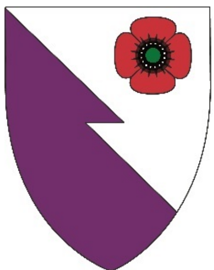
The Royal College of Emergency Medicine

Best Practice Guideline

The Patient who absconds



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Summary of Recommendations

• Emergency Departments should prioritise the clinical assessment of patients at high risk of absconding.

• An essential action to be performed as soon as the risk of absconding has been identified is to assess autonomy/capacity; ideally as part of a mental health triage tool.

• Emergency Departments should have a specific form for detailing a patient's physical features, if at risk of absconding.

• Emergency Departments should have written guidance detailing specific measures which may be activated to prevent absconding.

• Emergency Physicians requesting that a patient be restrained must be clear regarding the legal justification of their request and document this in the clinical notes.

• Restraint to prevent absconding should be a proportionate response and in the patient's best interest.

• Emergency Departments should have written agreements with security team regarding when restraint can be applied and how it is applied.

• Emergency Departments should have written guidance with actions to take if a patient absconds and when it is appropriate to contact the Police Service.

• Any children who abscond with or without an accompanying adult should trigger local safeguarding procedures.

• Emergency departments should record the number of patients who abscond and those cases in which the Police Service have been contacted in order to facilitate service improvement.

Scope

This guideline has been developed to assist Emergency Physicians in the management of patients who abscond from the Emergency Department (ED). In this document, 'absconding' is defined as a patient who has left the department unexpectedly, without the knowledge of clinical staff, and in whom there remains a potential risk of harm to self or others either through neglect or deliberate means. Some patients who leave without warning may present a risk to themselves whilst others may not.

This guideline does not refer to those patients who 'Did Not Wait', who 'Left without Being Seen', or who 'self-discharge'. The guideline seeks to provide some clarity around the legal basis for decision making in this area, in particular with regard to those patients who lack autonomy. The Legal Principles apply to patients over the age of 16 years in England and Wales.

Reason for Development

Patients who abscond from the ED cause considerable concern to Emergency Physicians with regards to the most appropriate course of action, how far their 'duty of care' extends and the legal basis of decision making.

Introduction

Emergency Physicians are frequently posed with the challenge of what action to take when a potentially non-autonomous patient attempts to leave or is noted to have left the ED. These non-autonomous patients may be a risk to themselves or others and may be detainable under the MCA 2005 or MHA 1983.[1] Such patients may be, for example; psychotic, suicidal, delirious or intoxicated.

The dynamic and fast pace of the ED often results in the Emergency Physician needing to make an immediate decision with incomplete information. Relevant ethical and legal principles of liberty and the duty to protect life may conflict. The law regarding these issues is complex and unclear; determining where the balance lies between these principles is challenging. The MCA 2005 and MHA 1983 were not designed for such problems. When considering this with a lack of relevant case law, it is clear that there is insufficient legal guidance for the Emergency Physician to base such decisions on.

This guideline has been developed to provide a framework to assist the Emergency Physician in these challenging scenarios.

Defining the Problem

Personal autonomy can be defined as the capacity to make decisions for oneself.[2]

In this guideline, individuals lack autonomy because they:

1. Lack capacity as defined by the MCA 2005.
2. Have an Identified mental illness and are potentially detainable under the MHA 1983.
3. Possibly lack requisite decision-making autonomy (but this has not been formally assessed).

This guideline does not apply to patients who are autonomous and choose to disengage with healthcare services.

This guideline does not apply to patients who have been placed on a Section 136 (s136) as this will provide adequate mitigation to the risk of absconding. However, this guideline will apply immediately to any patient who has been removed from a s136 while in the Emergency Department or where police have left the patient under the care of the Emergency Department but remain on a s136. Please refer to the RCEM s136 guidance for more information.[3]

A Duty of care exists once patients are booked into the Emergency Department.[4] This engages relevant ethical, legal and professional duties.

Where autonomy is lacking, this is not always known immediately. There may be a delay until patients are seen by a triage nurse, a clinician and possibly a mental health practitioner.

As well as an ethical duty to save life, there is a legal duty of the state to protect the article 2 right to life.[5] If a non-autonomous patient leaves an Emergency Department and suffers harm, there is a risk of a negligence liability. However, there is also a duty not to restrict liberty disproportionately. This right to liberty is protected under the HRA 1998 and the MCA 2005 with Deprivation of Liberty Safeguards (DoLS).[6] This right is also protected by the MHA 1983, as a patient must be detained under a section of the MHA 1983 in order to restrict liberty.[7]

Ultimately the law is unclear on these unique issues in the ED. Despite the limitations in statute and the lack of specific case law, existing statute and case law provide some guiding principles in determining where the balance lies between restricting liberty and protecting life.

Legal Principles:

1. A duty of care exists once a patient is booked in.[8] Therefore, active management of any problem is required.

2. The decision of a patient who possesses the requisite decision-making autonomy (as per MCA 2005 and MHA 1983) must be respected. This is in line with protecting the Article 5 right to liberty and security.[9] A patient with autonomy must be allowed to act on a decision even if the assessing clinician considers it 'unwise'.[10]

3. Where the MHA 1983 is engaged, this has primacy over the MCA 2005.[11] ED personnel do not have powers to detain under the MHA 1983. Options are limited to requesting a Section 4 (s4) (or s2 but this is slower) assessment or police assistance who can use a s136 in the ED.[12] The court has not yet recognised that even these MHA 1983 urgent powers may be too slow.[13]

4. Where the MCA 2005 is engaged, patients can be subject to restraint and detention, as long as it is proportionate to the risk. The MCA 2005 s4B allows a deprivation of liberty where necessary to provide 'life-sustaining treatment' or perform a 'vital act' which is reasonably believed to be necessary to prevent a serious deterioration in the person's condition.[14]

5. There is no statutory definition of a deprivation of liberty and no case law that addresses the issue of deprivation of liberty in the ED. In addition, there is no set timeframe for when a deprivation of liberty occurs. However, restraint and detention when used in the ED would likely be covered under the broader provisions of the MCA 2005. They would not usually amount to a deprivation of liberty. This approach is supported by the Deprivation of Liberty Safeguards Code of Practice which states that an urgent authorisation should not be used in an ED where it is anticipated that the person will not be in that environment with a few hours or a few days.[15] In addition, applying for an urgent authorisation is impractical and not routinely applied.

6. There may be exceptional circumstances where a deprivation of liberty occurs in the ED.[16] The chance of a deprivation of liberty occurring increases with the time and intensity of the restraint. Emergency Physicians are advised to discuss cases with the trust legal department if there is concern a deprivation of liberty is occurring, but only after any urgent intervention is completed.[17]

7. Ultimately, an overriding duty to protect life exists under article 2 of the European Convention on Human Rights.[18] Article 2 is likely to be engaged where a real and immediate risk to life is known or ought to be known.[19]

8. Common law may be used to justify actions taken to protect life where

statutory gaps exist. Therefore, when it has not been possible to assess a patient's capacity or MHA 1983 powers have not come into effect, the common law doctrine of necessity allows the ED clinician to use restraint and detention in order to protect life.[20] Any action taken must be proportionate and must take into account the patient's article 5 right to liberty.

Practical steps to reduce risks of absconding

On arrival, patients at risk of absconding should undergo mental health triage in order to formally assess and document the risk of absconding and self-harm. Each department should have its own processes for mental health triage. Department's should undertake regular audits of their mental health triage processes. Please refer to the RCEM Mental Health Toolkit for more information.[21]

- Part of the initial assessment for patients at risk of absconding should include the assessor making a judgement regarding whether the patient has autonomy/capacity. Capacity must be assessed for specific decisions. The specific question the triage nurse should be considering is "Do you think this patient has the capacity to decide to leave?". Ask the patient if they understand and agree with the initial treatment plan (provided at triage). Agreement with this initial treatment plan can be used to help assess capacity. If at a later time it is discovered that a patient has left the department without warning, then the nurse's initially assessment of capacity to decide to leave will help inform decision making at this stage.
- Patients who are at risk of absconding should have their physical description recorded during their initial assessment (triage) to facilitate subsequent identification (e.g. by police) in the event of absconding. It is essential to ensure the patient's contact details are up to date.
- Following triage, they should be informed of the likely time to see a clinician as well as who to contact if they have any questions whilst they are waiting.[22]
- Those patients at risk of absconding should be prioritised for early assessment, e.g. direct streaming to mental health team (where there is no co-existing 'medical' problem) or placed in a priority triage category. Parallel assessment of physical and mental health needs should be standard[23].
- Patients considered to be at high risk of absconding (or of self-harm) should be observed, either intermittently (e.g. every 15 minutes) or continuously if at very high risk. Training should be given to staff who carry out these observations. There should be very brief documentation of observations in the patient's notes.
- If a patient is threatening to leave, a senior decision-maker should assess the

patient whilst at the same time trying to de-escalate the situation, addressing the patient's reasons for wanting to leave and making a rapid determination of the patient's autonomy/capacity.

- If the assessing clinician believes the patient lacks autonomy and decides that restraint is appropriate (proportionate and in the patient's best interests), then this should be clinically led. If restraint is needed for more than 10 minutes, then Rapid Tranquilisation should be administered.[24] The legal basis for restraint or Rapid Tranquillisation should be recorded in the patient's notes (see box 1).

Box 1. Legal Basis for Restraint in the absence of autonomy

MCA 2005:

If they lack capacity, the MCA 2005 powers can be used to restrain and detain if necessary.

MHA 1983:

If the primary problem is related to mental health, then consider the use of the MHA 1983 and discuss with the mental health liaison service. A patient may benefit from MHA 1983 assessment if they have a severe mental illness, particularly psychosis. If they have already been placed on, or are subject to a Section 2, 4 or 136, then restraint can be used under the auspices of the MHA 1983. If they have not been placed on a section, then options are limited to requesting a s136 or a s4 (or s2 if on a ward).

Common-Law Doctrine of Necessity:

Where lack of autonomy is suspected but not confirmed (i.e. capacity assessment or MHA assessment not completed) then common law can be used to protect their right to life. This can only be employed where the risks to life are significant, and the use of restraint is a proportionate response. This decision should be made by the most senior clinician immediately available and be escalated to a consultant as soon as practically possible.

- Emergency Departments should have written agreements between themselves and security teams with regards to what levels of restraint can be provided and under what circumstances. EDs need to be mindful of the importance of documenting both the assessment of autonomy and the reason for restraint in the clinical record, without this intention it is unlikely security teams will feel justified in restraining a patient.
- Emergency departments should have a clear policy when a patient is discovered to have absconded. EDs should avoid immediately calling the police but instead undertake a thorough risk assessment. On discovering a patient has absconded, and there is a concern that the patient is at risk of harm to self or others, actions may include:

  1. Searching the ED and immediate surrounding area.
  2. Contacting security to help with the search as well as using CCTV.
  3. Calling the patient's contact number.
  4. Consider contacting the next of kin.

- In the event of not being able to find the patient the senor clinician on duty and the senior nurse should make a decision as to whether it is appropriate to contact the police or not. Police should only be contacted if:

  - A real and immediate risk to life exists.

AND

- Police assistance (requesting that they urgently locate and return the patient to the Emergency Department) represents a proportional response to the identified risk.

AND

- Individual patient vulnerability (e.g. child, learning disabilities, dementia, etc.) has been taken into account.

AND

- Efforts to contact the patient by telephone have failed.

AND

- No other person or service can facilitate the return of the patient, e.g. GP, SW, parent, relative.

- Staff should be aware of what specific information the police are likely to require; which department you are phoning from, who you are, who you are looking for, why the police need to find them, what steps have been taken so far to locate them and patient description.

- Before contacting the police, it is important to realise that the police do not have the power to bring patients back to the emergency department (ED) against their will unless:

  1. patient is under arrest (i.e. have committed a crime).

  2. patient has been placed under section 136 (authorises a police officer to remove a person to a place of safety <u>if she/he believes</u> that person is suffering from a mental illness).

- Once the police have been contacted to locate a patient who has absconded from the ED then an incident form (e.g. DATIX) should be completed. These clinical incidents should ideally be reviewed as part of a rolling governance programme with the police service.

- For those patients who have absconded and do not fulfil the criteria for police involvement, other options to consider are:

  1. Liaising with the community mental health team.

  2. Liaising with the GP or sending a discharge letter to the GP.

  3. Trying to contact the patient directly.

  4. Contacting a friend or relative if appropriate

  Local safeguarding procedures (children, vulnerable adults) should be followed.

- When a patient returns or is brought back after absconding, they should be re-triaged, considered high risk for further absconding and be seen promptly, preferably by a senior clinician. Clinicians should be mindful that after a period of absconding, the patient's condition may have changed for several reasons (e.g. ingestion alcohol or drugs). Previously instituted management plans may need to be reviewed in light of the new clinical assessment following the patient's return. For those patients brought back to the ED by the police, it is essential to establish whether the patient is on a section 136, under arrest or merely accompanying the patient. The intention or otherwise of the police to remain with the patient needs to be clear.

Revision

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Original

Catherine Hayhurst, James France, May 2013, revised June 2018

Review

Three years or sooner if important information becomes available.

Conflict of interest

None

Disclaimer

The College recognises that patients, their situations, Emergency Departments and staff all vary. This guideline cannot cover all possible scenarios. The ultimate responsibility for the interpretation and application of this guideline, the use of current information and a patient's overall care and wellbeing resides with the treating clinician.

Audit recommendations

Use of Mental Health Triage Tool for qualifying presentations;

Clinical Incident reporting for police involvement in absconded patients; Clinical Note documentation for those patients under-going restraint.

Keywords for search

Abscond, Restraint, Mental Capacity Act, Mental Health Act, Did not Wait

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[3] RCEM Section 136 Guidance. [https://www.rcem.ac.uk/docs/College%20Guidelines/A%20brief%20guide%20to%20Section%20136%20for%20Emergency%20Departments%20-%20Dec%202017.pdf Accessed 27th January 2020]

[4] See Darnley v Croydon Health Services NHS Trust [2018] UKSC 50 and Barnett v Chelsea & Kensington Hospital [1969] 1 QB 428.

[5] See European Convention on Human Rights 1950 and Human Rights Act 1998.

[6] Ibid.

[7] Mental Health Act 1983.

[8] See Darnley v Croydon Health Services NHS Trust [2018] UKSC 50 and Barnett v Chelsea & Kensington Hospital [1969] 1 QB 428

[9] See European Convention on Human Rights 1950 and Human Rights Act 1998.

[10] Mental Capacity Act 2005.

[11] *GJ v The Foundation Trust* [2009] EWHC 2972

[12] *R (Sessay) v South London and Maudsley NHS Foundation Trust* [2011] EWHC 2617

[13] Ibid

[14] Mental Capacity Act 2005.

[15] Social Care Institute for Excellence, 'Deprivation of Liberty Safeguards (DoLS) at a Glance' (2016) http://www.scie.org.uk/publications/ataglance/ataglance43.asp Accessed 10th February 2020.

[16] See *ZH v Commissioner of Police for the Metropolis* [2012] EWHC 604, *Gillian v United Kingdom* (App No 4158/05, 12th January 2010), *Austin v Commissioner of Police of the Metropolis* [2009] UKHL 5 https://www.lawsociety.org.uk/support-services/advice/articles/deprivation-of-liberty-safeguards-practical-guide/ Accessed 10th February 2020.

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[18] See European Convention on Human Rights 1950 and Human Rights Act 1998.

[19] See; *Osman v United Kingdom* (2000) 29 EHRR 245, *Keenan v United Kingdom* App no 27229/95 (ECtHR, 4th March 2001), *Orange v Chief Constable of West Yorkshire* [2001] EWCA Civ 611. *Savage v South Essex Partnership NHS Foundation Trust* [2007] EWCA Civ 1375, *Rabone v Pennine Care NHS Foundation Trust* [2012] UKSC 2, *Reynolds v United Kingdom* (2012) 55 EHRR 35.

[20] The defence of necessity has appeared in several notable medical law cases; *Gillick v West Norfolk and Wisbech AHA* [1985] UKHL 7 (17th October 1985); *F v West Berkshire HA* [1991] UKHL 1 (17th July 1990); *A (Children), Re* [2000] EWCA Civ 254 (22nd September 2000).

[21] RCEM Mental Health Toolkit. [https://www.rcem.ac.uk/docs/RCEM%20Guidance/Mental%20Health%20Toolkit%202019%20-%20Final%20.pdf Accessed 27th January 2020]

[22] See Darnley v Croydon Health Services NHS Trust [2018] UKSC 50

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