Missing persons’ policy and procedures
including Section 18 Mental Health Act 1983 - Retaking of patients liable to be detained, subject to guardianship or subject to SCT and who are Absent Without Leave (AWOL)

Lead executive | Medical Director - Compliance, Quality & Assurance
Authors details | Mental Health Act Team Manager - Safe Services Department

Type of document | Policy
Target audience | All clinical staff
Document purpose | To provide staff with relevant policy and procedures with regard to the safe return of those detained individuals who are absent without leave (AWOL).

Approving meeting | Patient Safety and Effectiveness Sub Committee 19-Jun-15
Implementation date | 19-Jun-15 followed by an annual compliance review

CWP documents to be read in conjunction with
- MH7
- GR1
- MH17
- CP5
- GR38
- CP10
- CP40
- GR12
- CP17

Leaves of absence for inpatients including patients detained under the Mental Health Act
Incident reporting, management and review policy
Conveying of mentally disordered persons
Clinical risk assessment policy
Health records policy
Safeguarding adults policy
Safeguarding children’s policy
Media policy
Guidelines for best practice following the unexpected death of a service user

Document change history
What is different? | The policy has been brought into line with the new MHA Code of Practice 2015. It also has amendments to the risk assessment and clarifies when the police will become involved in the missing person procedure.
Appendices / electronic forms | The appendix has been amended to add further checks to the action/notification checklist
What is the impact of change? | Action required will be determined by individual risk
Training requirements | No - Training requirements for this policy are in accordance with the CWP Training Needs Analysis (TNA) with Learning and Development (L&D)
Financial resource implications | None

External references
1. Mental Health Act, 1983, as amended by the Mental Health Act 2007
2. Mental Health Act Code of Practice 2015
3. Reference Guide to the Mental Health Act 2015
<table>
<thead>
<tr>
<th>Equality Impact Assessment (EIA) - Initial assessment</th>
<th>Yes/No</th>
<th>Comments</th>
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<tbody>
<tr>
<td>Does this document affect one group less or more favourably than another on the basis of:</td>
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<tr>
<td>- Race</td>
<td>No</td>
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<td>- Ethnic origins (including gypsies and travellers)</td>
<td>No</td>
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<td>- Nationality</td>
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<td>- Gender</td>
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<td>- Culture</td>
<td>No</td>
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<tr>
<td>- Religion or belief</td>
<td>No</td>
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<tr>
<td>- Sexual orientation including lesbian, gay and bisexual people</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>- Age</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>- Disability - learning disabilities, physical disability, sensory impairment and mental health problems</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Is there any evidence that some groups are affected differently?</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>If you have identified potential discrimination, are there any exceptions valid, legal and/or justifiable?</td>
<td>N/A</td>
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<tr>
<td>Is the impact of the document likely to be negative?</td>
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<tr>
<td>- If so can the impact be avoided?</td>
<td>No</td>
<td>N/A</td>
</tr>
<tr>
<td>- What alternatives are there to achieving the document without the impact?</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>- Can we reduce the impact by taking different action?</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

Where an adverse or negative impact on equality group(s) has been identified during the initial screening process a full EIA assessment should be conducted.

If you have identified a potential discriminatory impact of this procedural document, please refer it to the human resource department together with any suggestions as to the action required to avoid / reduce this impact. For advice in respect of answering the above questions, please contact the human resource department.

| Was a full impact assessment required? | No     |
| What is the level of impact?          | Low    |
Content

Quick reference flowchart showing route of action when person identified as missing from hospital...4

Quick reference flowchart for the National notification of missing persons.................................5

1. Introduction........................................................................................................................................6
2. Procedure...........................................................................................................................................6
3. Risk assessment..................................................................................................................................6
4. What should be done when a patient absents themselves from an inpatient setting? ........6
4.1 Action to be taken...........................................................................................................................7
   Table 1 - Health Risk Assessment Guide..........................................................................................7
   Table 2 - Datix category guide .........................................................................................................8
5. Procedure for Informing the Police of a Missing Person.................................................................8
6. Delayed Notification to the Police (detained patients) .................................................................8
7. National notification / alert of missing patients.............................................................................9
8. Care Quality Commission (CQC) notification ..............................................................................9
9. Procedure for Location and Return of Missing Patient ..............................................................9
10. Timescales for re-taking AWOL patients.....................................................................................10
10.1 Restricted patients .......................................................................................................................10
11. What should be done when a missing person is involved in a Serious Untoward Incident? ......10
12. AWOL Patient located out of area, within England ....................................................................10
13. AWOL Patients who have left the United Kingdom ....................................................................10
14. AWOL patients who have been located within the United Kingdom - Wales, Scotland, Northern
    Ireland, Isle of Man and the Channel Islands ....................................................................................10
15. Actions to be taken when AWOL patients return to the ward?................................................11
16. Timescales for the Return of unrestricted patients liable to be detained or subject to
    Guardianship or subject to SCT .................................................................................................11

Appendix 1 – Actions taken / notification checklist ........................................................................12
Quick reference flowchart showing route of action when person identified as missing from hospital

Service user identified as missing

Assess level of risk

**LOW RISK**
Table 1
- Conduct search of ward/hospital grounds. Contact care co-ordinator and family **Note 4.1**
- Inform bleep holder/modern matron. Inform MHA Team if detained. Complete missing persons’ form.
- No Police Action

**MEDIUM RISK**
Table 1
- Conduct search of ward/hospital grounds. Contact care co-ordinator and family **Note 4.1**
- Inform bleep holder/modern matron. Inform MHA Team if detained. Out of hours - inform Tier 2 on call. Complete missing persons’ form. Commissioners to be informed, if applicable.
- Inform Police

**HIGH RISK**
Table 1
- Conduct search of ward/hospital grounds. Contact care co-ordinator and family **Note 4.1**
- Inform bleep holder/modern matron and MHA Team if detained. Out of hours - inform Tier 2 on call. Complete missing persons’ form. Commissioners to be informed, if applicable.
- Inform Police & Ministry of Justice if restricted

If service user detained under MHA in a low secure unit and AWOL after midnight CQC notification to be completed.

Nurse in charge of ward to complete Datix **Note 4.1**

**Service user is found**

- Police/Bleep holder/modern matron to be informed immediately
- MHA Team/Ministry of Justice to be informed if applicable
- Approved Clinician to be informed and a review of care plan undertaken immediately
- Relatives/care coordinator to be informed
- Commissioners to be informed
- Care plan and risk history to be updated
Quick reference flowchart for the National notification of missing persons

**National notification of missing persons**

**Alert into Trust**

- Missing person alert reported from external agencies into the Trust

  - Communications distribute missing person details to relevant disciplines:
    - MHA Team
    - Crisis Teams
    - Liaison Psychiatry
    - Community Mental Health Teams
    - Modern Matrons

**Alert out of Trust**

- Trust staff to report missing person to locality Modern Matron / Clinical Support Manager / General Manager

  - MM/CSM/GM to liaise with police and family. Prior to a national alert being agreed the police must rate the patient as HIGH risk and agreement should be sought from the patient’s family

  - Communications Team to receive permission from the Trust’s Caldicott Guardian prior to national notification of missing person

  - Communications Team to assist the police with details of the national alert

- Police to issue national alert

**Name of CWP Caldicott Guardian:**
Dr Faouzi Alam
Medical Director & Caldicott Guardian
Trust Board Offices
Liverpool Road
Chester
CH2 1BQ

In the absence of the Caldicott Guardian staff must contact either the Head of Clinical Governance, or The Health Records Manager
1. **Introduction**

CWP has a duty to ensure the safety of all patients within its care, and seeks to put in place systems that are based on best practice, and in accordance with Mental Health Act legislation.

This policy aims to support staff in following set procedure whenever a patient is considered as ‘missing’. The circumstances will be:

- An informal inpatient has left the hospital without agreement of staff;
- An informal inpatient has not returned to the hospital at the agreed time or according to the leave plan;
- A detained patient has left hospital without authority of the responsible clinician;
- A patient who is liable to be detained has not returned from section 17 leave of absence at the agreed date / time according to the leave plan;
- A patient subject to a Community Treatment Order who has failed to respond to an effective formal recall notice from the responsible clinician;
- A patient subject to a Community Treatment Order who has absconded from the hospital where s/he has been recalled;
- A patient subject to Guardianship is absent without leave from place of residence;
- A person in the community in receipt of Aftercare under Section 117 Mental Health Act 1983 who has disengaged from services and is missing from usual place of residence.

Section 18 of the Mental Health Act 1983, as amended by the Mental Health Act 2007, provides specific powers for retaking detained patients who are absent without leave or who fail to return from leave, either at the end of leave or when recalled. It also applies to patients subject to Guardianship who are absent without leave from their place of residence, and patients subject to a Community Treatment Order (CTO) who have failed to attend hospital when recalled, or absconded following recall.

2. **Procedure**

This procedure re-iterates some key points of the Mental Health Act, 1983. It is essential that this procedure is read in conjunction with the Mental Health Act Code of Practice (and where necessary the Mental Health Act itself) as it is statutory guidance and provides detail not contained in this document.

For further guidance on the recording and sharing of information with regard to vulnerable adults, children and young people, refer to safeguarding adult’s policy and safeguarding children policy.

3. **Risk assessment**

All patients are subject to continual assessment including assessment of risk, as per the clinical risk assessment policy, and as such, the decision regarding risk should be made prior to a period of leave being agreed. Ideally, the decision should be made with the service user and/or their carer.

4. **What should be done when a patient absents themselves from an inpatient setting?**

Section 28.15 of the Code of Practice, Mental Health Act, 1983, (2015) only requires the police to be notified immediately if a patient who is missing is:

- Considered to be particularly vulnerable
- Considered to be dangerous AND/OR
- Subject to restrictions under Part 3 of the Act

There are also other cases where, although police assistance may not be required, a service user's history may make it desirable to inform the police that they are AWOL.

To manage the risks associated with patients who are absent without leave, the missing person’s procedure must be followed as outlined in the flow chart. The actions taken must be recorded as a clinical noted headed ‘Missing Person’ on CareNotes. The incident must be reported on the Trust Datix system as detailed in the table below – for further guidance refer to the incident reporting and management policy.
4.1 Action to be taken

The Trust is responsible for the welfare of patients in their care, and is therefore responsible for locating and returning a patient. When it is noticed that the patient is absent, ward staff must initially ascertain the level of risk as this will determine the action to be taken. If the risk is so serious and immediate and police resources are required, the police must be contacted immediately.

In all cases when an in-patient is absent the following action must be taken, using the checklist in appendix 1 as guidance:

- Staff to determine the level of risk/concern (see Table 1);
- Ward staff to inform the Responsible Clinician, modern matron, bleep holder, Commissioners (if applicable) and the Ministry of Justice if a restricted patient;
- Ward staff to conduct all reasonable enquiries and searches. This will include a search of all rooms on the ward, a search of the hospital building and grounds. Enquiries are to be made of staff and other patients on the ward (ensuring minimum information is given in order not to break confidentiality);
- Ward staff to make enquiries with relatives / carers / friends / care co-ordinator and other agencies involved (ensuring minimum information is given in order not to break confidentiality);
- Ward staff to telephone or text message the patient’s home phone or mobile phone if known;
- Where applicable discussion should take place between the ward and the community mental health team / crisis team / home treatment team / early intervention team / CAMHS to arrange a check of the patient’s home;
- Ward staff must report the incident via the Trust Datix system. For further guidance refer to Table 2 below and the Trust incident reporting and management policy.

For CTO patients who have been recalled and failed to attend hospital the community team in charge of the patient’s care must try to locate the patient during working hours. This may include contacting relatives and carers (ensuring minimum information is given in order not to break confidentiality). If the patient remains absent out of hours, the Emergency Duty Team must also be informed. The level of risk will be determined by the most recent care plan and this will determine whether or not police assistance is required.

Table 1 - Health Risk Assessment Guide

<table>
<thead>
<tr>
<th>LOW RISK</th>
<th>EXAMPLES</th>
</tr>
</thead>
<tbody>
<tr>
<td>DEFINITION</td>
<td></td>
</tr>
</tbody>
</table>
| There is no apparent risk that the individual may be exposed to significant harm OR There is no apparent risk that the individual poses a risk of significant harm to another person | - The individual is able to live independently without support.  
- The individual is able to interact safely within an unknown environment  
- The individual does not pose a risk of violence and has no history of self-harming  
- The whereabouts of the individual are known |

<table>
<thead>
<tr>
<th>MEDIUM RISK</th>
<th>EXAMPLES</th>
</tr>
</thead>
<tbody>
<tr>
<td>DEFINITION</td>
<td></td>
</tr>
</tbody>
</table>
| There is an apparent risk that the individual may be exposed to significant harm OR There is an apparent risk that the individual poses a risk of significant harm to another person | - An individual goes missing who is unable to interact safely within an unknown environment  
- The individual who is severely depressed with a history of self-harm who has gone missing but there are no grounds to believe they are imminently about to attempt suicide or cause serious self-harm.  
- The individual who has a history of moderate violence and whose behaviour is unpredictable.  
- The individual is at risk as a consequence of the effects of medication and poor physical health.  
- The individual is subject to the Mental Health Act. |
HIGH RISK

DEFINITION

It is suspected that the individual has
been the victim of a serious crime
OR
The risk posed is immediate and
there are substantial grounds for
believing that the individual may suffer
death or serious injury
OR
The risk posed is immediate and
there are substantial grounds for
believing that the individual may
cause death or serious injury to
another

EXAMPLES

- The individual has express plans/intent to commit
  suicide.
- The individual has expressed intent to cause serious
  self-harm.
- The individual has plans/intent to cause death-serious
  injury to another person.
- The individual is aged between 13 – 18 years.
- The individual is subject to the Mental Health Act,
  including restrictions and Community Treatment Order.

Table 2 - Datix category guide

<table>
<thead>
<tr>
<th>Risk Category</th>
<th>Category of incident</th>
</tr>
</thead>
<tbody>
<tr>
<td>High Risk</td>
<td>Report as Category B – an investigation proportionate to the incident will be required to be undertaken. See GR1 Incident reporting and management policy for guidance.</td>
</tr>
<tr>
<td>Medium Risk</td>
<td>Report as Category C – review regularly dependent on changing clinical risk</td>
</tr>
<tr>
<td>Low Risk</td>
<td>Report as Category D – review regularly dependent on changing clinical risk</td>
</tr>
</tbody>
</table>

5. **Procedure for Informing the Police of a Missing Person**

Ward staff will contact Cheshire / Merseyside Police giving as much detail as possible regarding the patient. The information should be clear and include:

- Personal details (e.g.: address, relative details, and contact numbers);
- Risk category;
- Type of risk;
- Mental state when last seen;
- Time limits for returning the patient into custody.

An incident number will be given and this, together with details of the incident, should be documented by ward staff as a clinical note on CareNotes.

**NB:** for service users detained on low secure units further detailed information is provided to Cheshire/Merseyside police on admission.

If the person is still liable to be detained and is required to return to the hospital, the responsibility for returning the patient rests with the hospital. Dependent on risk, police assistance can be requested, in which case the person may be returned to the hospital by police transport. However, the police may request ambulance or hospital transport to affect the return, if appropriate.

Where the police provide transport and/or escort a patient to hospital, handcuffs **should not** be used as a matter of routine, but may be used if the officer/s determines that circumstances make such use justifiable.

6. **Delayed Notification to the Police (detained patients)**

If a detained patient is absent from the ward and is assessed as low/medium risk consideration may be given to delaying notification to the police for a period of up to **48 hours** from the time they were reported as absent. This may be in the following circumstances:

A patient is late returning from an agreed period of Section 17 leave and there is no information available to suggest grounds for concern;
A patient who has absconded from the ward, whose risks and presentation are well known but there is no significant concern for the immediate period following their absence.

However, if concern exists, or the patient is unknown with regards to risks, presentation and vulnerability, then a delayed notification to the police is not considered appropriate.

7. National notification / alert of missing patients
If, following completion of the risk assessment, and in liaison with the Trust’s Caldicott Guardian, it is deemed that a national alert is a proportionate response in establishing the whereabouts of a missing patient; the flowchart at the beginning of this policy should be followed. This flowchart also shows how alerts from outside agencies will be distributed within the Trust.

8. Care Quality Commission (CQC) notification
For patients detained under the Mental Health Act, 1983, in a low secure unit, and who are AWOL after midnight on the first day of their absence a notification must be submitted to the Care Quality Commission. The notification will be submitted by the Mental Health Act Team, following completion by the nurse-in-charge of the ward/Ward Manager.

9. Procedure for Location and Return of Missing Patient
Following completion of all checks, as described above under Action to be Taken, if the whereabouts of the patient is known then every effort should be made by the ward and/or community team to arrange for the patient’s return. This should be done when it is considered that there is no immediate risk to the patient, staff or members of the public. If the patient is unwilling to return, or there are identified risks, then the police should be contacted to assist in their return. If the patient is informal the police cannot usually compel a patient to return, however vulnerability and perceived risk will be taken into account and police powers under the Police and Criminal Evidence Act (PACE) may be used.

Section 18 of the Mental Health Act, 1983, clarifies the circumstances when patients are considered to be absent without leave (AWOL), in particular when they:

- Have left the hospital in which they are detained without leave being agreed (under 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 community treatment order (CTO) (community patients) 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

Code of Practice Chapter 28.3
10. Timescales for re-taking AWOL patients

<table>
<thead>
<tr>
<th>SECTION</th>
<th>TIMESCALE</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Section 5(4) &lt;br&gt; - Section 5(2) &lt;br&gt; - Section 4 &lt;br&gt; - Section 2 &lt;br&gt; - Section 135 &lt;br&gt; - Section 136</td>
<td>May be taken into custody anytime up to the expiry of the section</td>
</tr>
<tr>
<td>- Section 3 or 37, 47, 48 (unrestricted) &lt;br&gt; - Section 7 (Guardianship) &lt;br&gt; - Community Treatment Order (CTO) - patients who have failed to attend hospital following recall</td>
<td>May be taken into custody anytime up to six months from the date which s/he absconded from hospital/place of residence, or the expiry of the section, whichever is the later</td>
</tr>
<tr>
<td>- Section 35, 36, 38</td>
<td>There are no time limits to re-taking an AWOL patient</td>
</tr>
<tr>
<td>- Patients subject to a restriction order, limited direction order or restriction direction</td>
<td>May be taken into custody anytime until the order ceases to have effect</td>
</tr>
</tbody>
</table>

10.1 Restricted patients
If the patient is subject to a restriction order the following people must be contacted:
- Cheshire & Merseyside Police Contact: Dial 101: this will put you through to the appropriate location;
- Ministry of Justice: Contact 020 3334 3555 (MoJ main contact telephone number);
- Relevant Commissioners must be informed as soon as possible the next working day.

11. What should be done when a missing person is involved in a Serious Untoward Incident?
Following the occurrence of a serious untoward incident, immediate action should be taken to ensure that service users, staff and the public are safe. This must be captured on the incident form within Datix (DIF2) within 72 hours of the date of reporting the incident (DIF1).

For further guidance, refer to the incident reporting and management policy. This includes consideration of implementing the staff support process, regardless of the outcome.

12. AWOL Patient located out of area, within England
The Managers of the detaining hospital are responsible for arranging return of the patient. Police officers from the appropriate authority will not be expected to travel outside area for this purpose. However, due to risks identified, if the Managers of the hospital wish to make out a case for the involvement of police officers, they should liaise with an officer of at least the rank of Inspector.

If arrangements for the return of the patient cannot be made that day, the local mental health services for the area the patient is located in should be contacted. Written authority from the detaining hospital will be faxed, authorising that authority to take the patient ‘into custody’ under section 18 until arrangements for the patient’s return can be made.

13. AWOL Patients who have left the United Kingdom
There is no power under the Mental Health Act to return patients who have left the United Kingdom.

14. AWOL patients who have been located within the United Kingdom - Wales, Scotland, Northern Ireland, Isle of Man and the Channel Islands
Special provisions apply for patients who have been located, or who have been detained under a corresponding or similar provision, within the United Kingdom.
15. **Actions to be taken when AWOL patients return to the ward?**

- If the patient has returned to the ward without assistance the ward staff must inform the police immediately.
- If the patient has been returned by the police, any incidents or issues arising from the patient’s absence will be reported to ward staff.
- Ward staff must inform relatives/carers/professionals/commissioners/ Ministry of Justice and Mental Health Act Team of the patient’s return.
- If required the CQC notification is to be completed informing the CQC of the patient’s return.
- Ward staff must document the patient’s return as a clinical note on CareNotes.
- A review of the patient’s care plan must be undertaken, to include re-assessment of risk factors and the potential for further absconding from the ward, and planned interventions to reduce this risk.

Recording of observations must commence on return to the ward to monitor the patient’s mental and physical health – refer to the physical health pathway and policy and therapeutic observation policy for in-patients for further guidance.

16. **Timescales for the Return of unrestricted patients liable to be detained or subject to Guardianship or subject to SCT**

<table>
<thead>
<tr>
<th>Return before 28 days of being AWOL</th>
<th>Return after 28 days of being AWOL</th>
</tr>
</thead>
</table>
| Section has not expired or not due to expire | Responsible Clinician must examine the patient within 7 days of return:  
Section has not expired or not due to expire  
Section has expired or is due to expire |
| Status remains and no form completion required  
Deadline for completing renewal form is extended for one week from date of return | RC to complete relevant form to confirm continued detention/CTO/Guardianship is necessary  
RC to complete relevant form which will automatically renew the section from the date it would have expired. |

Further guidance on the timeframe for the return of unrestricted patients liable to be detained can be found in Chapter 11 of the Reference Guide to the Mental Health Act, 1983, 2015 edition.
Appendix 1 – Actions taken / notification checklist

This checklist is an aide memoire to assist staff in following the processes required when a patient is declared missing. All actions taken should be recorded in the patient’s record; therefore this form does not need to be retained once these actions have been documented in the patient’s record.

<table>
<thead>
<tr>
<th>No</th>
<th>Notifications</th>
<th>When Missing (initials)</th>
<th>When Returned (initials)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Search of person’s room, ward and adjacent areas</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Search of hospital grounds/buildings etc</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Attempt to contact missing person by phone, if applicable</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Clinical Service Manager (CSM) / Modern Matron (days)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>2&lt;sup&gt;nd&lt;/sup&gt; tier (on call) by Bleepholder (out of hours)</td>
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<tr>
<td></td>
<td>If patient is detained under the Mental Health Act and subject to a restriction (e.g. Sec 37/41 or 49) the 2&lt;sup&gt;nd&lt;/sup&gt; tier on call (West &amp; Wirral), Ward Manager/Nurse in Charge (East) MUST inform the relevant Commissioners. Ward manager/nurse in charge to inform Ministry of Justice as soon as possible the next working day.</td>
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<tr>
<td>6</td>
<td>Responsible Clinician/approved clinician in charge (within hours)</td>
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<tr>
<td>7</td>
<td>Next of Kin/ Nearest Relative</td>
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<tr>
<td>8</td>
<td>Police (Cheshire &amp; Merseyside) - Dial 101 and ask for local area</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Switchboard</td>
<td></td>
<td></td>
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<tr>
<td>10</td>
<td>Security / Porters / CCTV</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>Community Mental Health team (if appropriate)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>Accident and Emergency (A&amp;E)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>General Practitioner (GP)</td>
<td></td>
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<tr>
<td>14</td>
<td>Social Services (if appropriate)</td>
<td></td>
<td></td>
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<tr>
<td>15</td>
<td>Mental Health Act Team (if appropriate)</td>
<td></td>
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<tr>
<td>16</td>
<td>Complete Datix form</td>
<td></td>
<td></td>
</tr>
<tr>
<td>17</td>
<td>Other (if appropriate)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Patient returned to ward</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Date: Time:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Signed: Position