early in the attendance. Practical steps should be taken after identifying a patient who has a high risk of leaving, and these include:

- Prioritizing early clinical and mental health assessment if they are a potential risk to themselves.
- Perform a capacity assessment; does this patient at this time have the capacity to decide to leave the ED / ward without being seen? Be aware that the patient's capacity may fluctuate; they may have capacity when assessed but might not if assessed an hour later, for instance.
- Placing the patient in a location which facilitates ease of observation.
- Undertake an Enhanced Care Bundle assessment and allocate a member of staff to care on a 1:1 basis, or in a cohorted area, to observe the patient, try to engage with them and keep them calm and comfortable.
- If a patient wishes to leave, establish why the patient wants to leave and try to address their concerns. If the patient is adamant that they wish to leave and they have capacity to decide this, then they should be managed as per local 'self-discharge' policy.
- For patients with a high risk of leaving it is recommended that the form at appendix 1 is used proactively to list a description of the patient's physical features should this be required by the police or hospital security in the eventuality of the patient leaving.

2. Purpose and Outcomes

The maintenance of patient safety is of paramount importance. This policy aims to minimize the risk to any patient who leaves the Trust without knowledge or agreement of the responsible member of staff and give staff guidance on what to do in these circumstances. It applies to all hospital 'in-patients' or outpatients and/or those identified as 'at risk' through the risk assessment process (5.1).

If a patient is identified as missing it is vital that all staff understand and follow a structured approach. This policy will:

- Provide guidance regarding assessing vulnerability and identifying when a patient should be regarded as a missing patient and whether they are a person at risk of significant harm.
- Outline the search process and the roles to be undertaken.
- Outline agencies and individuals to be informed and referred to.

This policy will specifically provide clarity on the following situations.

- Where a patient is missing **and there is a concern for welfare**
- Where a patient is missing **and there is potential for a medical emergency which may or may not be linked with mental health**.
- When a patient is missing and has **walked out of health care facilities** - with or without having been previously seen by medical / nursing teams e.g. from Emergency departments or Minor Injury Units.

This policy applies to all five sites of University Hospitals of Derby and Burton including Children's Services and to all clinical staff including all "bank" employees and those employed on a temporary / locum / honorary, agency or fixed term basis.

3. Definitions

Missing Patient	The term 'missing' as used in this document applies to patients who absent themselves without leave or fail to return in the agreed time frame. A patient should be considered missing if: a) They leave the ward or department without notifying staff and there has been no contact or agreement made with staff regarding their leaving. b) They fail to return within 15 minutes of the agreed time frame and there is no contact with staff. In the case of **vulnerable patients, the term missing should be applied as soon as their absence is noted.**
Vulnerable Patients / Persons	Those identified as vulnerable include: • Patients sectioned under the Mental Health Act / awaiting assessment for mental health concerns. • A patient that has been assessed as lacking mental capacity. • Patient being treated under a Clinicians 'Duty of Care.' • Patient with self-harming behavior / suicidal ideation. • Patients with confusion / cognitive deficits / dementia / suspected or confirmed delirium / Learning disability or neurodiversity. • Patients with traumatic brain injury. • Patients under the age of 18 years. • Patients subject to a deprivation of liberty authorization. • A patient with a particular health condition which could lead to collapse / medical emergency. • Patients with a health condition that can lead to sudden life-threatening incidents / medical emergency.
Responsible Member of Staff (RMS)	The person designated with overall responsibility for a ward or department at that time.
CCTV	Closed circuit television

<table>
<tr><td>Incident Co-ordinator</td><td>The person designated to co-ordinate the search see table below.
<table>
<tr><td>During normal working hours:
08:00 -17:00 hrs. Monday to Friday</td><td>Line manager e.g. Matron or unit bleep holder</td></tr>
<tr><td>Out Of Hours:
17:00hrs – 20:00hrs
20:00hrs - 02:00hrs Monday to Friday Bank Holidays and Weekends</td><td>Senor Nurse on call
Patient Flow Team Mobile:
07799337721</td></tr>
<tr><td>After 02:00hrs - 08:00 hours</td><td>Night Site Co-ordinator / Night Nurse Practitioners</td></tr>
</table></td></tr>
</table>

4. Key Responsibilities/Duties

Safeguarding Adult Boards (Staffordshire, Derbyshire and Derby City Local Authorities)	Safeguarding Adult Boards are required to lead adult safeguarding arrangements across its locality and oversee and coordinate the effectiveness of the safeguarding work of its member and partner agencies. The Trust is required, as a partner agency, to attend the Board and its sub- groups; participate in the work of the Board to achieve its aims and submit the findings of the Safeguarding Adult Assurance processes to the relevant forum at the SAB
Integrated Care Board (ICB) Derby and Derbyshire ICB and Staffordshire and Stoke on Trent ICB	The ICBs monitor Trust performance in safeguarding in regular meetings with the Trust.
Executive Chief Nurse	The Executive Lead is accountable to the Trust Board for all matters related to safeguarding.
The Head of Safeguarding & Vulnerable People Team	The Head of Safeguarding & Vulnerable People Team is responsible for alerting the Trust Safeguarding Group and Vulnerable People Group and Lead Executive Officer to any concerns or shortfalls in safeguarding practice within the Trust, advising with regard to the impact of relevant policy, enquiries or legislation, development or review of Safeguarding Adult training and Trust Policy and Procedures for Safeguarding Adults. The Trust Safeguarding Lead is also responsible for advice and support offered by the safeguarding team to staff and teams within the Trust.
Trust Safeguarding Group and Trust Vulnerable People	These groups meet quarterly and oversees that national developments regarding safeguarding adults are incorporated into Trust policies and processes. They also receive reports and monitor

Group	the implementation of adult safeguarding & vulnerable people processes throughout the Trust, agree assurance reports to the Trust Quality Assurance Committee and assist with compilation of evidence necessary to ensure compliance for registration with the Care Quality Commission and other external assurance processes.
DNDs and Divisional Business Units	Will ensure that this policy is disseminated across the Division and that staff are aware of this policy and that incidents of patients going missing are effectively reviewed in line with this policy
Incident Coordinator (Matron / patient flow)	The person designated to co-ordinate the search of the wider Trust, in collaboration with security staff and Porters, organizing any searches in a systematic way. An incident/search control room will be established on the ward/department from which the patient went missing. Other departments/professionals may be called upon to provide intelligence, equipment, and expertise in conducting the search. The Incident Coordinator is responsible for being the central point of contact and maintaining communications with the relevant ward / department, senior management within the Division and the Trust, including the Head of Communications and PR and the Chief Nurse and external agencies. In hours this will be a Matron and out of hours see this will be patient flow.
The Responsible Member of Staff (Ward / Departmental Managers)	The Responsible Member of Staff will ensure that the immediate search is co-coordinated, Missing Patient Checklist and Action Plan is completed, and that all communication and information is directed to the Incident coordinator. Initially, it is the responsibility of the Responsible Member of Staff to initiate and co-ordinate the local level search, then to hand the co-coordinating function over to the Incident Coordinator, if the initial search fails to locate the patient. They are responsible for ensuring staff know what is expected of them regarding handling incidents and provides feedback to staff following incidents.
Senior Manager on Call (Out of Hours)	Lead and co-ordinate the activities of the hospital, resolving, where possible, problems that arise according to Trust Policies, procedures, and guidance. Record incidents that occur out of hours and liaise with the incident coordinator as required
Security Advisor & Security Officers	The Security Advisor is responsible for maintaining a safe and secure environment within the Trust so that the highest possible standards of clinical care can be made available, working with Trust health and safety and NHS Security Management Services. The role of security staff is to support the search as directed by the incident coordinator and to provide escort to nursing staff if the missing patient is considered to be a risk to others. Security staff will help the search team and will be responsible for gaining access to locked areas and stairwells. CCTV images, where available, may be used. They will follow Trust policies and procedures detailed in the Trust Security Officer's Operational Manual.
Porters	Porters will be informed of a missing patient via the switchboard. All available Porters will be issued with a description of the patient and will undertake a search of the site. If the patient is sighted, they will report back to switchboard who will inform the ward.

Employees	All employees have a duty to familiarize themselves with, and follow, this policy and take responsibility for their own safety and that of their colleagues, patients, and visitors as part of their duty of care. Once it becomes apparent that a patient is missing, all employees have a responsibility for reporting incidents, and to assist in the search of the immediate area.
Patient Advice and Liaison Service (PALS)	It is good practice (during daytime hours) to inform PALS, of any patient reported missing on any site. This would be for information only, to increase their awareness, rather than for their assistance.
Estates Department	The Estates department becomes involved where a whole search of the hospital/building/grounds is required. The Estates department will provide access to high-risk areas, e.g., roof, plant rooms, and ducts.

5. Implementation of the Policy for Missing Patients

5.1 Missing Patient - Assessment and Process (see below and Appendix 1)

i) Firstly - The responsible member of staff (RMS) should identify if the missing patient is identified as vulnerable.

If any one of the statements below apply to the patient, they are classed as vulnerable.

- Patients sectioned under the Mental Health Act / awaiting assessment for mental health concerns or under a Deprivation of Liberty Authorization (DoL)
- A patient that has been assessed as lacking mental capacity.
- Patient being treated under a Clinicians 'Duty of Care.'
- Patient with self-harming behavior / suicidal ideation.
- Patients with confusion / cognitive deficits / dementia / Learning disability or neurodiversity / suspected or confirmed delirium.
- Patients with traumatic brain injury leading to challenging behavior, impulsivity, or confusion.
- Patients under the age of 18 years.
- Patients are subject to a deprivation of liberty authorization.
- A patient with a particular health condition which could lead to sudden collapse / medical emergency.
- Patients who have a social worker (whether a child or adult)

ii) **Secondly - The RMS must decide if it is appropriate to implement the policy** i.e., is the patient missing?

The patient is to be considered missing if the following applies.	**The patient <u>is not</u> missing if the following apply**.
• A patient has left the ward or department without notifying staff and there has been no contact or agreement made with staff regarding their leaving. • The patient fails to return within 15 minutes of the agreed leave period and there is no adequate contact or agreement made with staff. • In the case of vulnerable people, the term missing should be applied as soon as their absence is noted.	• a patient's whereabouts is known, *and* • they are not identified as a vulnerable person *and* • there is no immediate risk to him/herself or others, *but* • they are refusing to return (or their parents / carers are refusing to bring them back to hospital)
Action! If any one factor above is identified - Implement the missing patient policy	**Action!** Options that should be considered include contacting the patient, friends / family, advising to go to a walk-in centre or GP (e.g., to remove cannula))

iii) Thirdly you must consider if there is a genuine, real and immediate risk of serious harm to the patient or others ie

- an individual is at a real and immediate threat of death or serious harm, or it is assessed the individual has been subjected to at least serious harm.
- A real risk is one that is present and continuing.
- The risk does not have to be a probability, but the risk must be substantial.
- The risk must relate to death, serious harm, or some other form of degrading or inhumane treatment - such as being subjected to a sexual offence.

You should consider the following;

- Is there a real and immediate risk to life or serious harm to the patient or others?
- Is it an imminent medical emergency where life or serious harm may be a realistic concern?
- Is a child or other at risk of significant harm?
- Is the person suspected to have a mental health problem - is the threat to life originating from within the mental health condition?
- Has a crime been committed / threatened?

If the answer is yes to any of the above **but** whereabouts are unknown:	If the patient's **whereabouts are known** (ie the patient is not missing) but the above factors apply	If the patient's whereabouts are known (i.e., not missing) and none of the factors apply.

Action! Call the police on 999	Action! Call ambulance services **and** police on 999	Action! Advise to go to GP / walk-in centre or return to ED

5.2 Concern re hospital walk-out.

- Police **do not** have the power to bring patients back to a health care facility against their will **unless** they are under arrest (i.e., have committed a crime) or have been placed under section 136 of the Mental Health Act.
- However, both health agencies and the police have a duty to protect vulnerable individuals from an immediate and specific threat to their life or threat of serious injury.
- Both health and the police have a duty to protect a person from torture, inhuman or degrading treatment or punishment. Consequently, where a patient is vulnerable and likely to suffer a prolonged period of exacerbated pain or distress, both agencies have a duty to search for the missing person.
- The concerns and situation must be a genuine emergency – i.e., that an individual is at a real and immediate threat or has been subjected to risk of death or serious harm.

If the patient is vulnerable, at a real and immediate threat or has been subjected to risk of death or serious harm and <u>location is known</u>, Action! Ring 999 and ask for ambulance service. If the expected response time is greater than 30minutes then you must also ring 999 and report to the police.	If the patient is vulnerable, at a real and immediate threat or has been subjected to risk of death or serious harm and the patient's whereabouts <u>are not known.</u> Action! Ring 999 and report to police	**If there is no real and immediate risk to life or serious harm** family or friends can be contacted and relay advice for the patient to go to GP walk-in centre or return to ED/MIU

5.1 Search Process

Immediately it becomes apparent that a patient is missing, department staff must initiate a search of their own and adjacent areas. Staff should commence the Missing Person Checklist (see appendix 2).

If the patient at risk is not located within 10 minutes, staff must report to the Incident Co-ordinator and contact Security staff. In the case of Sir Robert Peel and Samuel Johnson Community Hospitals contact the Porters to assist in the search within the hospital grounds.

Security staff/ Porters at this stage will require a brief description of the patient including name and age if known. Security/Porters will attend the area to obtain a copy of the Missing Person Checklist (with appropriate details completed). The CCTV Controller must be informed by Security/Porters staff and the system monitored until the search is completed / abandoned.

To contact the Security Team: -

Royal Derby Hospital (RDH) Site

- Extension number 85900 - 24 hours or Bleep Security Team on 1332

- Security Team Leaders – Mobile Tel No. 07799337791

London Road Community Hospital (LRCH) Site

- Extension number 4087 – 24 hours or Bleep Security on 2222
- Security Team Leaders – Mobile Tel No. 07799337790

Queens Hospital Burton (QHB) Site

- Security – Extension number 5662 - 24 hours or Bleep Security Team on 360/384
  Mobile: #6464 also available on radio (walkie -talkie)
- Porters extension: 5400 – 24 hours

Samuel Johnson Community Hospital (SJCH) Site

- Porters extension 3035/3031

Sir Robert Peel (SRP) Site

- Porters extension 8391 – 24 hours

5.2 Actions and Timescales

Security will undertake a thorough search of indoor and outdoor areas. This will include locked areas and fire escapes. If the patient is not located the search will extend into all other indoor areas followed by all outside areas, grounds, subways beneath buildings and secured buildings.

Porters will be contacted via radio by the Security staff and given details of the patient to ensure the widest possible search is maintained.

If after searching for up to a MAXIMUM of 20 minutes the patient is not located, the Incident Co-Ordinator will contact the family / next of kin to enquire whether location of patient is known and inform the police or ambulance according to decision tree at page; the General Manager during office hours or the on- call Senior Manager for the Trust at other times.

Security staff will continue searching until the General Manager/ Senior Manager on- Call agrees to downturn the search.

The Incident Co-ordinator is responsible for maintaining communications with the relevant ward I department, and senior management within the Divisions and the Trust, including the Head of Communications and PR, and the Executive on Call. PALS may also be asked to support or liaise with relatives.

Should the period of duty end before the patient is located, staff going off duty MUST ensure on-coming staff are fully briefed regarding the incident. The Incident co-ordinator should advise relevant staff / departments of whom they are handing over the role to (and document on the bottom of the Missing Person Checklist).

5.3 De-escalation & conclusion of incident.

If the patient is located/ returns to the area, staff must ensure the Incident coordinator and Security staff, and all relevant personnel are notified. If the patient's family has been contacted during the incident, it is important that the de-escalation is communicated to them.

The staff will assess any injuries and ask for the medical doctor on call to assess if necessary.

The incident must be documented in full within the medical/nursing records and the missing person's checklist is to be filed within the health records. An Incident Record Form (IR1) must be completed by a responsible member of staff as soon as practical.

Security Officers must complete the station diary and complete a full report of the incident to include details of areas searched including times.

5.4 The Patient's Mental Capacity and Clinical Holding / restraint

The issue of mental capacity issue relates to a single point in time and to a specific decision. Individual patients cannot simply be described as "lacking capacity" - an assessment, proximate in time to the incident or matter to be decided must be undertaken. A patient's capacity may fluctuate from time to time (Refer to Trust Policy for MCA)

The Mental Capacity Act allows reasonable restraint and restrictions to be used if they are in a person's best interests.

Prior to restraining / restricting the patient to return to the ward staff must;

- Take reasonable steps to establish whether the individual lacks capacity in relation to the matter in question.
- Must reasonably believe that the person being cared for or treated lacks capacity in relation to the matter and needs to be returned to the ward.
- Must reasonably believe that clinical holding is necessary to prevent harm to the person or others who lacks capacity to return to the ward.

Restriction and restraint must be a proportionate response to the likelihood and seriousness of harm and the person carrying out the act of restriction / restraint must be trained and competent to do so.

Security staff can only be asked to restrain or forcibly bring a patient back to the ED if is reasonably believed that they lack capacity or if it is felt the patient is mentally ill and requires a mental health act assessment. In an emergency where there has been no chance to assess the patient's capacity but there is a significant risk of harm, a patient may be restrained and brought back to the area effectively under common law.

Monitoring Compliance and Effectiveness

The key requirements will be monitored in a composite report presented on the Trust's Monitoring Report Template:

Monitoring Requirement:	Review of missing patient / person episodes by divisional monitoring of datix to ascertain whether the process / policy was carried out appropriately - including use of checklist
Monitoring Method:	Audit, & incident analysis,
Report Prepared by:	Divisions
Monitoring Report presented to:	Trust Safeguarding Group
Frequency of Report	Quarterly

6. Equality and Diversity

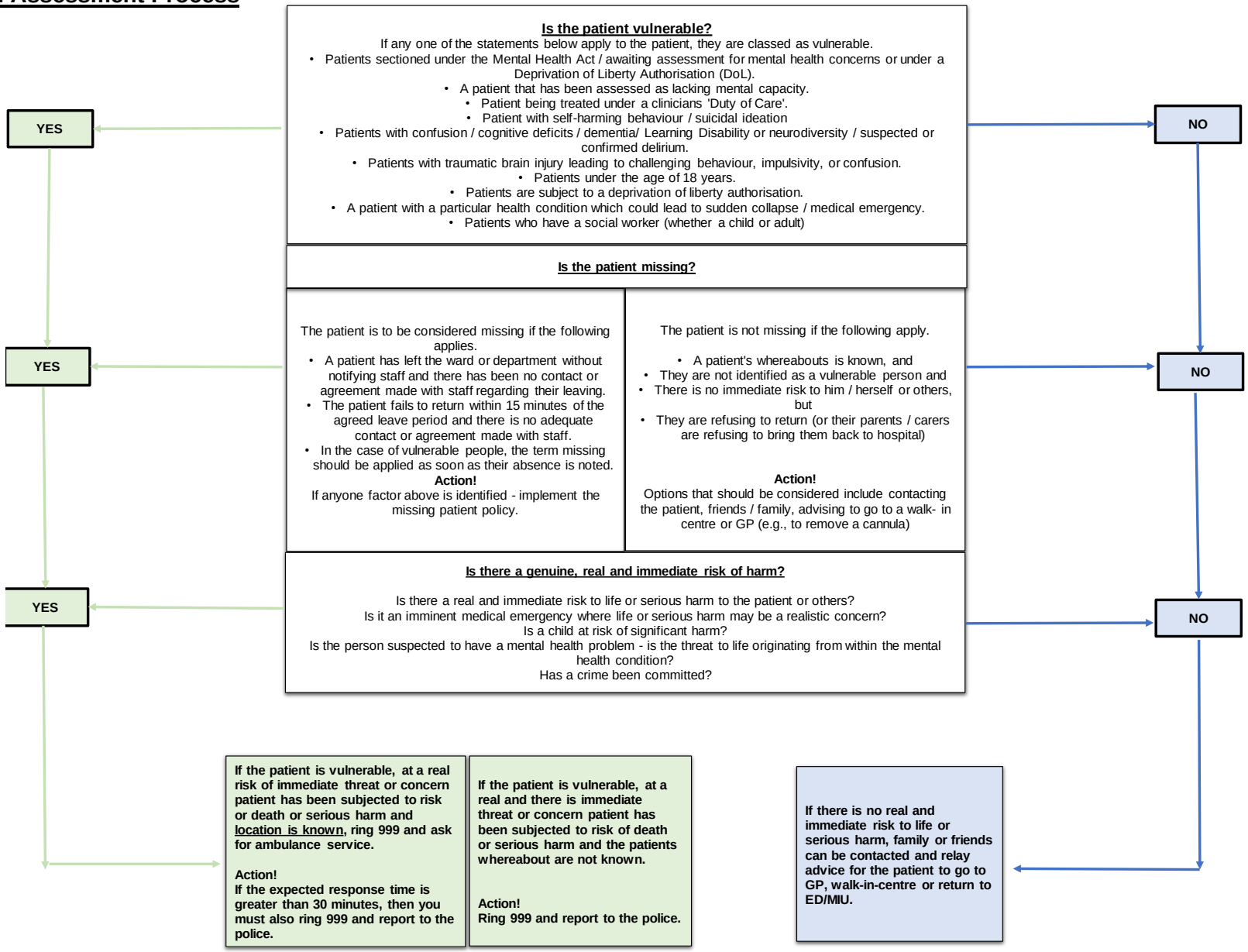
The Trust recognises the diversity of the local community and those in its employ. Our aim is, therefore, to

provide a safe and secure environment free from discrimination and a place where all individuals are treated fairly, with dignity and appropriately to their needs. The Trust recognises that equality impacts on all aspects of its day-to-day operations and has produced an Equality Policy Statement to reflect this. All policies are assessed in accordance with the Equality initial screening tool kit, the results for which are monitored centrally.

7. References

National Partnership Agreement: Right care, right person (Home Office and Department of Health and Social Care July 2023)
Mental Capacity Act 2005
Mental Health Act 1983

Appendix 1: Assessment Process



Appendix 2 – Missing Patient Checklist and Action Plan

University Hospitals of Derby and Burton NHS Foundation Trust

MISSING PATIENT CHECKLIST AND ACTION PLAN

Once it becomes apparent that a patient is missing the person in charge of the department should organise a search of the immediate area. If the patient is NOT located during this search this form should be completed and the Line Manager contacted.

DETAILS OF THE MISSING PERSON

Site: **Department/Ward**:

Name:

Address:

Alternative Address (if applicable):

Description

Sex: **Age:** **Height:** **Build:** **Hair:**

Eyes:

Last seen wearing:

Date & Time last seen: **By Whom:**

Risk Assessment.	
Is the patient:	
• Patients sectioned under the Mental Health Act / awaiting assessment for mental health concerns or under a Deprivation of Liberty Authorization (DoL)	**Yes / No**
• A patient that has been assessed as lacking mental capacity.	**Yes / No**
• Patient being treated under a Clinicians 'Duty of Care.'	**Yes / No**
• Patient with self-harming behavior / suicidal ideation.	**No /Yes**
• Patients with confusion / cognitive deficits / dementia / Learning disability or neurodiversity / suspected or confirmed delirium.	**Yes / No**
	Yes / No

• Patients with traumatic brain injury leading to challenging behavior, impulsivity, or confusion. • Patients under the age of 18 years (also consider under-born if woman pregnant). • Patients are subject to a deprivation of liberty authorization. • A patient with a particular health condition which could lead to sudden collapse / medical emergency. • Patients who have a social worker (whether a child or adult)	**Yes / No** **Yes / No** **Yes / No** **Yes / No** **Yes / No** **Yes / No** **Yes / No** (Any answer in the left hand column – patient must be identified as vulnerable person at risk of harm)
Any other relevant details **If English is not the 1st language – please state first language**	
Search of ward / surrounding area instigated by _____	**Yes / No**
Time designated as "Missing" and process implemented	
Security Team contacted by_____. Contact_____	**Time**

Designated Incident Coordinator **Name** **Title**	**Contact Number** **Bleep** **Mobile Telephone**
Form to be given to Incident Coordinator, who will contact & cascade as detailed below	**Name of person contacted / Date & Time Informed**
CCTV Controller	
PALS	
Relatives / Significant others	

Directorate Manager (within normal hours) **Senior Manager on Call (Out of Hours)**	
Medical Team responsible for patients care	
Communication with Directorate & Trust Senior Team **Associate Director** **Executive on Call** **Head of Communications and PR**	
Inform Police via switchboard	
Social Services / Care Team / Safeguarding Team (if appropriate)	
Patient Returned to Unit / Found. **Relatives / Significant others** **Security** **Police** **PALS** **Directorate / Senior Managers** **Directorate / Trust Senior Team** **Ward / Department Manager** **Social Services / Safeguarding Team**	**Please advise the individuals to de-escalate the incident**
Complete Datix IR1 and necessary documentation.	**Report Number_____.**
Additional Information:	

Appendix 3 – Missing Persons Reporting to the Police SBARD prompt sheet

S	**SITUATION** • Give **your Name, Designation** and **where you are based** e.g. ward • **Name of patient you are calling about? (have full details available to provide demographics and a description)** • **You are calling to report a MISSING PERSON**

B	**BACKGROUND**
	• **Date and time patient last seen**
	• **Efforts taken to make contact / establish whereabouts. Including**
	  ○ **Hospital / security search**
	  ○ **Attempts to contact patient direct and via relatives / friends**
	  ○ **If patient whereabouts known, the patient is not missing; contact primary care or ambulance to return patient if requires care in an acute**

A	**ASSESSMENT** **An individual is at a real and immediate threat of death or serious harm, or it is assessed the individual has been subjected to at least serious harm. (A real risk is one that is present and continuing. The risk does not have to be a probability, but the risk must be substantial.)** **The risk must relate to death, serious harm, or some other form of degrading or inhumane treatment - such as being subjected to a sexual offence.** **You should consider the following;** **Is there a real and immediate risk to life or serious harm to the patient or others?** **Is it an imminent medical emergency where life or serious harm may be a realistic concern?** **Is a child or other at risk of significant harm?** **Is the person suspected to have a mental health / cognition problem - is the threat to life originating from within the mental health / lack of capacity condition?** **Has a crime been committed / threatened?**
R	**RECOMMENDATION** • **Clearly state that you are reporting a MISSING PERSON who is VULNERABLE or at RISK to THEMSELVES and /or OTHERS and you require a police response**
D	**DECISION** • **Gain incident number and decision from the police risk assessment** • **Call ambulance if required.** • **If ambulance response is estimated to be longer than 30minutes - call police again.**

Appendix 4 - REPORTING A MISSING PATIENT TO THE POLICE

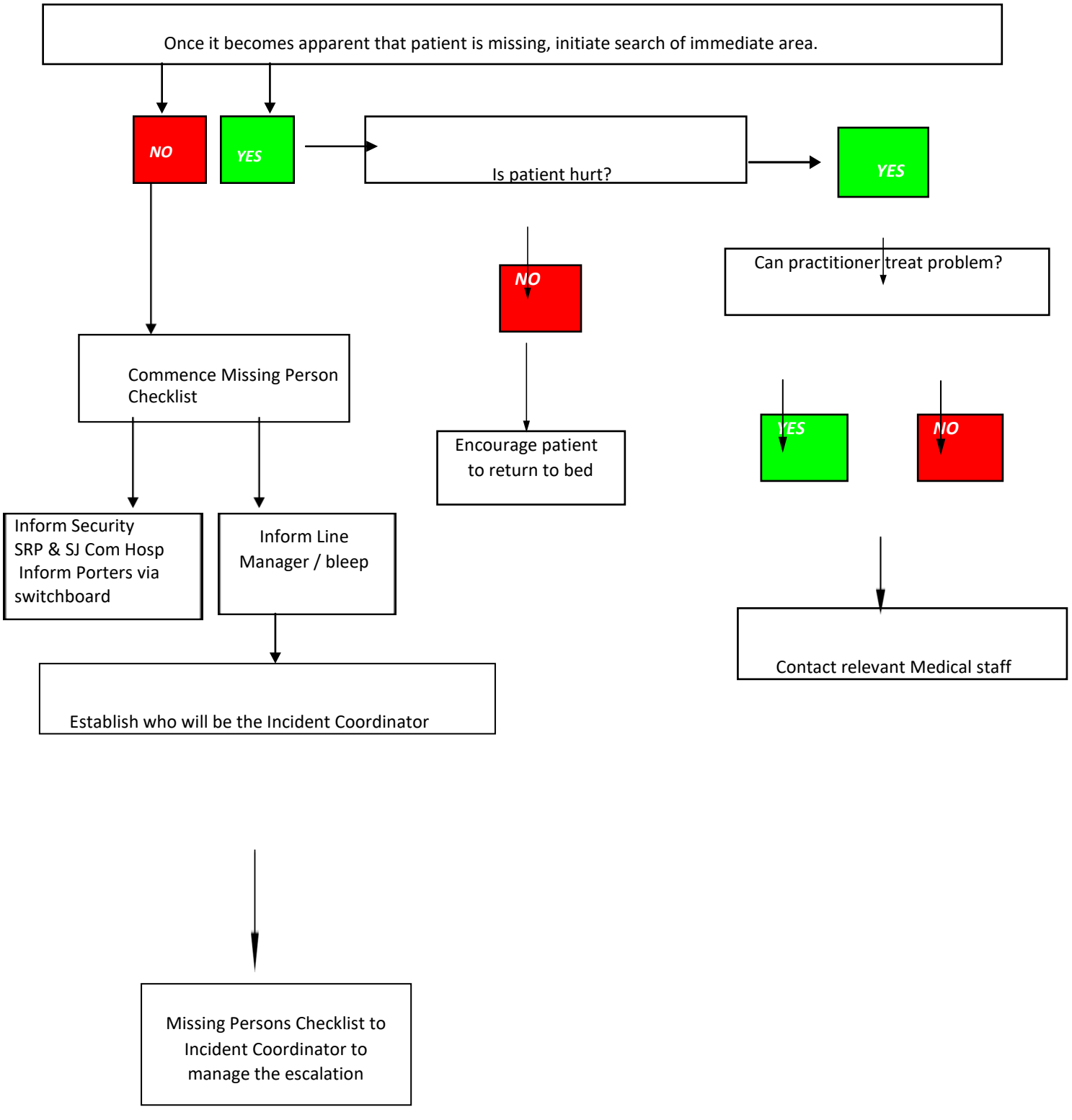
		ID Label	Initial	Tick	Date & Time
S	**SITUATION**	• **You are calling to report a MISSING PERSON** • **Name of patient you are calling about? (have full details available to provide demographics and a description)** • **Description Given:** _____ _____ _____			
B	**BACKGROUND**	• **Date and time patient last seen** _____ • **Efforts taken to make contact / establish whereabouts. Including** ○ **Hospital / security search** ○ **Attempts to contact patient direct and via relatives / friends** ○ **If patient whereabouts known contact primary care / ambulance call to return patient** _____ _____ _____ _____ _____ _____ _____ _____ _____			
A	**ASSESSMENT** **(As per Trust Policy for Missing Patients)**	**Detail immediate & real threat of serious harm to patient or others.**			

R	**RECOMMENDATION**	**Report detail of risk assessment above**			
D	**DECISION**	**Incident Number given by Police:_____** **Police Call Handler detail_____** **If calling ambulance note time of estimated arrival to address_____** **If longer than 30 minutes - notify police again** **Incident Number given by Police:_____**			

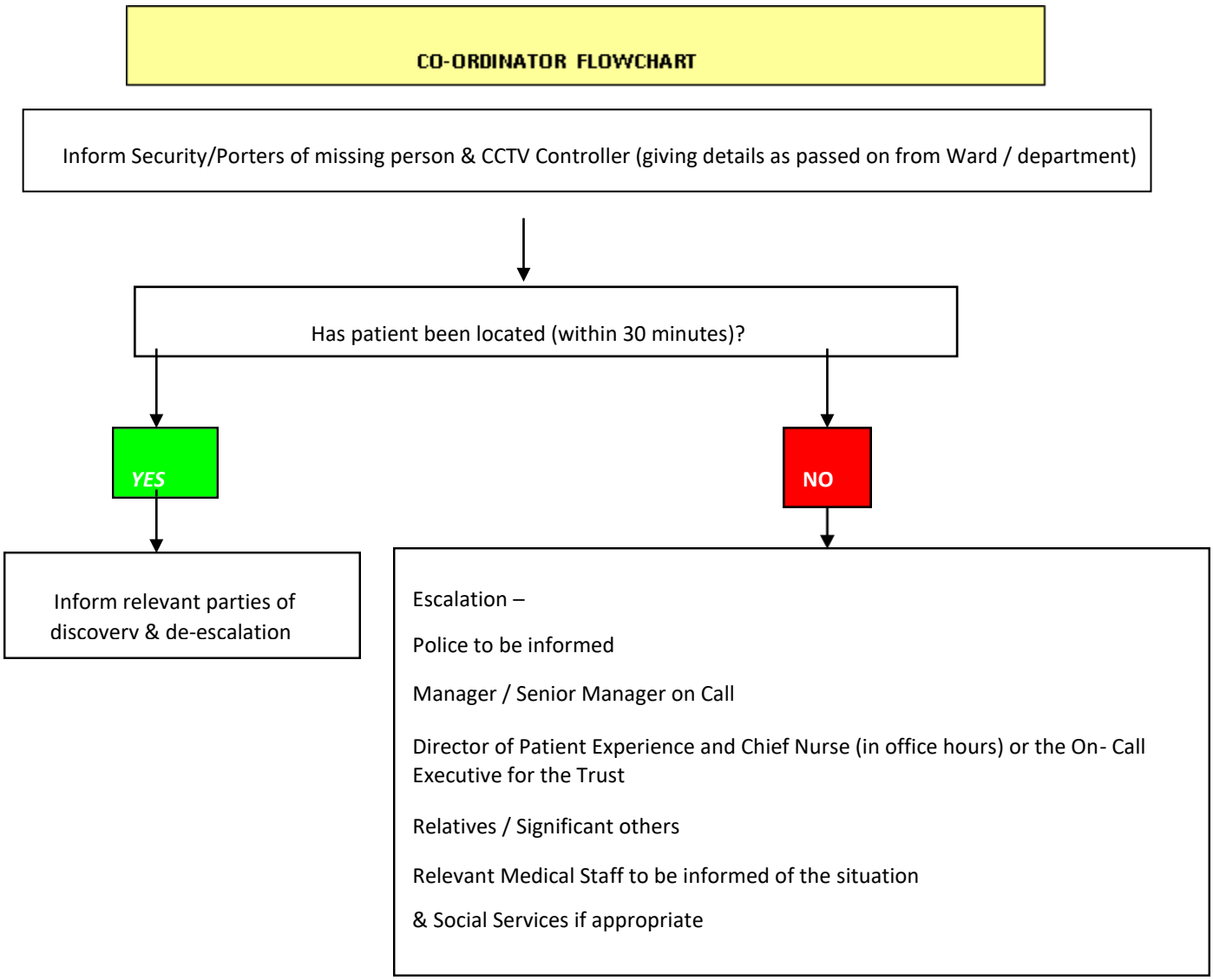
Signature and Designation: _____

Date & Time of Completion: ____/_____/_____ _____:_____

Appendix 4 – Ward/ department search and initiation of missing patient policy



Appendix 5 – Co-ordinator Flowchart



If co-ordinator reaches the end of their shift without the patient being located, they must hand over to another co-ordinator. Details to be completed at the bottom of the Missing Person Checklist and relevant departments / people informed of change of co-ordinator