missing people
Registered charity in England and Wales (1020419) and in Scotland (SC047419)

Missing from hospitals, health and care settings: An analysis of Reports to Prevent Future Deaths and Safeguarding Adult Reviews

The importance of improving health, care and policing responses to missing people

Introduction

Each year around 1,000 people die when they have been reported as missing. Following some of these deaths there will be reviews to understand what happened and what could be done to prevent similar deaths in the future:

- Coroners will investigate some of these deaths if they are *"deemed to be unnatural, violent, or where the cause is unknown"*. The Coroners and Justice Act 2009, provides coroners with the duty to make reports to a person, organisation, local authority or government department or agency where the coroner believes that action should be taken to prevent future deaths. These **Reports to Prevent Future Deaths (PFDs)** should ensure that lessons are learnt, and that others don't face the same outcomes or failures in the future.
- Safeguarding Adult Boards are responsible for carrying out **Safeguarding Adult Reviews (SARs)** if there are concerns that the multi-agency response has failed to safeguard someone who later died because of, or experienced, serious abuse or neglect. They are led by a 'Lead Reviewer' and will include inputs from any relevant agency. The aim of these reviews is to "promote effective learning and improvement action to prevent future deaths or serious harm occurring again".

The majority of missing adults are reported as missing from home, by family members. However, an estimated 18%[1] of incidents are reported from hospitals, other healthcare settings, or supported accommodation. Relatively little is known about these incidents, with inconsistent responses and recording across the country. In light of the recent rollout of the Right Care Right Person National Partnership Agreement, which in part informs the response to people going missing from these types of settings, it is vital that we better scrutinise learning that can help to prevent missing episodes, and inform better safeguarding responses when they do occur from these locations.

This review identified 12 PFD Reports and 9 SARs from the last 10 years that related to a death of a person who was missing from a healthcare, supported living, or an adult care setting.

These reports, and the consistent themes that we found within them, show that too many people are dying in circumstances that could have been different, and that much more should be done to prevent similar deaths in the future.

While every incident is different, we have found persistent themes in the professional responses to missing incidents that allowed 21 people to fall through the gaps. By improving multi-agency practice, and ensuring agencies are held to account on their policies, training and procedures to prevent missing episodes and find people who are at serious risk, we could save lives in the future.

It is worth noting that in a number of the reports, the Coroner or Lead Reviewer found that the missing person's family and friends had not been kept informed: some had not been told that the person was missing at all, and some had not been told that a missing investigation was closed or changed to a

[1] APPG-for-runaway-and-missing-chidren-and-adults.pdf

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concern for welfare incident. While we acknowledge the complicated nature of sharing information without consent for adults, it is clear in some of these reports that the professionals were not able to intervene to ensure the person's safety, and families and friends who could have taken action, were kept in the dark. In at least one incident this meant the family were left to find the body of their loved one themselves.

While this report summarises some of the key themes across 21 different reports, it is vital to remember that each of them relates to an individual who has lost their life, and could perhaps have been saved if there had been a better response in place. Unfortunately too many of the reports reveal the same issues, suggesting that lessons have not been learnt.

Everything possible must be done to ensure that no one else dies in similar circumstances.

Nimo Younis was 37 when she went missing. She had been detained in a psychiatric intensive care unit due to struggles with depression. On 24 January she was granted unescorted leave with the agreement that she would return by 8pm. She did not return at that time.

Due to failures in communication between health staff and the police; and misunderstandings of each agencies role, Nimo was not classified as a high risk missing person until 5pm the following day. She was found, having taken her own life, later that evening. Her loved ones believe her life could have been saved if action had been taken sooner.

"She was an inspiration and very appreciated, loved and admired. For us it is a travesty that someone so great should meet their death so tragically, especially as it transpires that perhaps if the two corresponding bodies which were in the duty of care, the police and the mental health services, had better communicated, the urgent need to intervene would have been actioned much sooner.

There were 22 hours to save our precious Nimo and a lot of time was wasted deciding who (the NHS or police) would be responsible to locate her prior to her suicide.

Nimo communicated that she was contemplating suicide and was in great need hours before it occurred and we definitely feel that this could have been prevented had the bodies (hospital and police) acted with more urgency."
Words written by friends of Nimo Younis, taken from the Camden New Journal[2]

In this report we include the real names and some details of people who died following a missing incident, as they were published in public records. We would like to express our condolences to their family members and loved ones. If your loved one is mentioned in our report and you would like to discuss the report or our findings you can contact josie.allan@missingpeople.org.uk.

[2] Our friend Nimo was so creative and generous | Camden New Journal

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Recommendations

There must be greater clarity in the roles and responsibilities of health, social care and police professionals in the response to missing people. No more people should die because they fall through the safeguarding gaps, or because no one could agree which agency was responsible for looking for them.

The following recommendations, if implemented, would help to close those gaps:

1. An estimated 18% of adult missing incidents are reported from healthcare and care settings, and yet there is no national, statutory guidance on agencies' roles and responsibilities in prevention and response.
   'The multi-agency response for adults missing from health and care settings: A national framework for England' should be implemented in safeguarding partnerships across England.
   a) The **Department for Health and Social Care** should endorse the Framework and support its rollout in all areas.
   b) **Safeguarding Adults Boards** should ensure they have multi-agency missing person policies in place that are in line with the Framework.
   c) **NHS Trusts and local authorities** should ensure that they have clear guidelines on information sharing to inform police risk assessments when someone is missing.
   d) **Police forces** should ensure that their risk assessment processes are effective when someone is reported missing and at risk of suicide. Anyone who is at immediate risk of serious harm should be considered a high-risk missing person.

2. There is little monitoring of health and care settings' approach to preventing missing episodes, and their response when they do happen. Ensuring inspections include a focus on the risks around people going missing would result in improved safeguarding and reduce the potential for a postcode lottery in the response.
   The **Care Quality Commission (CQC)** should consider missing incidents in their inspections. They should review reported incidents and assess the response; inspect policies and procedures within each setting; and assess knowledge of and compliance with those policies within practice.

3. The **Home Office** and the **Department for Health and Social Care** should ensure that the Right Care, Right Person National Agreement provides clarity on the roles and responsibilities of health and policing partners in the response to missing from hospital incidents, including how incidents can be prevented, and when they should be escalated for police involvement. Implementation of the RCRP National Agreement should be monitored to ensure it does not result in an increase in deaths following missing incidents from healthcare settings.

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Key themes

Multi-agency roles and responsibilities

In all of these cases, the Coroners and Lead Reviewers identified issues in either the understanding of, or delivery on, the roles and responsibilities of health, care and police professionals. Examples included:

- Health or care staff not reporting the person as missing soon enough,
- Health staff not following their own policies, including not staying with someone considered to be at risk, or not carrying out initial searches or attempts to make contact,
- Police not taking the concerns of health or care staff seriously enough,
- Health staff not being informed that someone could not leave a ward without an escort due to a high risk of suicide,
- Health staff not knowing what they were supposed to do if someone ran away while on escorted leave,
- Health and police staff failing to effectively review or connect previous missing incidents for relevant information to aid in prevention or the search for a person,
- Disagreements about what should have been done to prevent a patient from leaving resulting in no agency taking any action to actually find the missing person.

The lack of clarity and awareness of roles and responsibilities of each agency and staff within them led to serious gaps in the safeguarding response, which ultimately may have led to some of the fatal outcomes.

In some instances the Coroner or Lead Reviewer found that there were not sufficient policies in place to set out what each agency should be doing, while in others the policies were there, but one or multiple organisations didn't follow the recommended practice.

"Ben was missing for 7 days without this being escalated. The lack of urgency surrounding the non-reporting of his absence is cause for concern, given that Ben was found dead shortly after his absence was reported." Excerpt from Safeguarding Adults Review

It is desperately clear that there needs to be better policies, training, and multi-agency working, to ensure that people are prevented from going missing from hospitals and care settings in the first place, and if they do, to ensure a fast, effective safeguarding response.

"From the evidence I heard, the police / health trust partnership working allows each agency to regard such a situation as the other's responsibility, whilst nobody is on the ground attempting to retrieve a seriously ill patient who is meant to be inside a locked ward for their own safety.

Whether this is a matter of policy or practice, the result is the same. If partner agency working is to be effective in caring for this extremely vulnerable cohort of patients, there needs to be crystal clear understanding by all those involved, from the highest policy maker to the most junior member of a team at the sharp end, of how to tackle these difficult situations and exactly who is meant to be doing what."
Excerpt from the Prevention of Future Deaths report for Heather Findlay

Escorted and unescorted leave

It is particularly important that there is greater training and planning for patients when they are given leave from in-patient care if they are at risk of going missing, particularly if there are concerns about suicide.

Of the 16 deaths following people going missing from hospital, five had been on escorted leave when they went missing. Their reports identified issues with poor risk planning, staff not knowing how to best prevent the patient they were escorting from running away, or a lack of policy or training on what to do if this did happen.

A further four of the deaths occurred following unescorted leave. While the decision to allow unescorted leave might have been correct, these cases all highlighted issues with how both health and police staff responded when the patient did not return.

"When Ms Findlay ran off, the HCA escorting her was so panicked that she did not even think of following. Ms Findlay had run across a road and so chasing her at speed did present safety considerations. However, the ELFT policy, training, culture and expectation was such, that there the HCA did not at any point consider attempting to walk after her to keep her in sight. Clinical staff must be adequately prepared for such an eventuality. That means more than simply a change in policy wording."

Excerpt from the Prevention of Future Deaths report for Heather Findlay

"Senior police officers expressed concern that the mental health patients were allowed s17 leave without adequate risk management plans in place, creating a high-risk situation in circumstances that could have been reasonably foreseen"

Excerpt from a Safeguarding Adults Review

Risk assessments

In the majority of reports relating to deaths following someone going missing from hospital or supported accommodation, the Coroner or Lead Reviewer identified issues with the risk assessment. In some incidents the health or care staff did not share relevant information with the police, for example recent suicide attempts or suicidal ideation. This meant the police could not effectively assess the level of risk, and therefore couldn't assign appropriate resources and urgency in the response.

"When the police were contacted, staff completely failed to state the urgent and serious suicide risk which the deceased presented to themselves"

Excerpt from the Prevention of Future Deaths report for Hilary Guedalla

In other cases, even when health staff clearly communicated their very serious concerns, the police disagreed and assessed the risk as medium rather than high. In some instances the police disregarded that health staff had a better understanding of the patient's state of mind, or of their illness or condition.

"The Nurse-in-Charge indicated Mr Bari was at high-risk of suicide. The Constable felt the Nurse-in-Charge could not rationalise the high-risk category, and decided Tcherno was at medium-risk of suicide (having in her view followed College of Policing: Missing Person Authorised Professional Practice)... The fact the police had taken a different view about the level of risk was not explained to George Ward, and neither the Nurse-in Charge, Responsible Clinician, or Clinical Service Manager were aware."

Excerpt from the Prevention of Future Deaths report for Tcherno Bari

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These issues again suggest a lack of clarity around roles and responsibilities, including what information should be recorded and shared at the point of reporting someone missing; and may indicate poor working relationships between health and police professionals with a lack of trust in one another.

In at least 10 of the 21 reports we identified, the missing person died by suicide. This figure may actually be higher as some reports acknowledged the circumstances suggested suicide, even when the Coroner could not specifically confirm that outcome. In some of those cases, even when very clear information about suicidal intent and health staff's concerns were shared, the police still did not assess the missing person as high risk. This clearly does not align with the College of Policing Authorised Professional Practice Guidance on risk assessments, as a clear risk to life or serious harm should always generate a 'high risk' assessment.

"At the point of Ella's final departure from the ward, she was reported missing and it was reported that she was suicidal, but the police recorded her as medium rather than high risk. There was a considerable delay before a police unit attended the ward, and a further delay before her notes were reviewed and her risk level was increased to high."

Excerpt from a Safeguarding Adults Review

Right Care Right Person

Right Care Right Person[3] (RCRP) is a partnership model which *"aims to ensure vulnerable people get the right support from the right emergency services."* In practice this means reducing police attendance at mental health-related incidents, unless a crime has been committed, or there is a real and immediate threat of serious harm.

RCRP was initially trialled in Humberside in 2020, and has since been rolled out by multi-agency partnerships across the country, with the majority adopting the approach since 2023. Many of the PFD reports and SARs we have included in this analysis therefore predate the implementation of RCRP. However, the approach was specifically mentioned in two reports, and further roll-out may have an impact on similar incidents in the future.

A key aim of RCRP is to reduce police attendance at incidents where someone voluntarily leaves a healthcare setting, or is 'AWOL' from mental health services. National police and health guidance has stipulated that it should not be applied to missing person incidents. However, it is hard to exactly define what is a healthcare 'walkout' or someone voluntarily leaving, and what is a missing incident. In practice, there is a very real risk that RCRP will be inappropriately applied to the latter, so it is vital that all relevant agencies have clarity on when an incident of someone going missing from a hospital or care setting ***does*** meet the threshold for contacting the police, and how to escalate their concerns if they feel the police inappropriately apply RCRP, or do not fully consider concerns of high risk to the missing person.

This issue has already been evidenced in two PFD reports[4][5], where the Coroners raised concerns about the current implementation, including:

[3] Right Care Right Person toolkit | College of Policing
[4] Tcherno Bari: Prevention of future deaths report - Courts and Tribunals Judiciary
[5] Heather Findlay: Prevention of future deaths report - Courts and Tribunals Judiciary

- A lack of policies, protocols and training for health staff to adequately respond to a patient at risk of harm leaving the ward, without police attendance.
- The misidentification of risk resulting in the police not attending an incident under RCRP principles, even when they are missing and there is a real, immediate risk to life.
- A lack of clarity about which agency is responsible, resulting in no one looking for the person.

On reviewing the reports, we also believe there may be a risk that the police may refuse to investigate a missing incident under RCRP principles because they believe health colleagues should have prevented the circumstances in the first place (for example, by physically restraining the person), regardless of the risk the missing person is now facing.

"I asked the MPS [Police force] what is meant to happen if an escort is following a patient who has run away and about whom the escort is worried. I was told that this is primarily a health problem... I heard nothing of an ELFT [NHS Trust] protocol that would advise staff on the ward to come out to assist an escort who already following a patient. I heard nothing of a trust contingency plan that would allow a ward to function without the doctors and nurses needed to undertake such a task. I heard nothing of any training given to doctors and nurses in how to restrain a patient in the middle of the street and to transport them back to the ward."

Excerpt from the Prevention of Future Deaths report for Heather Findlay

While there are many benefits to reducing unnecessary police attendance at mental health incidents, there is a risk that applying the principles too broadly to missing incidents, including those reported from hospitals, will result in more fatal outcomes.

Methodology

Missing People carried out a rapid analysis of PFDs and SARs using keyword searches for "missing person" and "reported missing". Each report was then read to establish whether the person was missing (had been reported missing to the police, or the Coroner or report suggested they should have been) at the time of their death; whether they were missing from a health or care setting; and whether the multi-agency response to the missing incidents could have been improved. All relevant reports were then coded to identify key themes and patterns.

Location missing from	Number of reports
Hospital or clinic[6]	16
Supported/semi-independent accommodation	3
Care setting	2

This review is in no way exhaustive. There may be other PFDs and SARs related to missing people which did not come up through the keyword search, or aren't published on the Courts and Tribunals Judiciary website. However, the findings bring to light some key issues that are important for English and Welsh Governments, and local safeguarding partnerships, to consider and address.

[6] This includes one person who was reported missing from a B&B where they had been placed by the mental health team responsible for his care.

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This review identified 12 relevant PFDs. We have included their names in the table below as the reports are public record, and because we believe they should be acknowledged and remembered.

	Month/year of death	**Coroner court**
Tcherno Bari	Sep 2024	Birmingham and Solihull
Mark Anthony Summerset	Feb 2024	West Sussex
Michael Crane	Jan 2024	Inner North London
Sydney Piper	Mar 2023	East London
Kenneth Rippon	May 2022	County Durham and Darlington
Rebecca Fisher	Apr 2022	Manchester South
Leroy Hamilton	Dec 2021	Birmingham and Solihull
Hilary Guedalla	Oct 2021	Inner North London
Jack Taylor	Mar 2021	West Sussex
Christopher Ryan	Dec 2020	West London
Heather Findlay	Jun 2020	Inner North London
Nimo Younis	Jan 2019	Inner North London

We also identified 9 relevant SARs. We have not included the names of the people identified in our SARs review as they are not public record and the majority use pseudonyms.

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