Missing person guidance consideration for residential care and domiciliary care

Worcestershire Safeguarding Adults Board

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Document Control

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Revision History

Date	Version	Changes made	Author
09.12.17	0	New document	Sarah Cox
11.12.17	0.1	Added introduction	Richard White
08.01.18	0.2	Further clarification in induction and some of the actions. Use of plainer language.	Suzanne Hardy
01/06/18	0.3	Typographical changes, title changed, expansion of justification for care environment considerations	Suzanne Hardy
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06.02.2024	2.	Reviewed and updated	M Carter and R White

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Consulted on the Policy/Guidelines

Organisation	Date
WSAB Policy Sub Group	15/12/2018
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Acknowledgements

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1.0 Introduction

A Safeguarding Adult Review was completed in 2015 and published on the WSAB web page, as Michael Upwood, relating to the death of an individual who left a care environment without those responsible knowing and subsequently was found dead in a field. The learning from this very sad and untimely death highlighted, amongst other aspects, the need for all health and social care providers to address their responsibilities for the physical safety of those they are providing care for. In particular this relates to how providers the actual presence within a caring situation of an individual and what action to take if an unsafe exit from a place of a care is identified.

Regulation 12 of the Health and Social Care Act 2008 requires that Providers are;

- 'Assessing the risks, to the health and safety of service users, of receiving the care or treatment.
- 'Doing all that is reasonably practicable to mitigate any such risk.'

The regulators for Health and Social Care, The Care Quality Commission, (CQC) understands that there may be inherent risks in carrying out care and treatment, and they will not consider it to be unsafe if providers can demonstrate that they have taken all reasonable steps to ensure the health and safety of people using their services and to manage risks that may arise during care and treatment.

WSAB has identified the following which providers should consider within their own policy and procedure frameworks.

The guidance is not an exhaustive list of actions but should be seen as a prompt to review provider policies and procedures.

2.0 Assessment process

1. Where any doubt exists regarding the persons Mental Capacity to make a decision to leave the care environment, with or without support, a Mental Capacity assessment should be completed. The outcome of the capacity assessment should inform a proportionate risk assessment to maintain the person's physical safety and consider the least restrictive outcome. It would be expected that a Best Interest Decision is also completed to support the outcome of the Mental Capacity Assessment. Consideration for an application for an emergency/ standard or community authorisation under Deprivation of Liberty Safeguarding (DoLS) may also be required as part of wider care planning.

2. The Risk assessment process should identify, amongst other aspects, a review of the past tendency of the person being assessed to seek to leave their care environment and the reasons for this.

3. The Risk assessment process should clearly address the provider's ability to maintain the physical safety within the providers care environment.

3.0 Care environment considerations

1. The provider should address the need to alarm or secure all exits to ensure safety of all those within the care environment and support awareness of all movement in and out of the environment. This is to include other aspects such as fire safety. Where the alarm is supported by a locked door (either key or keypad operated) it is expected by CQC that a

Mental Capacity Assessment and supporting Best Interest Decision will be available in each person's Car Plan.

2. The provider should consider how the access points to enter and exit the care environment are managed to ensure safety of all within the care environment.

3. The provider should consider what process is necessary to monitor individuals within the care environment to be confident that all who should be in the premises are accounted for.

4. The provider should consider an exit safety check when changing staff teams assume responsibility for the care of individuals within the care environment.

5. The provider should complete The Herbert Protocol for all vulnerable people they support, this is a national scheme that encourages carers, family and friends to provide and put together useful information, which can then be used in the event of a vulnerable person going missing. Link to information on Herbert Protocol

6. The provider should consider placing in easy access a box containing:
    - A plan of the care facility
    - A plan of the grounds identifying any outbuildings
    - An ordinance survey map of the area.
    - The Herbert Protocol information/ pen picture of all individuals within the care facility.
    - Protocol for a missing person.

4.0 On discovering a person is missing from the care environment

Immediate

The order of actions cannot be set out rigidly as each situation will potentially demand a unique arrangement. However, the following should form a framework to follow.

The point where the Police are informed is dependent on the assessment of the Incident Controller. As a general guide the earlier the Police are informed, and their additional skills are available in the situation the safe return to the care setting is to be considered.

- The senior manager on duty should assume overall responsibility by becoming the Incident Controller. The Incident Controller allocates the staff team to perform key roles and maintains a record of decisions taken for future learning opportunities.

- The Incident Controller should assess the risk level and ensure any breach of security is secured.

- The Incident Controller should allocate the following tasks to be completed as applicable – this list should not be seen as exhaustive:

    - Allocate staff to ensure the safety of any remaining individuals and releasing staff to complete the actions, consider requesting further support.

    - Contact the individual on mobile phone, if s/he has one.

- A to search service address is systematically completed the outcome is reported to the Incident Controller.,
- A search of the grounds is systematically completed the outcome is reported to the Incident Controller.
- A search of out building is systematically completed the outcome is reported to the Incident Controller.
- The Service manager to be informed.
- The Incident Controller personally informs the missing persons family.
- Staff/family to search home surrounding area and use the information from the Herbert Protocol and support from the family for notable places the individual may have wished to visit.
- Taxi companies to be contacted to ascertain if they have attended the service site and transported a person from the site.
- Local train station to be searched and British Transport Police officers informed as applicable.
- Local bus station to be searched as applicable.
- Staff to make contact with any known friends of … and to include use of social media as appropriate.

The Incident Controller to Inform POLICE after tasks completed 'unless there are immediate concerns that the adult is in danger' if so, then inform Police immediately.

Have available the following information.

Name of Adult:

Date of Birth/Age:

Location Missing From:

Home Address (if different):

Family Contact Details:

Summary of Care and Support Needs: - ideally with up-to-date clear photograph

Details regarding mobility and fitness:

Information from the Herbert Protocol/ pen picture. Link to information on Herbert Protocol