AGENDA ITEM
3.3

MENTAL HEALTH ACT MONITORING COMMITTEE
ERRORS AND BREACHES OF THE APPLICATION OF THE MENTAL HEALTH ACT 1983 (APRIL –JUNE 2021)

Date of meeting	04/08/2021
FOI Status	Open/Public
If closed please indicate reason	Choose an item.
Prepared by	Mr Phil Lewis – Head of Mental Health Nursing Alison Thomas, Team Leader Mental Health act Office
Presented by	Mr Phil Lewis – Head of Mental Health Nursing
Approving Executive Sponsor	Executive Director of Primary, Community & Mental Health
Report purpose	FOR DISCUSSION / REVIEW

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)		
Committee/Group/Individuals	**Date**	**Outcome**
Mental Health Act office staff		SUPPORTED

ACRONYMS	
MHA	Mental Health Act
CTMUHB	Cwm Taf Morgannwg University Health Board
CAMHS	Child & Adolescent Mental Health Services

IHI	Institute of Healthcare Improvement
CTO	Community Treatment Order
RC	Responsible Clinician
CoPW	Code of Practice for Wales
AMHP	Approved Mental Health Professional

Summary

Throughout Quarter 1 there were 33 minor errors on section papers that were all rectified within the fourteen- day time limit. This compares with 21 in Q4 of the previous year, which represents an increase of 66.64%.

There were 4 fundamentally defective errors during this quarter.

- Invalid Section 2 – Improper use of Section 2.
- 2 Lapsed Section 136s – Patients not assessed within 24 hours.
- Invalid Section 17F Revocation of CTO.

1. SITUATION/BACKGROUND

1.1 The purpose of this report is to present data regarding errors and breaches that occurred during the application of the Act and to highlight learning and actions taken to reduce occurrence. The report covers Adult, Older Persons and CAMHS managed by CTMUHB. Activity is regularly monitored in the MHA Operational Group.

Section 15 of the Act allows for the rectification of statutory detention documentation completed by Doctors and AMHPs within 14 days of admission to hospital. Within this report it is helpful to consider the categories of errors & breaches of the Act.

1.2 Rectifiable Errors

These are minor errors resulting from inaccurate recordings which can be rectified under Section 15 of the Act. Examples include incomplete addresses and misspelled names.

The application or medical recommendation, if found to be incorrect or defective, may, within that period, be amended by the person by whom it was signed. Upon such amendments being made the application or recommendation shall have effect and shall be deemed to have had effect as if it had been originally made.

1.3 Fundamentally Defective

These are errors which cannot be rectified under Section 15 and render the detention unlawful, therefore resulting in a breach of the Act. Examples include unsigned section papers, incorrect hospital details or the wrong form being used. Medical recommendations and applications that are not signed cannot be remedied under Section 15 and therefore render the detention invalid.

Administrative and medical scrutiny of section documentation is carried out by the MHA Office and medical staff approved under Section 12 of the Act to ensure compliance and to identify any amendments needed within the target time limit. The majority of errors recorded within this report are minor, relating to demographics, but all breaches are reported via Datix to enable monitoring and for training to be put in place as necessary.

2. SPECIFIC MATTERS FOR CONSIDERATION BY THIS MEETING (ASSESSMENT)

2.1 The total number of **minor** errors across all services was 33 and these were all rectified within the time limit. This can be broken down further into detaining hospitals and wards.

	Angelton	POW			RGH					Ty Llidiard
Sections	**2**	**14**	**PICU**	**ITU**	**Admissions**	**22**	**PICU**	**Seren**	**St David's**	**Enfys**
Section 2	2	5	1	0	7	1	1	2	2	0
Section 3	1	0	0	0	0	1	1	2	0	2
Section 4	0	1	0	0	0	0	0	0	0	0
Section 5(2)	0	0	0	1	0	1	0	0	0	0

Section 17F CTO Revocation)	0	0	0	0	1	0	0	0	0	0
Total	**3**	**6**	**1**	**1**	**8**	**3**	**2**	**4**	**2**	**2**

2.2 The table below provides a more detailed breakdown of the type of error

Rectifiable Errors		**Angelton**	**POW**			**RGH**					**Ty Llidiard**	
Responsible for Error	**Forms**	**2**	**14**	**PICU**	**ITU**	**Admissions**	**22**	**PICU**	**Seren**	**St David's**	**Enfys**	**Total**
AMHP	HO2	2	2	1	0	2	0	1	1	1	0	**10**
AMHP	HO6	1	0	0	0	0	0	1	0	0	0	**2**
Doctor	HO3	1	1	0	0	0	0	0	0	1	0	**3**
Doctor	HO4	0	1	0	0	3	1	0	0	0	0	**5**
Doctor	HO8	0	0	0	0	1	1	0	1	1	1	**5**
Doctor	CP7	0	0	0	0	1	0	0	0	0	0	**1**
Doctor or Nurse	HO12	0	0	0	1	0	1	0	0	0	0	**2**
Nurse	HO14	1	2	0	0	1	0	0	3	0	2	**9**
Other UHB	TC1	0	0	0	0	0	0	0	0	0	1	**1**
	Total	**5**	**6**	**1**	**1**	**8**	**3**	**2**	**5**	**3**	**4**	**38**

* Some detentions contain multiple errors on the section papers

2.3 The breakdown of errors will assist the MHA team in identifying areas of concern, which will highlight the priority areas for MHA training

2.4 The overall aim is to reduce minor errors from being made and eliminate any fundamental breaches of the Act.

2.5 The total number of fundamentally **defective** errors across all services in Quarter 1 was 4 in comparison to 2 in Quarter 4 for the previous year. This is broken down below into hospitals and wards.

Fundamental Errors	**POW**	**RGH**	**Ty Llidiard**
Sections	**A&E**	**22**	**Enfys**
Section 2	0	0	1

Section 136	2	0	0
Section 17F CTO Revocation)	0	1	0
Total	**2**	**1**	**1**

2.6 The first and second breaches of the Act referred to the same patient, in relation to the improper use of Section 2 and a lapsed S136.

The patient was detained under Section 2 of the MHA.

Prior to a MHA assessment, the clinical team were aware that the nearest relative would not agree to detention for further treatment under Section 3. An application should have been submitted to the County Court to displace the nearest relative. The 28-day assessment under S2 would have continued under S29, until the displacement had taken place. The RC decided not to further detain the patient as they were agreeing to remain in hospital on an informal basis.

The young person absconded whilst outside the hospital and was picked up by the police on a S136 and taken to A&E in Bridgend. The patient was not assessed under S136 but sedated, intubated and admitted to ITU.

S136 lapsed without the patient being reviewed and no 36 hour extension applied for.

The Doctor placed the patient on Section 5(2) in ITU and was transferred to Ty Llidiard once medically fit, which resulted in detention under Section 2.

An independent RC scrutinised the medical recommendations, which failed medical scrutiny, as there had been no significant change in presentation.

In line with Chapter 14 of the CoP for Wales, the Clinical Director confirmed that it was an improper use of Section 2.

The MHA office informed the RC to discharge the patient and to inform them that they were now in hospital on an informal basis.

2.7. The third incident relates to the lapse of a Section 136.

Under S136 a Mental Health Act assessment should take place within 24 hours but can be extended for a further 12 hours.

A patient was picked up on a S136 and transported to A&E in Princess of Wales Hospital, Bridgend for medical treatment prior to the mental health assessment. When the patient was deemed medically fit, the S136 MHA assessment took place the following day on ward 14, which was outside the 36 hours. The Doctor had failed to apply for the necessary extension prior to the expiry of the 24-hour period.

2.8 The fourth incident relates to the invalid revocation of a CTO under Section 17F.

The RC and Hospital AMHP had revoked a patient's CTO without the patient having been formally recalled to hospital under s17e.

The RC had not completed the Form CP5, which is the power to recall a patient on a CTO and the nursing staff had not completed the Form CP6. This should have been done at the point the patient is admitted to hospital which authorises the date and time of 72-hour assessment period.
The MHA team informed the RC, AMHP and nurse of the correct protocol.

3. KEY RISKS/MATTERS FOR ESCALATION TO BOARD/COMMITTEE

3.1 The number of minor errors rose by 66.64% from 21 to 33. The team continue to roll out the basic scrutiny checklists and have booked two training sessions for 6th August in the CAMHS unit and 24th August for newly qualified staff on the acute MH wards in RGH.

3.2. Two training events have been organised for 20th July and 14th September with an external provider, which will focus on the use of the Mental Health Act 1983.

3.3 S136 training is in the process of being arranged for staff in A&E, crisis teams and CAMHS.

3.4 Whilst both fundamental breaches and errors are addressed with individuals involved there is no clear mechanism to share learning, patterns of errors or overall performance with the professionals involved outside of the Quality Safety and Patient Experience meetings. We are looking at the various professional committees where we could feed this information in to trigger improvements.

3.4 Due to staffing shortages within Cardiff and the Vale mental health Act office there have been delays in receiving national data regarding breaches and errors. It is forecast that this will be available mid-August and will be included in next quarters report.

4 IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	There are no specific quality and safety implications related to the activity outined in this report.
Related Health and Care standard(s)	Governance, Leadership and Accountability
	If more than one Healthcare Standard applies please list below:
Equality Impact Assessment (EIA) completed - Please note EIAs are required for <u>all</u> new, changed or withdrawn policies and services.	No (Include further detail below) If yes, please provide a hyperlink to the location of the completed EIA or who it would be available from in the box below. If no, please provide reasons why an EIA was not considered to be required in the box below.
	Not Required.
Legal implications / impact	There are no specific legal implications related to the activity outlined in this report.
Resource (Capital/Revenue £/Workforce) implications / Impact	There is no direct impact on resources as a result of the activity outlined in this report.
Link to Strategic Well-being Objectives	Work with communities and partners to reduce inequality, promote well-being and prevent ill-health

5 RECOMMENDATION

5.1 The MHA Monitoring Committee is asked to:

- **DISCUSS** the report
- **NOTE** the actions