Coroner K.M.W Parkinson
Coroner's Court of Victoria
Level 11, 222 Exhibition St
Melbourne Victoria

NorthWestern Mental Health

North West Area Mental Health Service

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- **Coburg Integrated Community Team**
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35 Johnstone Street
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MELBOURNE HEALTH

NorthWestern Mental Health is part of Melbourne Health Service

www.mh.org.au
ABN 73 802 706 972

18 November 2013

Re: Finding into Death with Inquest into the death of Mr Hassen Yassin. Court reference: 2011 / 291

Dear Coroner Parkinson,

Please see below the NorthWestern Mental Health (NWMH) response to recommendations made in the Finding into Death with Inquest into the death of Mr Hassen Yassin. Court reference: 2011 / 291. This Finding was delivered on 20 August 2013.

Recommendation 1.

That the North Western Mental Health Service review the security arrangements relating to exiting the Broadmeadows Inpatient Facility, in the context of admission of Involuntary patients to the low dependency unit at that facility

- Broadmeadows Inpatient Psychiatry Unit (BIPU) is a 25 bed acute unit comprised of 21 beds in the low dependency area (unlocked) and 4 beds in the high dependency area (locked). In 2012-13, BIPU had 665 admissions, 326 of which were of involuntary patients under the Mental Health Act with an average length of stay of 12 days.
- In effect, this means that the four most acutely unwell consumers are in the high dependency area at any given time. Clinical staff have to operate within the spirit and the intent of the Mental Health Act, which proposes that consumers be afforded the highest standard of care in the least restrictive setting, appropriate to their needs. There is no doubt that very acutely mentally ill consumers have care provided to them in the low dependency area but nevertheless it would be inappropriate for this part of the ward to be locked all of the time.
- The low dependency area entrance is a generally open between the hours of 0830hrs to 2100hrs. However, dependent on the level of acuity and also the clinical presentation of admitted patients at the time, there is an established process for locking the unit during these times.
- All consumers admitted to BIPU undergo a clinical risk assessment utilising a standardised risk assessment tool (CRAAM - Clinical Risk Assessment and Management), which includes risk assessment for absconding from the unit. This risk assessment guides decision regarding the clinical setting in BIPU (low dependency vs intensive care) most appropriate to the consumers needs. All consumers have a safety plan developed and their risks are monitored utilising the standardised risk assessment tool.
- Changes have been made to the front door and the configuration of locks at BIPU to enable better visualization and control of persons entering and leaving the ward. The entrance to BIPU is now able to remain locked if required, with an override switch located at reception to allow patients who do not present a risk to self or others to enter and exit the door as required.

Recommendation 2.

That the North Western Mental Health Service review of procedures relating to notifications to police of absconding patients and documentation on patient file and follow up of same with police by the Mental Health Service staff.

- NWMH regularly reviews its policies and procedures as part of a governance framework.
- NWMH reviewed its "missing patient " procedure in June 2012 and this has been further reviewed and revised in October 2013. Besides the NWMH procedure, BIPU has a local protocol to follow for notifications to Police of absconding patients. This local procedure has been reviewed and revised in May 2013. Please find attached the current procedure and protocol.

Recommendation 4.

The secretary of the department of Health and /or the Chief Psychiatrist should ensure that the state-wide co-ordinated procedure for notification of and locating absconding mental health patients is adapted in order to ensure that a co-ordinated approach is adopted and follow up occurs. This procedure may appropriately be advised by way of the existing procedure published by the Department of Health in relation to accessing services.

- This recommendation is most appropriately responded to by the Office of the Chief Psychiatrist.

Recommendation 5.

In the absence of a state wide procedure the responsibility for the follow up of an absconding patient ought to rest primarily with the facility from which the unauthorised absence occurred. There should be no administrative transfer of care to another facility until the patient has been located. This approach would appear to be supported by existing Departmental directives referred to in the footnote to Rec.4

- NWMH contends that there are a number of practical impediments to placing the onus of responsibility for follow-up of an absconding consumer on to the service from which the consumer absconded versus the "usual" service to which the consumer normally attends. For example it would not be practical for a service based in Broadmeadows to actively follow up an absconding consumer in Dandenong, Frankston, Shepparton or Lakes Entrance.
- Notwithstanding this, NWMH agrees that active steps need to be taken by the service from which the consumer has absconded to inform and liaise with the consumer's service of origin to ensure that appropriate steps have been taken to locate the consumer and re-assess him / her prior to determining future treatment decisions. If needed, the community team can liaise with the police to apprehend and return the consumer to the inpatient facility. It is noted that almost all absconding consumers return to their current residential address / area of origin after absconding from the inpatient facility.
- Victorian Mental Health Services provide services to the community based on geographic catchment areas. The attached describes the roles and responsibilities of the treating team in the consumers "catchment area of origin". One of the responsibilities is to...."*Admit the client to the inpatient service in the area in which the client is being assessed; or, Locate a bed in an alternative inpatient facility*". There is no state wide procedure however that directly relates to Absconding patients from Out of Area Inpatient facilities.

- http://www.health.vic.gov.au/mentalhealth/pmc/access_across_regions.htm
  http://www.health.vic.gov.au/mentalhealth/cpg/comm_treat_order_guidelines.pdf

Recommendation 6.

During the course of the inquest it became apparent that there were limitations upon access by responsible clinicians to the RAPID database in a context of an absconding involuntary patient. Access arrangements to absconding patient details ought to be received in order that all information or that database is available to any mental health clinician state wide with responsibility for follow up of an absconding patient.

- This recommendation is most appropriately responded to by the Department of Health who has oversight, governance and responsibility for the Client Management Interface (CMI).
- An explanation of the information contained within CMI and what can be viewed by clinical staff from any Area Mental Health Service in Victoria is described below. Access to local sub centre's screening register i.e record of any contact to triage regarding a patient, outside of business hours, is restricted to the local area i.e in this case Werribee services, however the CMI does show the following to all state wide services – as described below and tabled at the hearing.

(1) "Rapid" Client Enquiry (available to Victoria wide Area Mental Health Services)

The Client Enquiry screen is an information screen within the Victorian Mental Health State wide database, 'Rapid'. It contains details about a patient, accessible Victoria wide by staff with the relevant permission level working within a Victorian public mental health service. The screen shots show evidence of:

- Currently registered consumers with AMHS
- All episodes of previous and current care and types
- Mental Health Act status of the consumer
- All admissions and discharges including absconding status.

(2) Screening Register Detail (only available to the local Area Mental Health Service)

Screening Register Detail is a function within the Victorian Mental Health State wide database, 'Rapid'. Screening Register information is stored on the local data store, Client Management Interface (CMI). Screening Register details are only accessible by campuses within a local CMI, therefore the attached Screening Register Details page has been provided by Werribee Mercy Mental Health Program (WMMHP). Information contained within this document indicates:

- Any contact made with triage of the local AMHS
- Action plan by triage or the local AMHS following that contact.

Yours sincerely

Dr Vinay Lakra

Director of Clinical Services North West Area Mental Health Service

CC

Dr Ruth Vine, Executive Director NWMH

Dr Peter Burnett, Director Clinical Governance, NWMH

Mr Peter Kelly, Director Operations, NWMH

Attachments

1. Melbourne Health Missing Patient Procedure
2. NWMH Missing patient procedure
3. NWAMHS procedure for contacting police for absconded patients from BIPU
4. NWMH memo to staff – " Missing Persons Reports and Victoria Police"

PROCEDURE: Missing Patient			
Category:	Access	Ref No.:	MH01.09
Sub-Category:	Access	Version No.:	2.1
Issue Date:	19 Mar 2013	Expiry Date:	06 Apr 2015
Department:	Melbourne Health		

DEPARTMENT	Melbourne Health
NAME OF DOCUMENT	Missing Patient
NUMBER	MH01.09
EXECUTIVE SPONSOR	Executive Director Nursing Services
FUNCTIONAL GROUP	Daphne Lyle –Nurse Unit Manager John Cade; Sue Donaldson – Quality and Patient Safety Consultant, Catherine Daniel – Consultation Liaison Psychiatry Nurse; Donna McVean – Nurse Unit Manager; Fiona Becker – Nurse Unit Manager; Cynthia Kiernan – Manager of Security
IMPLEMENTATION STRATEGY	In accordance with the communication plan
EVALUATION STRATEGY	Incidents of missing patients will be reported through RiskMan. Each incident will be investigated and the effectiveness of the procedure will be evaluated at this time.
ACHS EQuIP CRITERIA	1.1.1 The assessment system ensures current and ongoing needs of the patient consumer/patient are identified.
SUMMARY	This procedure outlines steps to follow when a patient or resident is unaccounted for.

1. ASSOCIATED POLICY

MH02 Care Planning and Implementation Policy

2. PURPOSE AND SCOPE

This procedure outlines the actions to be followed when a patient is missing from Melbourne Health.

3. DEFINITIONS

Absent/absconded patient	When the person has left the grounds without the knowledge of the nurse in charge of the shift. This includes a patient on leave who does not return at the prescribed time.
At risk patient	Where there is a known immediate risk to self, where there is a known immediate risk to others – this risk must be clearly documented in the medical record by medical staff following appropriate consultation.

4. RESPONSIBILITIES

4.1. Responsible staff are indicated in the attached flowchart and action cards.

5. PROCEDURE

5.1. For actions and timeframes refer to:

a Flowcharts:

i Missing Patient Flowchart – City and Royal Park Campuses; and

ii Missing Patient Flowchart – Satellite Sites.

b Action Cards:

i Missing Patient Action Cards for City and Royal Park Campuses; and

ii Missing Patient Action Cards for Satellite Sites.

5.2. If staff consider the patient a risk, they should complete as much of the Missing Patient Details Form as possible as a pre-emptive step. If possible, take a photograph of the patient.

5.3. Staff must not leave the campus or facility to look for the patient.

5.4. Security staff will undertake a search of the campus and complete either:

a Comprehensive Campus-wide Search Checklist – City Campus

b Comprehensive Campus-wide Search Checklist – Royal Park Campus

7. REFERENCES

7.1. Mental Health Act

7.2. Aged Care Act

8. FURTHER INFORMATION

8.1. Quality and Patient Safety Consultants

9. DOCUMENTATION

9.1. Missing Patient Flowcharts

a City Campus;

b Royal Park Campus; and

c Satellite Sites

9.2. Missing Patient Action Cards

a City Campus;

b Royal Park Campus; and

c Satellite Sites

9.3. Comprehensive Campus Wide Search Checklists

a City Campus

b Royal Park Campus

9.4. Missing Patient Details Form – order through Supply

9.5. Patient Alert Form 00 - order through Supply

10. REVISION AND APPROVAL HISTORY

Date	Version	Author and approval
February 2002	0	
June 2006	1	Quality Manager, Ambulatory & Continuing Care (Chair); Nurse Coordinator, Ambulatory & Continuing Care; Nurse Unit Manager, Aged Care Unit 2, RMH Royal Park Campus; Nurse Unit Manager, Aged Care Unit 1, RMH Royal Park Campus; Nurse Unit Manager, Emergency Department, RMH City Campus; Facilities Services Officer, Operation, RMH Royal Park Campus; Facilities Services Officer, Support, RMH Royal Park Campus; Security Coordinator, RMH City Campus; Operations Manager, NWMH
November 2010	2	Sue Donaldson, Quality and Patient Safety Consultant, Paula Dimakos, Quality and Patient Safety Consultant, Lucy Horgan, Residential Operations, APMHP, Ruth Vincent, Quality and Patient Safety Consultant, Robyn Garlick, Acute APMH, Shelly Saunders, Clinical Psychiatry, Graham Dolby, Facilities Management, Peter Ewels, Security, Leonie Walsh, IWAMHS, Jacquie Flude, Consumer Liaison Officer, Julie Munro, Incident Systems Manager. Approved and authorised by the Clinical Policy and Procedure Review Committee.

PROCEDURE: Missing Patient/ Absconded Patient	
Category: Access	Ref No.: NWMH01.02.04
Sub-Category: Discharge	Version No.: 4
Issue Date: 15 Nov 2013	Expiry Date: 29 Nov 2016
Department: NorthWestern Mental Health	

DEPARTMENT	NorthWestern Mental Health
NAME OF DOCUMENT	Missing Patient/Absconded Patient
NUMBER	NWMH01.02.04
SPONSOR	Director of Clinical Governance, NWMH
FUNCTIONAL GROUP	NWMH Clinical Risk Committee
IMPLEMENTATION STRATEGY	NWMH Clinical Risk Committee will be responsible for the review of procedures relating to missing patient across youth, adult & aged services NWMH Clinical Risk Committee is responsible for the dissemination of information across their local area services, for consumers, carers and staff. NWMH Clinical Risk Committee will refer all procedures for endorsement to Director of Clinical Governance, NWMH and will provide regular updates.
EVALUATION STRATEGY	All updated procedures will be reviewed within the structures of NWMH Riskman and incident reporting and Clinical Risk Committee in line with the 3 year MH review process. Review may be completed earlier in response to changes in clinical procedures and/ or legislative requirements. Flagging for identification of this procedure will be in line with the MH iPolicy and the delegated author.
EQuIP NATIONAL CRITERIA (NSQHSS) **NATIONAL STANDARDS FOR MENTAL HEALTH SERVICES (NSMHS)**	NSQHSS 1.8 1. Mechanisms are in place to identify patients at increased risk of harm NSMHS 2.11 The MHS conducts risk assessment of consumers throughout all stages of the care continuum, including consumers who are being formally discharged from the service, exiting the service temporarily and / or are transferred to another service. 2.13 The MHS has a formal process for identification, mitigation, resolution (where possible) and review of any safety issues.
VERSION SUMMARY	This version has been updated to provide a clearer process for when informal patients are missing and the police involvement

EXECUTIVE SUMMARY

- For all missing /absconded patients, clinical staff must attempt to locate the patient including contacting next of kin / carer.
- Staff must notify the Consultant Psychiatrist for any missing patient. Consultant Psychiatrist must make appropriate decision for further options considering clinical risks.

- Clinical staff must notify police of all involuntary patients or patients identified at risk within a timely manner
- Inpatient/ECATT clinical staff must liaise with Community team to assess or apprehend the patient.
- Appropriate MHA paperwork must be completed.

1. ASSOCIATED MELBOURNE HEALTH POLICY

MH01 Access Policy

2. PURPOSE AND SCOPE

Please read this procedure alongside MH01.09 Missing Patient procedure.

2.1. To inform staff about the process for when an involuntary patient is absent, missing or absconded from an approved mental health service without permission.

2.2. To inform staff about the process for when an informal patient has not returned from leave by the appointed time or is missing.

2.3. The reporting of an involuntary patient absent without leave is in accordance with Section 43 of Victoria's Mental Health Act 1986.

3. DEFINITIONS

Absconded patient	An *involuntary patient* will be deemed to be absent without permission when the person has left the hospital grounds without approval and with the intention of not returning. An involuntary patient who has not returned from leave by the appointed time or is missing (whereabouts unknown) are subject to the same protocol as if they absconded from the hospital.
Missing / absent	Patients who do not have a MH Act legal status are deemed *'informal' patients*. An informal patient is deemed to be absent when staff are unable to locate the patient within a reasonable time or it is evident that the patient has no intention of returning. An informal patient who has not returned from leave by the appointed time or is missing (whereabouts unknown) are subject to the same protocol as if they are absent from the hospital.

4. RESPONSIBILITIES

4.1. All NWMH staff including medical, nurses, allied health and administrative personnel.

5. PROCEDURE

In the absence of an involuntary patient without permission or absence of an informal patient **(note: 5.1 – 5.7 refer to missing patient within inpatient and ECATT services and 5.8 refer to community patients only)**

5.1. Clinical staff are responsible for:

a. Searching of the ward/campus within the first hour of the patient identified as missing

b. Attempting to locate patient by contacting residence, family and or significant others

c. Completion of a detailed risk assessment (documented on either a *Community Risk Screen form/ Clinical Risk Assessment and Management form (CRAAM))* must be carried out in order to determine the appropriate action to be taken when a patient is noticed to be missing

d. Reporting to the Consultant Psychiatrist immediately and Program/ Line Manager

e. Informing the relevant Community team after consultation with Consultant Psychiatrist

f. Reporting and documenting the absence to the police (for involuntary or patients identified at risk - for the purpose of apprehending the patient and returning the patient to the approved mental health service for ongoing treatment).

g. Completing a *missing person report* as per local AMHS paperwork. Information for locating a patient reported as missing can be found within the Department of Health and Victorian Police – Protocol for Mental Health (2010)

h. Notifying police if they locate the patient or if the patient returns to the AMHS

i. Entering Incident on Riskman

j. Documenting in the clinical file/ electronic health record a detailed summary of process and outcomes

k. Notifying next of kin and/or Primary Carer (as required)

l. Storing and data entry of all information for the client in the appropriate clinical storage systems, within clinical file or electronic database

5.2. Consultant Psychiatrist, in consultation with clinical staff, must decide on one of the following options and consider potential risks. After - Hours clinical staff will be responsible for documenting the information after discussion with Consultant Psychiatrist.

a. For Involuntary patients
   i. Patient is absent without leave and return is actively sought
   ii. To discharge the patient – MHA 16 Discharge from Involuntary patient status
   iii. Place the patient on authorised leave – MHA21 Leave of absence for an involuntary patient

b. For Informal patients
   i. Consider whether the patient meets criteria for involuntary treatment under the MHA
   ii. Patient is absent without leave and return is actively sought
   iii. To discharge the patient
   iv. Place the patient on leave

c. Consultant Psychiatrist is to ensure the relevant legal documents are completed.

5.3. Community team clinician is responsible for:

i. Follow up of the client as agreed in consultation with clinical ward/community staff and Consultant Psychiatrists (for example face – face contact, phone call and or home visit).

ii. If required, additional support should be sought for and provided by rostered staff for crisis assessment and brief intervention

5.4. If missing patient returns within 24 hours to an approved mental health service, clinical staff are to:

a. Review the ongoing treatment needs

b. Inform appropriate people of patients return, including Carer/ family, Community Team, on - call consultant

c. Notify police even if the patient returns to the service without police involvement.

d. Complete an updated risk assessment (documented on the *Clinical Risk Assessment and Management form (CRAAM))*

5.5. If patient doesn't return within 24 hours to an approved mental health service, clinical staff are to:

a. Contact triage and inform them of the details of the missing patient.

b. Discharge the patient (for involuntary patients legal status will need to be entered prior to CMI separation) from a held bed in the Inpatient Unit.

NOTE - Printed or downloaded version are uncontrolled and subject to change

i. Patient's return should still be actively sought in collaboration with the Community team and police if the risk assessment warrants it.

ii. Under the Department of Health and Victorian Police – Protocol for Mental Health (2010) the AMHS must update the police on any changes to the legal status of the patient.

c. Continue to make attempts to contact the patient and liaise with the relevant Community team for follow up.

d. Inform the key clinician/treating team for these patients. The key clinician/ treating team must continue to attempt to contact patient daily initially, then as appropriate after discussion with Consultant Psychiatrist

e. Update the patient's next of Kin/Primary Carer of the patient's continued absence.

5.6. If missing patient is located after 24 hours, take the patient to an approved mental health service. Clinical staff in consultation with Consultant Psychiatrist are to:

a. Reassess the need for admission

b. Make an appropriate decision about best course of action for their treatment, which may include admission to IPU

c. Inform the patients NOK/Primary Carer the patient has been located, and planned course of action

d. Provide appropriate information to police to help appropriate course of action. This information can be provided under Section 120A of MHA.

i. Police have no apprehension power for informal patients as will treat them as a general missing person. This means that if the police find the patient and have no concerns about their current welfare and the patient does not wish to return to an AMHS then police can only notify the service that the patient has been located and cannot divulge their whereabouts without patient consent.

ii. Police must confirm this status when they locate the patient. Police do have the power to apprehend involuntary patients who are reported as absent without leave/ absconded. If and when the police locate the patient they will confirm with the AMHS that the person is an involuntary patient.

5.7. Program Managers must ensure that a RiskMan journal entry is completed on patients return.

5.8. For missing patient in the community and other bed based services including adult and aged care services:

a. Report to the Consultant Psychiatrist

b. Key Clinician to liaise with next of kin and/or Primary Carer (as required)

c. Key Clinician to enter incident on Riskman.

d. Key Clinician to report and document the absence to the police if required (missing persons report).

i. For informal client's police have no power to apprehend and the will treat the patient as a general missing person.

e. Consultant Psychiatrist, in consultation with clinical staff to decide:

i. For patients on Community Treatment Order

- Complete the revocation of the community treatment order – MHA10 - Revocation of Community Treatment Order; or
- Discharge the patient from CTO - MHA 16 Discharge from Involuntary patient status

ii. For Informal patients -

- Consider whether the patient meets criteria for involuntary treatment under the MHA
- Discharge the patient

5.9 For Out of Area/Out of Region patients, Inpatient/ECATT staff must notify the triage service of the patient's catchment area of origin for follow up in the community including recommending home visit by their community team to review the patient. This includes action prescribed in 5.5 above.

6. ASSOCIATED POLICIES/PROCEDURES

6.1. MH01 Access Policy

6.2. MH01.09 Missing patient

6.3. MH05.01 Clinical Documentation

7. REFERENCES

7.1. Mental Health Act 1986

7.2. Department of Health and Victoria Police

8. FURTHER INFORMATION

8.1. Director of Clinical Governance, NWMH

8.2. DCS, AMHS

9. DOCUMENTATION

9.1. MH Risk Assessment

9.2. NWMH CRAAM

9.3. MHA16 Discharge from Involuntary patient status

9.4. MHA21 Leave of absence for an involuntary patient

9.5. Missing Patient Flowcharts

9.6. Missing Patient Details (Police Notification Form).and Documentation as per local , AMHS

9.7. Department of Health and Victorian Police – Protocol for Mental Health (2010)

10. REVISION AND APPROVAL HISTORY

Date	Rev No	Author and approval
June 1999	1	Director, NWMH
January 2010	2	NWMH Continuous Improvement Committee. Authorised by Peter Burnett, Director of Clinical Governance
July 2012	3	Clinical Risk Committee, NWMH; Author Vinay Lakra, Director of Clinical Services, NWAMHS and Authorised by Peter Burnett, Director of Clinical Governance, NWMH
October 2013	4	Members of Acute Inpatient managers committee, NWMH Clinical Risk Committee, NWMH; Author Vinay Lakra, Director of Clinical Services, NWAMHS and Authorised by Peter Burnett, Director of Clinical Governance, NWMH

Notification of Missing Person's to Victoria Police

Staff making a notification of a missing person, or a person Absent Without Leave (AWOL), to *Broadmeadows Police* must complete the following steps:

1. The notification must be made as soon as possible after the client is noticed to be missing or AWOL from the ward.

2. **BIPU Staff member to phone** (1st call) Broadmeadows Police Station on **ph 9302 2822** and inform the Police Officer that you wish to report a client as a "Missing Person" or as "AWOL" from Broadmeadows Inpatient Unit. Obtain the Police Officer's name and badge number and record these details as well as the time of notification to Police in the medical record. Record also, the steps that have been taken to locate the missing / AWOL client. Complete a risk man.

3. **Police will call BIPU** (2nd call) to confirm missing person report and provide a case number. This is to be recorded in the progress notes along with the confirming Police officer's name & ID number, and time call.

4. If you require guidance or assistance please consult with the ANUM or NUM.

Peter Kelly.
Director Operations NWMH
May 2013

Notification of Missing Person's

PHONE Broadmeadows Police Station on **9302 2822**

- inform the Police Officer reporting client as a "Missing Person" or "AWOL" from Broadmeadows Inpatient Unit.
- Obtain Police Officer's name, badge number, time & record medical record.
- Record the steps already taken to locate the missing / AWOL client
- Complete Riskman
- Document in Progress Notes

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Police to call and confirm missing person report and Case Number

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Insert Case Number into Progress Notes (Include Police Officers name, badge ID & time phone call received

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Any further assistance contact ANUM or NUM

Refer to Director of
Operations AWOL memo
May 2013

Memorandum

To	NWMH Nurse Unit Managers
From	Peter Kelly. Director Operations NWMH
cc	A/Prof Ruth Vine, Executive Director NWMH
Date	14 November 2013
Subject	**Missing Persons Reports & Victoria Police**

1. Reporting of missing persons or Absent Without Leave (AWOL) patients from NorthWestern Mental Health (NWMH) bed based facilities is a relatively common occurrence.

2. There are things that NWMH staff can do that would be of great assistance to Victoria Police (Vicpol) in respect to the reporting of missing persons and also during subsequent communications between our two agencies.

3. It is important for clinical staff to understand the procedures that Vicpol must follow when responding to a missing persons report. It is also important to understand that Vicpol procedures have changed markedly in recent years in response to various Coronial recommendations that have arisen from Inquests into the deaths of missing persons. Vicpol is mandated to undertake the following tasks / procedures following receipt of a missing persons report.

   - Vicpol are required to conduct investigations in relation to missing persons and to take active steps to locate the person. Vicpol commit very significant amounts of time, energy and resources conducting these investigations.

   - A missing persons report is entered by Vicpol on to the Law Enforcement Assistance Program (LEAP) database and the event cannot be "closed off" until Vicpol have confirmed that the individual is safe and well.

   - Vicpol has high levels of success in locating the vast majority of missing persons within 2-3 days of receipt of the missing persons report.

   - When Vicpol accept a missing persons report they are required to conduct a risk assessment. The risk assessment obviously informs the steps, and the degree of urgency that Vicpol will apply to individual cases. In conducting the risk assessment Vicpol will seek relevant information from clinical staff such as (a) when the person was last sighted and by whom (b) what clothes the person was last sighted in (c) current medications and risks associated with non-adherence (d) current mental state (e) next of kin details etc

- Vicpol are required to periodically contact the service from which the person was reported missing to check that (a) the person has not returned of their own volition and (b) that if Vicpol do locate the person – are they still required to be returned to the unit from which they went missing.

- If the person does return of their own volition, Vicpol members are required to "sight" the person, or otherwise confirm that they are safe and well before this event can be "closed off" on LEAP. Under certain circumstances Vicpol will accept a facsimile or email from the senior nurse on the unit confirming that the person has returned and that they are safe and well.

How can NWMH staff assist Vicpol in relation to Missing Persons?

4. NWMH staff should offer every assistance to Vicpol in relation to missing persons.

5. Clinical staff are able to provide sufficient information, reasonably requested by Vicpol, to enable members to conduct their investigations in response to a missing persons report. The provision of such information referred to in bullet point 4 above is permitted under Section 120(a) of the Victorian Mental Health Act.

6. Clinical staff should assist Vicpol members if (a) they attend units to make enquiries in relation to missing persons (b) if they request to "sight" a missing person who has retuned of their own volition or (c) if they request that the clinician confirm via facsimile or email that the person has returned of their own volition and is safe and well.

7. Clinical staff should seek guidance from senior staff if they are uncertain as to what level of detail can be provided to Vicpol members.

8. Please view this memorandum in conjunction with the relevant Melbourne Health and NWMH policies;
    - MH 01.09 Missing Patient
    - NWMH 01.02.04 Missing Patient / Absconding Patient

Peter Kelly. Director Operations NWMH