Lancashire Constabulary

PERSONS
Finding a Solution

Crime & Disorder Reduction Category

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Missing Persons - Finding a solution

Summary,

The Mental Health Unit (MHU) at Queens Park Hospital regularly reports missing people to Blackburn police. During 1999 there were 156 calls for help from the MHU and for 2000 the number was 148. All of the patients were vulnerable and officers spend vast amounts of time searching for patients.

Analysis revealed that there was a core of patients who repeatedly went 'missing'. Some were reported missing 12 times in a month. Further investigations showed that it was easy for them to leave the unit because there were poor procedures for monitoring patients, poor liaison between the hospital and police and a lack of understanding of police powers under the Mental Health Act.

To try and resolve this situation, an officer was seconded to the hospital for a period of three months with the plan to develop a partnership and to look for long-term solutions. Amongst the decision taken were:

- To improve patient monitoring
- To make the swipe card entry system for access to the wards more effective
- To photograph patients
- To secure the smoking facilities
- To create a `new' MHU missing person form
- To change the working practices around the current MHU section policy
- To **improve police knowledge** and **understanding**
- To improve patient handover
- To provide alternative care
- To regulate and review patient leave

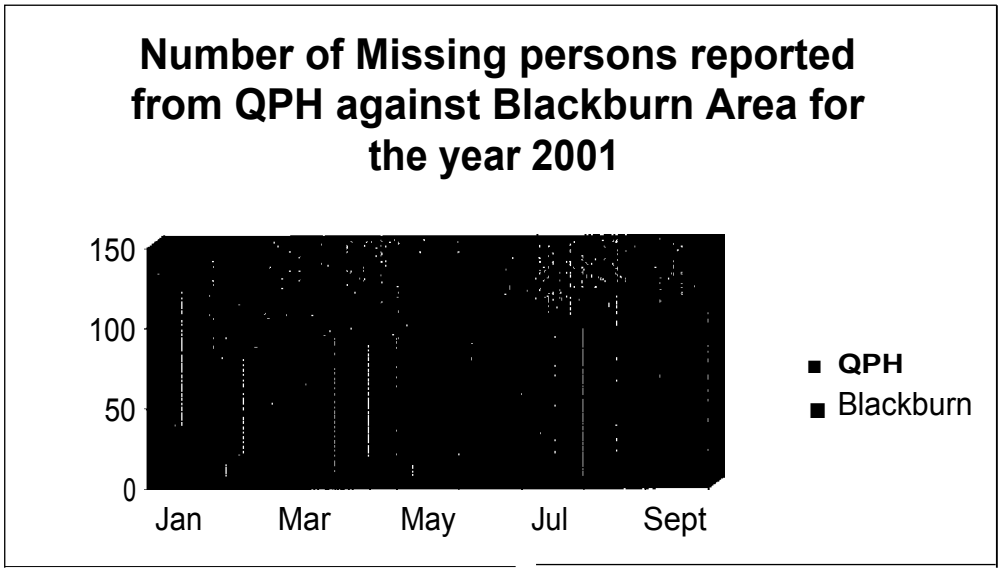
When all the proposals were implemented there was an immediate improvement over the first three months of 2002, compared with the same period in 2001. This equated to a 73% reduction in the number of patients reported missing from the hospital unit. The most frequent absconders are now more effectively controlled within the unit by implementing the changes mentioned above and by reviewing current working practices.

Contents

1. Scanning

Queens Park Hospital Blackburn contains a Mental Heath Unit (MHU) that has four wards and 74 beds. The wards receive 650 patients annually and serves a population of 250,000 people from the Blackburn, Darwen and Ribble Valley area. The patients have varying degrees of mental health problems, ranging from mild depression to psychotic tendencies. Others who attend receive treatment for drug and alcohol related illnesses.

Over the past five years Queens Park Hospital reported, on average, 150- 200 missing persons annually. In 2001, on average, 17 reports of missing persons per month were reported by the MHU to the police for the Blackburn area. This equated to 16.5% of all the missing persons reported to and dealt with by the police in Blackburn.



Each missing person reported from Queen Park Hospital MHU took on average 18 hours of police time to deal with the incident. The searches ranged from relatively simple searches, being found at a known address or in the locality, to full searches with air support and associated search teams. This represents a major drain on police resources in the Blackburn area. At Queens Park the input into reporting a missing person by staff was minimal, usually involving a telephone call to the police and the completion a form.

The volume of reported missing persons and the problems associated with this had existed for years without any major intervention by the police or the Local Heath Authority. The approach adopted by the unit was that if a patient went missing they would report the fact to the police and the police would respond to the situation as dictated. There was no attempt to implement any long-term solutions.

PC Michael Winward was tasked to do some further analysis and this highlighted major issues in the volume of missing persons the police were being asked to deal with from the Unit. The Unit had not realised that there was a drain on police resources as a result of reporting patients missing so frequently.

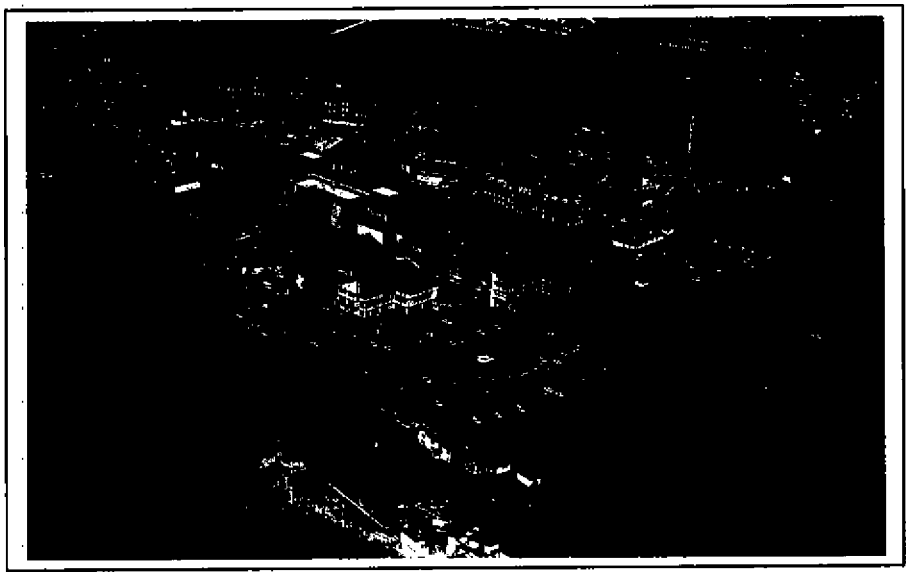
2. Analysis of the problem

It was not difficult to find confirmation of the volume of missing persons from the MHU. The 'problem' was confirmed by analysis of the following areas:

- 9 Force intelligence systems - incident reports
- 9 Social services
- ➢ Health authority
- 9 Hospital security
- ➢ Probation service
- ➢ Relatives of the patients.

2.1 Location

The MHU was originally situated in an old Victorian building until July 2001 when it moved to a purpose built premises amongst the new regenerated site at Queens Park Hospital. This will be a single site hospital complex serving the communities of Blackburn Hyndburn and the Ribble Valley Health trusts. It was hoped that the new facility would reduce the problem in itself but the number of missing persons remained constant at an average of 17 per month. Although the building offered the potential to be more secure, the hospital had failed to make any use of the additional, modern security measures that had been provided. The new MHU had a swipe card system that was available to control patient access to and from the building. This system was not being used effectively. Those who had a less restricted access were letting those patients who had restricted access out of the building.



Aerial view of the Queens Park Hospital Complex

The MHU incorporates four wards, one of which is the Calder Ward, a medium secure unit, available for use for those patients who suffered a more severe mental condition. This ward was available as a more secure option for those patients. who repeatedly absconded but it was not being utilised by staff to its full potential and for better control of those patients.

The geographic area offers a number of particular risks when dealing with mental health patients who may be suicidal. There are two large reservoirs opposite the Unit; the Leeds Liverpool Canal is a short walk from the hospital and the M65 motorway is close by. Transport links, particularly bus routes, give patients the opportunity to travel to their hometowns around East Lancashire. The hospital is on exposed moorland and suffers extremes of temperature during the winter. All these factors affect the search parameters adopted by the police.

The patients at the MHU are all vulnerable by the nature of the illnesses suffered. As well as the inherent vulnerability, some, when away from the unit, are involved in drug abuse, alcohol abuse and prostitution. Anecdotal evidence suggests that approximately 65% are involved in this activity when away from the unit without permission.

Over the past five years the MHU has reported a large number of patients missing and unfortunately four have been found dead.

	Date of Death	**Reason**
Female	**Jan 1999**	Drowned in a local reservoir (Suicide)
Male	Apr 2000	Overdose of heroin at own home
Female	2001	Drowned off the Blackpool coast. (Suicide).
Female	Jan 2002	On home Leave- jumped from high building (Suicide).

Other 'victims' involved in the problem are the relatives who are subject to many enquiries from the police once the person has been reported. Added to which is the stress and concern caused when the whereabouts of a loved one is unknown.

Whilst it cannot be said that the police are 'victims' in the problem in the same way as the patient or relatives, the staff hours spent tracing missing persons who have left the unit creates a drain on the resources covering the Blackburn area. The average time spent by a police officer dealing with a missing person from the MHU is 18 hours. If this were to be reduced, time would be freed allowing more time for working within the community of Blackburn.

2.3 Participants :

The MHU can accommodate 74 patients and the initial analysis revealed that there was core of repeat absconders.

Month	No of missing persons reports from MHU	
January 2001	33	4 repeat absconders = 12 reports
February 2001	15	3 repeat absconders = 4 reports
March 2001	9	2 repeat absconders = 6 reports
April 2001	**14**	1 repeat absconders = 3 reports
May 2001	14	3 repeat absconders = 8 reports
June 2001	**28**	3 repeat absconders = 16 reports
July 2001	13	1 repeat absconders = 3 reports
August 2001	**14**	2 repeat absconders = 6 reports
September 2001	**16**	3 repeat absconders = 6 reports
	Total 156 (Average 17.33 per month)	

In one example from the year 2000, a patient was reported missing 33 times in 6 months. The average repeat absconder will be reported missing 12 times in a 3-month period, based on figures from 200012001.

Sectioned patients had easy access to leave the MHU and there were poor monitoring procedures by staff. Despite a modern swipe card system there was little or no restrictions imposed when using these cards.

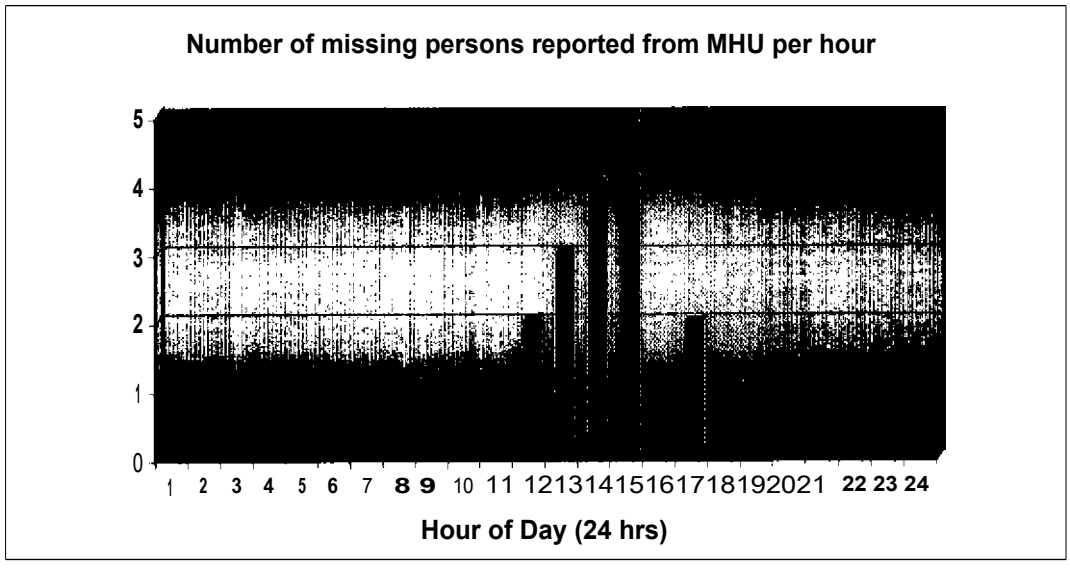
There were no photographs taken of the patients, so when reported missing there was no current record of their physical appearance.

Each time a patient went missing, a form was completed 'in-house', in accordance with hospital policy. The staff were supposed to complete the form attaching one to the patient folder, and the other sent to the MHU general office, so that the 'missing persons' could be monitored. This was not done, as the staff were unaware of this system, and the Unit did not record the frequency of missing persons by any other means.

There was no internal liaison at the hospital between the MHU and the security staff. Once a patient had gone missing, no official procedure was in place to inform security. It was more than likely that the police would have the report, and have conducted searches before the on-site security were made aware of the situation.

There was poor liaison between the police and the hospital. The police officers that were attending to report the missing person had a lack of knowledge of he legislation in relation to the Mental Health Act and the powers afforded to them for detention of the patients and a general lack of understanding.

The times of day that the patients were absconding was analysed. 60% were going missing between 12 pm and 3pm. This coincided with the staff handover period. Patients were only being supervised by one person instead of six to eight staff and the person left to supervise during the handover period was generally inexperienced. The patients took advantage of this fact.



Analysis of police records identified a group of 20 patients who had absconded on five or more occasions. This figure is generated from Police records in the year 2001. The Hospital had never identified this or taken specific action in respect of these patients.

2.4 Aims and Objectives

After the analysis, the following was established.

The project aim is:

To increase the professionalism of dealing with reports of missing from homes across a number of agencies with an emphasis on reducing demand whilst retaining the health and safety of individuals.

This is achieved by the following objectives:

For the Mental Health Unit to take an active role in implementing actions that will prevent persons absconding.

A reduction in the number of missing persons reported by MHU

A reduction in the repeat absconder rate

A reduction in the police officer time spent reporting missing persons from the MHU

A transferable solution to dealing with missing persons at similar establishments and environments

3. Response

PC Winward, an officer on the policing team responsible for this area of Blackburn, was seconded to work fulltime at the hospital based in the security office. His aim was to develop a partnership with the MHU, to analyse the problems and to develop solutions. He began the secondment in October 2001.

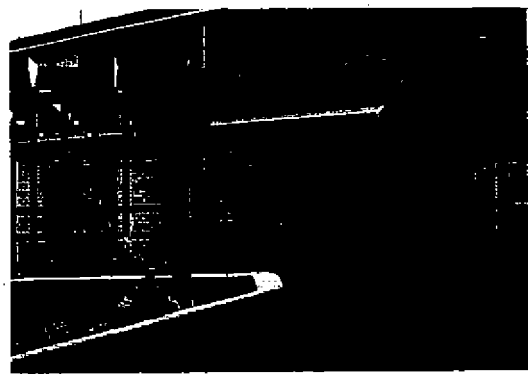
3.1 Absconders by Time of Day

Analysis of misper reports showed that 60% of patients who absconded did so between 12pm and 3pm. This was identified as the shift handover time at the Mental Health Unit. The Unit staff were in the practice of handing over in a private room whilst confidential matters were discussed. This left the patients unsupervised and gave them an opportunity to abscond. Practices have now been changed at the Unit to ensure that adequate staff are available at handover times. Handover is now completed on a rotation system, i.e. two morning staff brief two afternoon staff and so on, rather than a whole team being briefed at once. This allows patients to be properly supervised and exits to be monitored, therefore reducing the opportunity to abscond.

3.2. Smoking Facilities for Patients on Darwen Ward

The majority of patients at the Unit smoke. They are not permitted to smoke in bedrooms or on the ward itself. A room had been provided for them to smoke in, accessible only from the Darwen ward by leaving this door shown below going through the garden area, or by a door off a main public corridor.

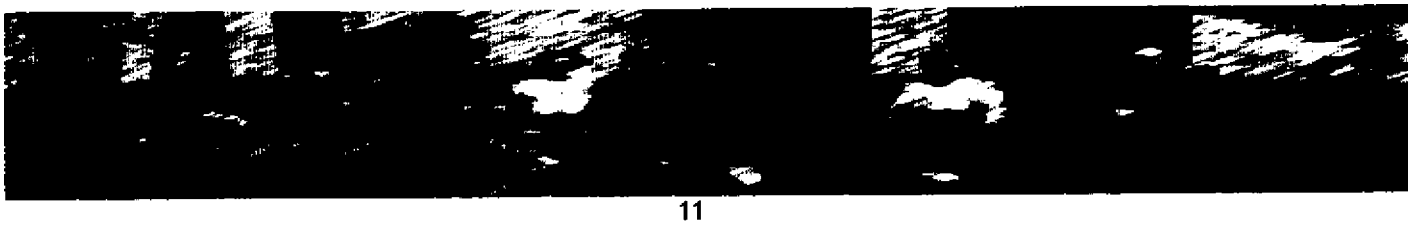
The following photograph sequence demonstrates the problem.



This is the external view of the smoking room. This is the entrance from the garden area, used freely by patients in the restricted area.

Inside, this is the door from the corridor. This door was unlocked and the corridor seen is NOT part of the secure area for the MHU.

This then becomes the 'corridor to freedom'. With the door unlocked, patients left the ward via the smoking room and down this corridor.



They arrived at these doors, again unrestricted and could gain access to the outside world, unchallenged.

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This is the external view of those doors, and the exterior of the MHU.

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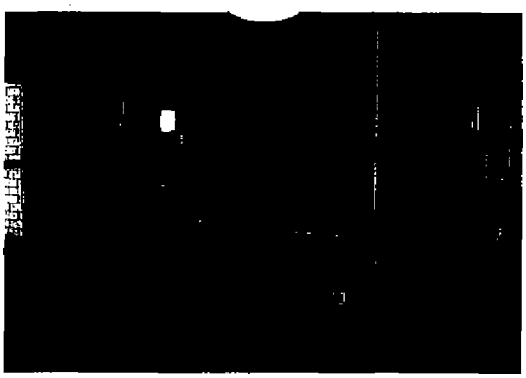

The simple, and yet obvious solution to the number of absconders who were abusing this opportunity to leave the Darwen ward was to lock this door.

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3.3 Patients Entry and Exit by Swipe Cards

The Unit has always operated an `Open Door' Policy; the Unit is not operated as a prison but as part of a Hospital. In the original premises prior to July 2001 the doors of the Unit were open and patients could leave as they pleased. The Hospital Authorities decided when constructing the new unit to install a `Swipe Card'. system. Each patient was issued with a **swipe card that gave access to** their bedroom, dormitory ward doors and other communal facilities. The system had the ability to programme the cards individually and restrict access to certain areas. Although this gave staff an excellent opportunity to control the access by patients and remove opportunities for absconding, no use had been made of this system and patients had unrestricted access to all areas, and were able to leave the Unit unchallenged.

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Much work was done in this area with a variety of options suggested to the Hospital Authorities. The following actions were instigated:

- All Swipe Cards were reprogrammed to give access to dormitory areas only.
- High risk absconders had Swipe Cards removed. This has also been extended to any patient who assists another to abscond.

This improved the general security of the Unit and staff are now required to monitor patients movements more closely as they must specifically request access to certain areas.

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3.4 Repeat Absconders

Analysis of police records identified a group of 20 patients who have absconded on five or more occasions. The hospital had never identified this or considered that this was an issue for them to address.

The problem has been reduced by the increased security measures which have been outlined above and increased awareness by staff of the problems. However there are two other areas of concern that arose:

- Patient Leave.

  Under s17 Mental Health Act, a doctor can grant either home leave or leave within the hospital grounds to a patient who is detained under the Mental Health Act. Certain patients were abusing this and failing to return from home leave or absconding whilst on ground leave. In some of the worst cases patients were using this as an opportunity to purchase alcohol and drugs or commit crime.

  This was addressed directly with the consultants that patients in their care were abusing the trust placed in them. Having analysed this issue and identified specific problems, leave has been heavily restricted to these patients.

- Alternative Care.

  Concern had been expressed by Police that some of the repeat absconders were not receiving the necessary care, as they were absent from the Unit for so much time. In these cases it was suggested that care arrangements for these individuals be reconsidered with a view to placing them back in the community under the Community Psychiatric Nursing Team. This was a particular success in the case of one regular absconder who would travel throughout the Country and abroad to Ireland. Under these arrangements he is no longer reported as missing to the Police.

3.5 <u>improvements in police and hospital procedures.</u>

The second part of the response looked at what measures could be introduced to improve Police and Hospital procedures when absconders are reported. Despite the above measures no Hospital Unit could ever be made totally secure. A review of Missing Persons logs actually suggests that it is those who do not regularly abscond and appear to be of lower risk that are actually at more danger of self-harm. The two most recent fatalities were considered low risk. (In fact there is little history of harm to high-risk regular absconders.)

3.6 Hospital Missing Persons Report Form

Queen's Park Hospital has for some years had a report form for missing persons. (See appendix A) This included certain actions to be taken by staff, such as searches of wards and grounds, informing security, together with history and description of the person. It was clear that much of this was not being done as contact with the police became the priority and there was no accountability for completion of this form. Many examples could be quoted of no search being carried out, and officers finding missing patients in the grounds, in the ward, even in the bath on the ward!
Originally, Hospital Policy required that all patients, whether informal or detained under the Mental Health Act, should be reported missing within an hour. This led to many unnecessary reports to the police of informal patients who were in fact free to leave whenever they chose.

A new form was designed and introduced by PC Winward (See appendix B) to include more detail required prior to reporting a missing person and a separate sheet of actions that must be endorsed by the 'nurse in charge' prior to informing the Police. This placed the onus back onto the ward staff to ensure that the searches and checks were carried out prior to the police being informed.

3.7 Hospital Policy

Hospital Policy has also looked at the reporting of missing 'informal patients'. These are voluntary patients where there is no power to detain them at the hospital, and if reported missing there would be no power for the police to detain, unless they fell under S136 Mental Health Act (mentally disordered persons found in public place). As a result of police involvement these patients are now examined subjectively by the 'nurse in charge' and reports only made to the police where there is genuine concern for the patients welfare, or there is genuine risk to the public.

3.8 Photographs

These are considered essential in any police missing person investigation. However, there were no facilities or policy to take photographs at the hospital. Police were forced to rely on their own photograph library, which was generally out of date. Often no such photographs were available. There was considerable resistance by the hospital to introducing photographing of patients on both legal and moral grounds. This proved to be the most controversial and difficult change to implement. It had to be passed by the Hospital Trusts Ethics Committee and approved by Consultants. The hospital also took legal advice that came down in favour of photographing those patients who represented a risk of absconding.

Approval has finally been gained for the photographing of patients and finances agreed for a digital camera.

3.9 Police Knowledge and Understanding

Police Officers receive little or no training on the Mental Health Act or in dealing with Mental Disorders. PC Winward designed and produced a pocket book sized laminated card which has been issued to all officers in the Division explaining powers under the Mental Health Act. (See appendix C). This gave officers a checklist of their powers in relation to persons missing or found where they considered the Mental Health Act to be an issue.

3.10 Hospital Security.

Queen's Park Hospital employs outside contractors to provide uniformed security at the Hospital. They can provide a valuable resource in locating absconders at an early stage. PC Winward has arranged training sessions for security staff to make them aware of their powers. This opportunity has also been taken to improve training of the security staff in relation to crime problems at the Hospital. The staff are now sufficiently confident to self train others.

4. Assessment

The measure of success for this work is the achievement of our objectives.

This table show the number of missing persons reported to police in the months specified

Month	No of missing persons reports from MHU	
January 2001	33	4 repeat absconders = 12 reports
February 2001	15	3 repeat absconders = 4 reports
March 2001	9	2 repeat absconders = 6 reports
April 2001	14	1 repeat absconders = 3 reports
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August 2001	14	2 repeat absconders = 6 reports
September 2001	16	3 repeat absconders = 6 reports
	Total **156** (Average 17.33 per month)	

Following Analysis and implementation the picture changed dramatically. This effect is as a direct result of the actions taken by PC Winward and the team at Queens Park Hospital.

Month	No of missing persons reports from MHU	
October 2001	14	1 repeat absconders = 2 reports
November 2001	10	1 repeat absconders = 5 reports
December 2001	**4**	0 repeat absconders = 0 reports
January 2002	5	1 repeat absconders = 2 reports
February 2002	2	0 repeat absconders = 0 reports
March 2002	8	1 repeat absconders = 4 reports
	Total 43 (Average 7.1 per month)	

The steps taken have shown a significant decrease in the number of missing patients being reported as such to the police. By comparing the first three months of 2002 against the same period 2001, we have shown a 73% reduction in the number of missing persons reports received from the MHU at Queens Park Hospital.

From the table above, we can also note the reduction in the number of repeat absconders from the ward, reducing the large number of reports these persons were responsible for creating therefore reducing the time officers are now spending dealing with them as missing persons.

Already we have made reference to the fact that each missing from home reported entails on average 18 hours of officer time per report. By reducing the average number of reports per month from 17.33 to 7.1 it is clear that the number of officer hours used on dealing with missing persons from the ward has been dramatically reduced.

The issues that have been highlighted here can, and are already, being used to address issues elsewhere. PC Winward has used the knowledge gained from the ¡mplementation of this work, to begin addressing similar problems in repeat missing persons from children's homes in the Divisional area.

The work completed here is transferable, once any problem has been identified and the. analysis completed, measures that have been put in place here could be replicated to great effect elsewhere.

Attached in appendix D is anecdotal evidence from those affected by the work.

5. Difficulties in Implementation

The main difficulty was a fear by the hospital management of the introduction of new working practices between the hospital and the police. For example, the introduction of the 'new' missing from home form had to be taken to the Policy Group within the hospital for its agreement to be used. Once its use had been agreed the staff were concerned over its use. This fear was allayed when PC Winward provided the staff with training on why the form had been introduced and how to complete it. The awareness created by the procedures listed on the form has had a drastic but welcome effect on how the staff on the ward operate.

The photographing of patients was also a massive hurdle to overcome, but details of this have already been discussed in paragraph 3.8.

6. Exit strategy

PC Winward will soon return to full duties at Blackburn, on the area covering Queens Park Hospital. When he does, he will maintain the partnership links created by this work, visiting the unit, and ensuring that there are no new issues developing from the 'steps already put in place.

Already there have been other issues arising out of the work completed. Persistent and determined absconders are finding other avenues to leave the unit, which are more difficult, including breaching fire doors, and climbing from windows. Because of the actions detailed above this activity has been picked up by staff and PC Winward early and new security measures have already been put in place to combat these problems.

If PC Winward was to move on, then the area will maintain a responsibility to the partnership that has been created, and the role of liaison officer to the hospital will remain. The unit is part of the ever-expanding Queens Park Hospital site, which, with construction still taking place, will be one of the largest hospitals in the country.