

**DETAINED PATIENTS
 ABSENT WITHOUT LEAVE POLICY**

This policy relates specifically to mental health staff in the Partnership. It does not relate to staff working in a community healthcare in-patient setting. The policy is compliant with current legislation and best practice guidance in mental health care.

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Applies to:	All registered nursing staff on inpatient wards All registered medical staff working on inpatient wards Senior/on-call managers Non registered staff for information only

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DOCUMENT CONTROL

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Amendments Explanation of the difference between AWOL and absconding whilst in custody. Slight changes to process of working with police. New guidance about S135 (2). To ensure that that this policy links in with CTO policy and S.17 leave policy and procedures. New CQC reporting process. Addition of legal requirements when an AWOL patient returns after more than 28 days absent. 3 new appendices.			
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1. INTRODUCTION

- 1.1 The term 'absent without leave' (AWOL) has a very specific meaning, and must never be applied to describe any situation involving a patient who is not subject to The Mental Health Act.
- 1.2 **This policy explains the differences between 'absent without leave' and 'absconded from custody', and describes the procedures to be followed by staff when it becomes necessary to return a patient who is liable to detention to hospital.**

2. PURPOSE & RATIONALE

- 2.1 A) To inform hospital staff what action to take when a detained patient is absent without leave from the hospital where they are liable to be detained.
B) To inform staff what action to take when a patient has absconded from custody
- 2.2 All staff caring for detained patients should be familiar with the procedures detailed in this document. This policy relates specifically to mental health staff in the Partnership. It does not relate to staff working in a community healthcare in-patient setting. The policy is compliant with current legislation and best practice guidance in mental health care.

3. DUTIES AND RESPONSIBILITIES

- 3.1 The **Trust Board** has a duty to care for patients detained by the Trust, which extends to those patients absent without leave from the Trust.
- 3.2 The **Director of Governance and Corporate Development** is responsible for this policy covering Detained Patient's Absent Without Leave within the Trust, but will delegate authority for the operational implementation and ongoing management of this policy to the **Mental Health Act Coordination Lead**
- 3.3 The **Nurse in Charge of the shift** is responsible for advising the Mental Health Act Administrators when a patient becomes AWOL.
- 3.4 Each **registered healthcare professional** is accountable for his/her own practice and will be aware of their legal and professional responsibilities relating to their competence and work within the Code of practice of their professional body.
- 3.5 **All staff** caring for detained patients should be familiar with the procedures detailed in the document and other related policies.
- 3.6 **Line managers** are responsible for ensuring all staff are conversant with this policy and related policies.
- 3.7 The **Head of Clinical Governance and Risk** is responsible for reporting Serious Incidents to the Strategic Executive Information System (see section 14 of this policy and the Serious Incidents Requiring Investigation (SIRI)

Policy).

COMMITTEES AND GROUPS WITH OVERARCHING RESPONSIBILITY

- 3.8 **The Mental Health Legislation Committee** will be the group responsible for the continued development of this policy and will identify and disseminate organisational learning during the monitoring of AWOL incidents reported on DATIX.
- 3.9 The **Clinical Governance Group** will be responsible for approving any changes to this policy and ensuring updates are compliant with the requirements of National Guidance, CQC and NHSLA Risk Management Standards.

4. DEFINITIONS

- **RC** – Responsible Clinician
- **Patient**- person subject to The Mental Health Act
- **Nearest Relative** – As defined in section 26 of the MHA '83
- **Part III Restrictions** – Usually Section 41 Ministry of Justice restrictions
- **RiO** - Electronic Patient Record
- **AMHP** - Approved Mental Health Professional

- 4.2 Under section 18 of the Mental Health Act, patients are considered to be AWOL in various circumstances, in particular when they:
- have left the hospital in which they are detained without leave being agreed (under section 17 of the Act) by their responsible clinician
 - have failed to return to the hospital at the time required to do so under the conditions of leave under section 17
 - are absent without permission from a place where they are required to reside as a condition of leave under section 17
 - have failed to return to the hospital if their leave under section 17 has been revoked
 - are patients on a 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.

- 4.3 The Act distinguishes between people who are absent without leave (AWOL) and those who have 'absconded' in other circumstances. Patients in the situations described in 4.2 above are 'AWOL'. In some situations, patients may 'abscond' and be 'at large' rather than 'AWOL'. This is because it is possible for patients to be in 'custody' under The Mental Health Act, but for there to be no means of granting 'leave'. Patients may abscond from custody when they are:

- being transferred between hospitals under S.19
- being transferred to detention in hospital in England or Wales from Scotland, Northern Ireland, the Isle of Man or any of the Channel Islands; or
- subject to hospital orders or hospital directions and who are being detained in a place of safety pending admission to the hospital specified in the order or direction, or while being taken from court to that place of safety or from it to the relevant hospital
- being conveyed to hospital on the basis of an application for admission for assessment or treatment under section 2 or 3
- being conveyed to hospital on the basis of an emergency application under section 4
- detained in a place of safety under section 135 or 136
- being conveyed in England or Wales en route to Scotland, Northern Ireland, the Isle of Man or any of the Channel Islands, in accordance with a transfer warrant
- being conveyed in England or Wales en route from detention in Scotland or Northern Ireland, in accordance with a transfer warrant (or its equivalent), or from the Isle of Man under section 84, but yet to arrive at the hospital to which they are to be admitted
- being conveyed from the Isle of Man or any of the Channel Islands, in accordance with a transfer under section 85, but yet to arrive at the hospital to which they are to be admitted
- on escorted leave (although such a patient becomes AWOL if they remain 'at large' beyond the time they were required to return to hospital, or if the RC revokes their leave)

4.4 The rules about retaking patients who have absconded and who are not AWOL can be quite complicated, but in most cases the patient is treated as if they are AWOL. For example, a patient who absconds whilst being transferred between two hospitals under S19 is treated as being AWOL from both hospitals. For detailed guidance about all these rules see Appendix A.

4.5 The decision to report a patient missing, or to recall a patient from leave, will be based purely on the patient's legal status or clinical needs/risk and not because of their race, religion, age, gender, sexuality, belief or disability.

5. PROCEDURE WHEN A DETAINED PATIENT ABSENTS THEMSELVES FROM A HOSPITAL (Inpatient Ward)

5.1 Once it becomes evident a detained patient is missing (in the case of the low secure unit the correct wording is 'has escaped' rather than 'is missing'), the following actions should be undertaken:

- The nurse in charge should inform the RC or, if outside normal working hours and it is appropriate to inform them, the duty RC. The nurse in charge should use their discretion and only inform the duty RC if there is a significant perceived risk to the patient or others and/or the duty RC is likely to be of assistance in helping return the patient to hospital.
- If outside 9am to 5pm, or at weekends/bank holidays the nurse in charge

should ensure that the RC with on-going overall responsibility for the patient's care is informed as soon as possible in the next working day, particularly if the patient is still missing.

- The nurse in charge should ensure all staff in the building are informed and initiate a comprehensive search of the building and grounds
- If appropriate, other patients on the ward should be asked whether they are aware of the missing patient's whereabouts, when they last saw the patient and if anything was said to indicate where she or he might have gone
- Staff involved in the search should sign and record the time of their inspections when they have searched the areas/buildings allocated to them.
- A record of all communication including a list of all persons contacted (including times) should be recorded as a progress note within RiO/the patient's healthcare record and again updated when further contact is made.

5.2 When there is an identified risk, the Nurse in Charge should use their discretion in informing the Service manager, or On Call manager.

5.3 If appropriate, and on the basis of an assessment of risk to the patient and/or others, addresses where the patient might go (usually family or friends) should be contacted by telephone to see whether the patient is there, or to alert them to the possibility of the patient arriving.

5.4 If not covered by 5.3 (above), where the patient has been missing for more than 2 hours, the nurse in charge should, unless doing so is likely to cause distress to the patient or put them at risk, inform the patient's nearest relative that the patient is absent without leave. This can be done by telephone, but if the nearest relative cannot be contacted by phone, the nurse in charge should request that the care coordinator or member of the appropriate community mental health team contact them.

5.5 If the patient has a care coordinator or probation officer, the nurse in charge should inform them the patient is missing.

5.6 The nurse in charge should inform the patient's GP.

5.7 Where the patient is considered to be, or has a history of being, vulnerable and/or, dangerous or where they are subject to restrictions under Part III of the Act, the police should be informed.. 'The police' here includes the British Transport Police. The police should be given sufficient detail to allow them to identify the individual and be told what the time limit is for taking them into custody.

5.8 The police will (where appropriate and in line with the Data Protection Act) share any information they have about the patient's vulnerability or any risks they are known to pose to others.

- 5.9 If staff visit the patient, the patient grants access and agrees to return, a decision about appropriate transport should be made. If staff have any doubts at all about their ability to manage any risks, then they should call for an ambulance, or for police assistance if that is deemed necessary.
- 5.10 If refused access by a third party to a property where an AWOL patient is believed to be, it may be sufficient in gaining access to the patient to remind the third party that they may be committing an offence by knowingly harbouring the patient (Section 128(3) MHA: “ Where any person knowingly harbours a patient who is absent without leave or is otherwise at large and liable to be retaken under this Act or gives him any assistance with intent to prevent, hinder or interfere with his being taken into custody or returned to the hospital or other place where he ought to be he shall be guilty of an offence.”)
- 5.11 If the whereabouts of the patient are known, and the patient refuses to return, then consideration should be given to the need for applying for a warrant under section 135(2). See Appendix B for details.
- 5.12 If the patient returns to the ward, the nurse in charge should re-contact all those contacted when the patient was missing to inform them of their safe return. If the patient returns during the night, without difficulty, the on-call manager may be informed the following morning.

6. PROCEDURE WHEN A DETAINED PATIENT FAILS TO RETURN FROM LEAVE

- 6.1 Should the patient fail to appear on the ward at the agreed time, the nurse in charge should inform the patient’s RC, who should decide, on the basis of risk to health and/or the safety of self or others, whether further time should be allowed for the patient to return.
- 6.2 Outside normal working hours, the nurse in charge should use their discretion and only inform the duty RC if there is a significant perceived risk to the patient or others and/or the duty RC is likely to be of assistance in helping return the patient to hospital. If the duty RC is not contacted, the nurse in charge should immediately follow the procedures 6.3 – 6.11 (below).
- 6.3 If outside normal working hours the nurse in charge should ensure that the RC with on-going overall responsibility for the patient’s care is informed as soon as possible in the next working day, particularly if the patient has still not returned to the ward.
- 6.4 The nurse in charge should ensure that efforts are made to establish the whereabouts of the patient, initially by contacting by phone the address where the patient was living as a condition of leave
- 6.5 If contact can be made with the patient, effort should be made to persuade them to return to the hospital with the time of arrival being no later than that agreed with the RC beforehand.
- 6.6 If no contact can be made with the patient, or if the patient refuses to return

after contact has been made, or if they do not return by the new agreed time, the RC should be informed immediately and, again on the basis of risk, decide what delay, if any, is acceptable in returning the patient to hospital.

- 6.7 If appropriate, and on the basis of perceived risk, sufficient hospital staff should be made available to visit the patient in the community to return him or her to hospital. The service manager (or on call manager) should be contacted to help facilitate this process.
- 6.8 At this stage then follow 5.7-5.12 above

7. PROCEDURE WHEN A DETAINED PATIENT ABSCONDS FROM ESCORTED S.17 LEAVE.

- 7.1 The patient's escort should immediately inform the nurse in charge or ward manager that the patient has absconded, either by telephone or face to face if the patient has absconded soon after leaving the hospital building.
- 7.2 The nurse in charge should immediately inform the patient's RC (if outside normal working hours this would be the duty RC, who should only be informed if there are significant concerns and/or the duty RC can be of assistance in returning the patient to hospital). If the nurse in charge has immediate and significant concerns for the welfare of the patient or others, and cannot immediately make contact with the patient's RC, steps 7.4 – 7.10 (below) should be initiated while attempts to contact the patient's RC continue.
- 7.3 When there is an identified risk, the Nurse in Charge should use their discretion in informing the Service manager, or On Call manager at an appropriate hour.
- 7.4 Where the patient is considered to be vulnerable, dangerous or where they are subject to restrictions under Part III of the Act, the police should be informed. The police should also be informed if the patient has a history of vulnerability or dangerousness. The police should be given sufficient detail to allow them to identify the individual and be told what the time limit is for taking them into custody (see 5.7 and 5.8 above).
- 7.5 The nurse in charge should ensure that efforts are made to establish the whereabouts of the patient, initially by contacting by phone the address where the patient was living before being admitted to hospital.
- 7.6 Follow steps 5.3-5.12 above.

8. PROCEDURE WHEN THE RC DECIDES TO RECALL A PATIENT SUBJECT TO S.17 LEAVE

- 8.1 A patient subject to Section 17 Leave can be recalled at any time if the Responsible Clinician believes it necessary in the interest of the patient's health or safety or for the protection of other people.
- 8.2 The Responsible Clinician is obliged to provide written notification to the patient of their recall. It is at the Responsible Clinician's discretion whether advance notice is given or whether the written notification is provided at the time

attempts are made to return the patient (see Appendix C for template letter).

- 8.3 In emergency circumstances, when the patient's Responsible Clinician has stated the patient needs to be returned to hospital but there has not been time to furnish written notification to that effect, the patient should be asked to return. If he /she refuses to return, they should be treated as AWOL.
- 8.4 Full reasons for recall should be explained to the patient and a record of the explanation placed in the patient's notes.
- 8.5 An RC's notification of recall does not provide any power of entry to any place where the patient is. If entry is denied, it may be necessary to apply for a warrant under S135 (2) of the MHA. See Appendix B

9. PATIENTS SUBJECT TO A CTO WHO ARE AWOL

- 9.1 A CTO patient who has failed to attend at the place required when recalled (see CTO policy for details of recall process) is AWOL.
- 9.2 A CTO patient who has returned to hospital after being recalled, and who then absconds before a decision is made about whether or not to revoke the CTO is AWOL.
- 9.3 In either of these circumstances, follow the procedure described in 5.3-5.12 above

10. TIME LIMITS APPLICABLE TO RETURNING PATIENTS LIABLE TO BE DETAINED

- 10.1 No patient can be returned to hospital beyond the date when the period of them being liable to be detained has expired, unless they are subject to section 3 when they can be returned at any time within 6 months beginning with the date of them being absent or the end of their current period of detention if longer.
- 10.2 Restricted patients can be returned at any time.
- 10.3 See Appendix A for full details

11. RECORDING AWOLs

- 11.1 The nurse in charge must **record on RiO** all incidents of when the patient is AWOL. This is done through accessing the bed-list, selecting leave then AWOL.
- 11.2 The record should contain details of the incident of AWOL, together with any **lessons learnt** which might inform the better resolution of any future incidents of the patient being AWOL.
- 11.3 Ash Ward, because is designated as low security is required to notify CQC of any unauthorised absence of a person detained or liable to be detained under the Mental Health Act 1983, and of the return of persons from unauthorised absences. No other ward is required to notify CQC about unauthorised absences.

- 11.4 Absences are notified using part 1 of the form accessed via the CQC website- see link below. Returns from absences are notified using part 2 of the form. Part 2s can be submitted separately from Part 1s where that is needed:

[Click here to access form on CQC website](#)

- 11.5 In February 2016 CQC announced that it intends to replace the form above with an online system called the 'provider portal'. The Trust will work with CQC to implement this new system.

12 PROCEDURE WHEN AN AWOL PATIENT RETURNS OR IS RETURNED

- 12.1 Anyone who has been notified of a patient's AWOL status should be informed when the patient is found or returned. This is especially important where the people/agencies who have been informed are actively looking for the patient. The Code of Practice states: "Where the police have been informed about a missing patient, they should be told immediately if the patient is found or returns." (para 28.18)
- 12.2 It is good practice when a patient returns after a substantial period of absence without leave always to re-examine the patient to establish whether they still meet the criteria for detention, a CTO or guardianship. The patient's RC should undertake this examination. If the RC does not carry out this examination personally, they should review the conclusions of any examination as soon as possible.
- 12.3 The patient's care plan should be reviewed and updated where necessary to include specific actions which experience suggests should be taken if that patient were to go missing again.

13 PROCEDURE WHEN THE PATIENT RETURNS AFTER BEING AWOL FOR MORE THAN 28 DAYS.

- 13.1 Where patients (other than restricted patients) have been AWOL for more than 28 days, section 21B of the Act requires that the Responsible Clinician (or the nominated medical attendant for a Guardianship patient) must examine the patient within a week of the patient's return and then provide a report that the criteria for continued detention or being subject to a CTO or guardianship are still met. Otherwise, the patient's detention, CTO or guardianship will end automatically.
- 13.2 The report must be recorded on: Form H6 for a patient who is liable to be detained, Form G10 for a patient who is subject to guardianship, or Form CTO8 for a community patient. Completed forms H6 and CTO8 must be sent immediately to the MHA administration team so that an administrator can sign Part 2 on behalf of the hospital managers. Form G10 must be sent to the relevant person within Somerset County Council. Responsible Clinicians/nominated medical attendants should refer to the Somerset County Council Guardianship guidance/policy for details.

14. UNTOWARD EVENT REPORTING

- 14.1 To ensure accurate reporting and effective monitoring, all untoward events including Detained Patients AWOL must be reported using the on-line Datix Untoward Event Reporting form on the Intranet and recorded within the patient's Electronic Record. Immediate actions taken and lessons learned to reduce the risk of similar incidents will be reported locally within the Untoward Events Report form.
- 14.2 Patients who are AWOL who are at serious risk of harming themselves or others will be recorded as a Serious Incident and staff will follow the Serious Incidents Requiring Investigation (SIRI) Policy and Procedure.
- 14.3 The Head of Clinical Governance and Risk will report SIRIs to NHS Somerset and is responsible for reporting to the Strategic Executive Information System (see Serious Incidents Requiring Investigation (SIRI) Policy).

15. TRAINING REQUIREMENTS

- 15.1 The Trust will work towards all staff being appropriately trained in line with the organisation's Mandatory Training Matrix (training needs analysis). All training documents referred to in this policy are accessible to staff within the Learning and Development Section of the Trust Intranet.

16. MONITORING COMPLIANCE AND EFFECTIVENESS

- 16.1 The Clinical Governance Group will audit AWOLs and monitor adherence to the procedural guidelines through incident reports.
- 16.2 The Mental Health Legislation Committee will review assurance of the effectiveness of the policy by monitoring any issues arising from:
- internal audits
 - clinical audits
 - complaints
- 16.3 Audit results will be discussed at the Mental Health Legislation Committee who will identify good practice, any shortfalls, action points and lessons learnt.
- 16.4 Any incidents of serious incidents relating to the Detained Patients AWOL will be monitored by the Clinical Governance Committee.
- 16.5 Any significant failings in compliance will be reported to the Trust Board through the quarterly Quality Report.

17. REFERENCES, ACKNOWLEDGEMENTS AND ASSOCIATED DOCUMENTS

17.1 References

Jones R. 'Mental Health Act Manual – 16th Edition - Sweet & Maxwell 2013
MHA '83 Code of Practice, The Stationery Office 2015

17.2 Cross reference to other procedural documents

Being Open and Duty of Candour Policy

Clinical Assessment and Management of Risk of Harm to self and Others Policy

Community Treatment Order (CTO) policy

Consent & Capacity to Consent to Treatment policy

Integrated Care Planning Approach (ICPA) Policy

Observation Whilst Maintaining Safety and Patient Engagement Policy

Record Keeping and Records Management Policy

Risk Management Policy and Procedure

Scheme of Delegation of Hospital Managers' Functions

Section 17 leave policy

Serious Incidents Requiring Investigation (SIRI) Policy

Untoward Event Reporting Policy

All current policies and procedures are accessible in the policy section of the public website (on the home page, click on 'Policies and Procedures'). Trust Guidance is accessible to staff on the Trust Intranet.

18. APPENDICES

18.1 For the avoidance of any doubt the appendices in this policy are to constitute part of the body of this policy and shall be treated as such.

Appendix A Time limits for retaking patients who are absent without leave or who have absconded from legal custody under the Act [sections 18 and 138]

Appendix B Section 135(2) Procedure- Using a warrant to return a patient to hospital when the patient is AWOL or has absconded from custody.

Appendix C RC letter recalling a patient from Section 17 leave

Time limits for retaking patients who are absent without leave or who have absconded from legal custody under the Act [sections 18 and 138]

A patient who, at the time of absconding, was (or was treated as)	may not be retaken after
liable to be detained on the basis of a nurse's record under section 5(4)	six hours starting at the time the nurse made the record
liable to be detained on the basis of the report of a doctor or an approved clinician under section 5(2)	72 hours starting at the time the doctor or approved clinician furnished the report, or 72 hours starting at the time a nurse made a record under section 5(4) if the patient was held under that power first
being conveyed to hospital on the basis of an application for admission for assessment or treatment under section 2 or 3	14 days starting with the day the patient was last examined by a doctor for the purposes of a medical recommendation in support of the application
being conveyed to hospital on the basis of an emergency application under section 4	24 hours starting at the time the patient was last examined by a doctor for the purposes of the medical recommendation in support of the application
detained on the basis of an emergency application under section 4, where the second medical recommendation has not yet been received	72 hours starting at the time the patient was admitted (or treated as admitted) to the hospital on the basis of the emergency application
detained on the basis of an application for admission for assessment under section 2 (or under section 4, where the second medical recommendation has since been received)	28 days starting with the day the patient was admitted (or treated as admitted) on the basis of the application
detained on the basis of an application for admission for treatment under section 3	the later of: six months starting with the day the patient went absent; or the date on which the authority under which they were detained at the time they went absent is due to expire (ignoring any possibility of it being renewed or replaced by a different authority and any extension allowed because of the patient's absence)
liable to be detained on the basis of an unrestricted hospital order, hospital direction or transfer direction under Part 3	

A patient who, at the time of absconding, was (or was treated as)	may not be retaken after
a CTO patient who had been recalled to hospital	the later of: six months starting with the day the patient went absent; or the date on which the community treatment order is due to expire (ignoring any possibility of it being extended or revoked and any extension allowed because of the patient's absence)
subject to a restriction order, limitation direction or restriction direction (whether or not conditionally discharged)	the restriction order, limitation direction or restriction order ceases to have effect (which may not be until the patient dies)
subject to guardianship on the basis of an application for guardianship under Part 2	the later of: six months starting with the day the patient went absent; or the date on which the authority under which the patient was subject to guardianship at the time the patient went absent is due to expire (ignoring any possibility of it being renewed and any extension allowed because of the patient's absence)
subject to a guardianship order under Part 3	
detained in a place of safety under section 135 or 136	the earlier of: 72 hours from the time the patient absconded; or the end of the period for which the patient may be detained, i.e. 72 hours from the start of the patient's detention in the place of safety
subject to a remand under section 35 or 36 or an interim hospital order under section 38	No time limit is specified. The patient may be arrested by any police officer (or other constable) and, when arrested, must be brought before the court that made the remand or interim hospital order as soon as practicable.
being conveyed in England or Wales en route to Scotland, Northern Ireland, the Isle of Man or any of the Channel Islands, in accordance with a transfer warrant	the end of the period during which the patient could be retaken if no transfer was being attempted. (This is because, until the transfer is complete, they remain subject to detention or guardianship in England)

A patient who, at the time of absconding, was (or was treated as)	may not be retaken after
being conveyed in England or Wales en route from detention in Scotland or Northern Ireland, in accordance with a transfer warrant (or its equivalent), or from the Isle of Man under section 84, but yet to arrive at the hospital to which they are to be admitted	the end of the period during which the patient could be retaken if they had already been admitted to hospital in England or Wales and had then gone AWOL. This will vary depending on the type of application, order(s) or direction(s) to which they would be treated as subject on completion of the transfer
being conveyed from the Isle of Man or any of the Channel Islands, in accordance with a transfer under section 85, but yet to arrive at the hospital to which they are to be admitted	the end of the period during which they could be retaken had they absconded while still in the Isle of Man or the relevant Channel Island

Section 135(2) Procedure- Using a warrant to return a patient to hospital when the patient is AWOL or has absconded from custody.

1. Applying for a warrant and coordinating subsequent actions can be complicated. Following this guidance will help, and another source of help is from the AMHP service. AMHPs will have received training in this area, and will have had experience of applying for and then accompanying police 'executing' warrants. Staff may contact the AMHP service for advice and guidance, but AMHPs will not generally become involved beyond the provision of advice.
2. The S135 (2) warrant is issued if it appears to the justice of the peace on information laid on oath by any constable or any other authorised person, that there is a need to take or retake a patient (liable to be taken or retaken) into custody, and:
 - a. there is reasonable cause to believe the patient is to be found on the premises
 - b. that admission to the premises has been refused or is anticipated
3. This type of warrant, therefore, may be needed to return a patient liable to be detained in a hospital under the Mental Health Act who is absent from a hospital ward without leave and is believed to be in a known property.
4. A Patient subject to section: 2,3,4,35,36,37,38,47 or 48 of The Mental Health Act is absent without leave (AWOL) if she or he:
 - a. Has left the hospital in which they are detained without leave being agreed (under section 17 of the Act) by their responsible clinician
 - b. Has failed to return to the hospital at the time required to do so under the conditions of leave under section 17
 - c. is absent without permission from a place where they are required to reside as a condition of leave under section 17
 - d. has failed to return to the hospital if their leave under section 17 has been revoked (in writing by the RC)
 - e. is on a community treatment order (CTO), and has failed to attend hospital when recalled
 - f. is on a CTO and has absconded from hospital after being recalled there
 - g. is a conditionally discharged restricted patient (37/41 or 47/49) whom the Secretary of State for Justice has recalled to hospital
5. In other words- if the person is already 'on' a section, has gone home (or to another property), needs to be brought back to hospital and is refusing to let anyone in, then a S135(2) warrant would be needed to force entry and bring them back to hospital.

6. Staff attempting to return a detained patient to hospital must first try to be admitted to the patient's home or where he or she is staying, and be refused, or have good reason to expect to be refused admission, before obtaining a warrant.
7. This type of warrant does not apply when there is a need to gain access to a person in order to carry out an assessment, and the person is not already subject to the Mental Health Act. That scenario would require a S135 (1) warrant and only AMHPs may apply for these.
8. Use of the section involves an interference with the patient's private and family life under article 8 of the Human Rights Act. Consequently, entry to the person's home must be a proportionate measure in all the circumstances. With respect to AWOL hospital patients or patients subject to s.137 (patients who have 'absconded' whilst 'in custody' (usually en route to hospital)) requiring further assessment and / or treatment in a hospital who present with risks to self / others, use of s.135 (2) would appear to be proportionate.
9. S.135 (2) warrants are not required if a co-occupier / co-owner will give permission to enter. They are also not required to enter rooms in premises where the occupier has no exclusive right of occupation (e.g. hotels, residential care homes). The owner/manager of such establishments can provide access without a warrant.

Who may apply for a warrant?

10. Warrants may be applied for by:
 - a. **a constable**- it is extremely unlikely that a police officer would ever agree to apply for such a warrant
 - b. **any officer on the staff of the hospital**- this is not defined anywhere, but is likely to mean any qualified member of inpatient staff (including bank and agency staff). It does not include staff who work in community teams- they are 'any other person'- see below,
 - c. **any AMHP**- it is unlikely that an AMHP would apply for a s135 (2) warrant. If they are the patient's care coordinator or care manager they may agree to do so.
 - d. **any person authorised by the hospital managers**- this 'authorisation' power has been delegated to: the patient's responsible clinician, ward managers and duty or on-call managers. Any of these people may authorise a person they think appropriate to apply for a warrant. Such authorisation may be verbal, but should be confirmed using the template provided within this guidance (see p.7).

During 'normal' office hours

11. Obtaining a warrant when a patient is subject to Section 17 leave and has gone AWOL (i.e. has absconded whilst on escorted leave, has failed to return at the required time, or has failed to respond to a notification of recall from their RC), or when a patient absconds during the 72 hour period of a CTO recall- The RC should take overall responsibility for ensuring that the correct procedure is followed. The most senior Registered Mental Health Nurse (RMHN) on duty at the time from the ward from which the patient is AWOL should be the person who applies for a warrant, attends court and follows the procedures outlined below. Where the most senior RMHN on duty is a Band 5 nurse with less than six

months post qualification experience or an agency nurse then the decision to apply for a warrant should be discussed with the on call manager or duty/ward manager at weekends.

12. Obtaining a warrant when a patient has failed to present themselves after being recalled from their CTO- The RC should take overall responsibility for ensuring that the correct procedure is followed, and the patient's care coordinator should be the person who applies for a warrant, attends court and follows the procedures outlined below. If the care coordinator is not immediately available, their manager must allocate a suitable replacement as a matter of urgency.

Out of hours and weekends

13. The ward from which the patient is AWOL will take responsibility for obtaining a warrant for any AWOL patient, and will work jointly with the crisis resolution and home treatment team to plan attendance with the police to execute the warrant.

Planning prior to applying for a warrant

14. Discussion should start immediately with the police about arrangements to 'execute' the warrant should it be granted. All known risks must be shared with the police so that they can decide upon the urgency of their response, and how many officers should attend. Whilst the police's control centre will be the first point of contact, a request should be made to speak with the local shift sergeant, or the duty inspector directly.
15. The discussion with the police should agree how best to execute the warrant safely. Consider the safety of all staff involved, as well as that of the patient. The police will expect to be provided with a written risk assessment. Agree where the 'place of safety' will be should there be a need to remove the patient. This would usually be a hospital based place of safety. The police are extremely unwilling ever to use a police station as a place of safety for S135 (2). Their view is that there should always be enough time for a suitable hospital based place of safety to be found for a S135(2)- even if the patient would be considered too 'risky' to be cared for safely in the 'usual' place of safety. The police will expect us to have made suitable arrangements for an appropriate place of safety to be available that is not a police station. This could, for example and with prior agreement, be a psychiatric intensive care unit, or the ward from which the patient is absent.
16. Prior to the warrant being executed, consideration must be given to securing the premises after entry has been made. The Council's housing department can be very helpful in providing the attendance of a locksmith and/or a carpenter to make the property safe afterwards. A locksmith can also help the police gain entry, and avoid the need for forcing entry. There may also be family members who could help with this respect.
17. The Local Authority may have a responsibility to take reasonable steps to prevent or mitigate the loss of or damage to an adult's 'movable property' (this includes pets). This responsibility sits in Section 47 of The Care Act. A social worker employed by Somerset County Council should be contacted to discuss this.

How is a warrant obtained?

18. The applicant must complete Form MH72 – the written information, which should not be signed until the applicant has sworn the oath. Stocks of these forms should be available on all wards and in some community teams. Provision will be coordinated by the MHA administration team in Yeovil.
19. Work out which Court is the one to contact. Within which jurisdiction is the patient?
 - a. Taunton (Taunton Deane West Somerset): 01823 257084
 - b. Yeovil (South Somerset and Mendip): 01935 426281
 - c. Wells: 01935 426281
20. Ask to speak to someone about arranging for an urgent application before a Justice of The Peace for a warrant under S135 (2) of The Mental Health Act. This will usually be the Legal Advisor (used to be called the Clerk) or a member of their office staff.
21. The Court may request that information is faxed or securely e-mailed to them as soon as possible to help the process.
22. Arrange a time, and check that the court has a stock of the warrant forms (form MH73). These forms consist of differently coloured carbonated copies of the top sheet, and The Partnership Trust does not keep stocks.
23. Courts sometimes charge for the issue of a warrant. Check how much it will cost, and obtain the cash from the petty cash either of the ward, or the community team. It will be about £20 (that is the price in Jan 2016)
24. Out of Court office hours: a Legal Adviser can be contacted out of hours via Avon and Somerset police control 0845 4567000. This should only be done where the application cannot wait until the next working day. If it appears likely during office hours that a warrant may be required please make contact with the Court as soon as possible to make arrangements
25. Attend the court, ensuring you have: the completed Form MH72, your Trust identification badge and the notification of your authorisation if you are 'any other person' and not a member of hospital staff (see 10(d) above).
26. Completing Form MH72: It has a small space for a written statement, which can be extended or attached using a separate sheet, giving the reasons why the person is liable to be retaken, and cover the following:
 - a. Reason for applying for a s135(2) including brief background information
 - b. How urgent it is and why
 - c. Whether the patient has been given notice (to justify Article 8 (2) rights under the HR Act) of the application for a warrant and, if this has not happened, the reasons why.
 - d. The statutory criteria being relied on for the application
 - e. Why a warrant is necessary. Provide any information or evidence relevant to the question of whether a warrant is necessary. This should include details of any attempts already made to gain access or make contact with the patient.

f. Plans for the execution of the warrant.

27. When appearing before the Justice of the Peace, the applicant must swear on oath (or affirm) and give the reasons why the person is liable to be taken or retaken.
28. If the Justice of the Peace decides to issue the warrant he/she signs and keeps MH72 showing acceptance of the information. This is given to the Justice's Clerk.
29. The Justice of the Peace then signs MH73 and this original warrant is given to the applicant to give to the police officer who will execute the warrant by entering the premises.

Once the warrant is obtained

30. Confirm arrangements with the police for their attendance to execute the warrant.
31. It is extremely unlikely that the police will agree to convey the patient to the place of safety. Alternative conveyance arrangements must be made. The ambulance service should be approached first. It can prove difficult to arrange for an ambulance to attend at the same time as the police. The ambulance service will generally not 'pre-plan' any attendance, and is likely to ask to be called again once they are actually needed. This can make the safe management of 'executing' a warrant very difficult. In this situation, discuss options with a senior manager. It may be possible to arrange for a private ambulance to attend at the same time as the police.
32. The Mental Health Act requires only that a 'constable' executes a S135 (2) warrant. The constable 'may' be accompanied by a registered medical practitioner, or by any of the people listed above (see para 10). As a minimum the Trust expects that the person who applied for the warrant attends, or that they arrange for someone else to attend in their place. A doctor should attend if possible. Consider whether it would be appropriate for a family member or carer to attend.
33. When attending the property, ensure that the lone working policy has been followed. Staff should never attempt to do this alone. If the police have not arrived, do not approach the property. Wait for the police to arrive, and call them to find out why there has been a delay.
34. When the police arrive, discuss and agree the best way to proceed- i.e. who should knock on the door and try to talk to the patient. Should the police 'hang back', or should they make their presence obvious? Basically try to make sure that the least amount of force as possible is used. Sometimes people who have been refusing to open the door to health or social care staff will open the door and be very cooperative towards police officers. Each situation needs to be assessed and managed individually.
35. A S135 (2) warrant authorises a constable 'to enter the premises, if need be by force, and remove the patient.' At a suitable point after entry has been gained the police officer must sign the warrant. The first copy (pink) is given to the occupier of the premises or left on the premises. The police should retain the second copy

(green), and the third (yellow) should be placed/scanned on the file in the ward to which the patient is returned.

36. A warrant may only be used once. If, upon entering the property, the patient is not present, the same warrant cannot be used again. A warrant lasts for one month and the top copy MUST be returned, signed by the police, once it has been executed or within one month if it has not been used, to be securely filed at the Magistrates Court.
37. There is no power to stay in the premises and carry out an assessment. It would only be possible to remain within the premises longer than is necessary to 'remove' the patient if the patient grants clear and capacitated consent. Given any such circumstances, however, it is doubtful any consent would be valid, because it would be difficult to show that the patient was free from 'undue pressure'.
38. Once the patient has been removed and conveyed to the place of safety they should be assessed as soon as possible by their responsible clinician (which is the on-call consultant out of hours) to decide a new care plan.

RC letter recalling a patient from Section 17 leave



Dear (*Patient name or name of person in charge of patient during leave*),

As your responsible clinician I have decided that, *in the interests of your health or safety or for the protection of other people* it is necessary that you should return to hospital.

I am therefore revoking your section 17 leave. You must return to *ward name immediately OR by no later than time/date*. If you *refuse to return immediately OR fail to return by this time* you will be absent without leave, and may be returned to the ward by any member of the hospital staff, an approved mental health professional, a police officer or anyone authorised in writing by the hospital managers.

Yours sincerely,
Responsible clinician