AGENDA ITEM
(3.5)

MENTAL HEALTH ACT MONITORING COMMITTEE
ERRORS AND BREACHES OF THE APPLICATION OF THE MENTAL HEALTH ACT 1983 (JULY – SEPTEMBER 2020)

Date of meeting	(04/11/2020)
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 2 there were 31 minor errors on section papers that were all rectified within the fourteen day time limit. This compares with 41 in the previous quarter which represents a 24% improvement.

There were 3 fundamentally defective errors during this quarter.

- The first incident was a Section 2 application which constituted a professional conflict of interest as both medical applications were from Doctors within the same team.

- The second incident relates to a detention on a medical ward. The detaining Doctor accessed the required paperwork over the internet and erroneously completed the English version rendering the section invalid.

- The third breach applied to the same patient, who was detained on a general ward who did not have proper receipt of papers resulting in the invalid detention.

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 31 and these were all rectified within the time limit. This represents 21% of all detentions throughout quarter 2. This can be broken down further throughout localities.

	Number of errors	% of errors	% of errors for total detentions
Merthyr	4	13.0%	17.4%
Cynon	5	16.1%	21.7%
Taff	6	19.3%	23.1%
Rhondda	6	19.3%	23.1%
Bridgend	6	19.3%	23.1%
Out of area	4	13.0%	15.4%
Total	**31**	**100%**	

2.2 The majority of errors were due to the following.

- Incomplete addresses
- Misspelling of names and addresses
- Abbreviations

2.3 The MHA team have introduced basic scrutiny checklists to be distributed to the wards. The intention is for the receiving officers/ ward managers, along with the Approved Mental Health Act Professional (AMHP), to check the accuracy of the statutory documents at the point of detention. Clarification is being sought as to whom this responsibility falls within the general hospital wards and basic receipt and scrutiny training made available.

2.4 The 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 2 was 3 in comparison to 0 in Quarter1. This is broken down below into localities

Area	Number of errors	% of errors	% of errors for total detentions
Merthyr	1	33.0%	4.3%
Cynon	0	0%	0%
Taff	0	0%	0%
Rhondda	0	0%	0%
Bridgend	2	67%	7.7%
Out of area	0	0%	0%
Total	**3**	**100%**	

2.6 The first breach of the Act was in relation to a Section 2 detention, which constituted a professional conflict of interest between the two doctors, who completed the medical recommendations.

Both medical recommendations were completed by Doctors from within the same team rendering the detention fundamentally defective

2.7 As this incident occurred over the weekend, the MHA office picked up this error on the Monday morning.

2.8 As the admission document revealed a fundamental breach of law (incapable of rectification under Section 15 of the MHA 1983), the patient's R.C was contacted to exercise their power under Section 23 to discharge the patient from section, by completing a Form HO17.

2.9 The ward staff were asked to inform the patient that they were no longer detained under the MHA 1983 but of informal status.

2.10 As the patient was refusing to stay on the ward informally, the use of the doctors holding power under Section 5 was applied until a fresh application for Section 2 was completed.

2.11 In order to reduce this risk, a briefing (SBAR) from the incident and the learning has been submitted to the Mental Health Senior Medical Council for sharing and learning

2.12 The second incident relates to a detention on a medical ward. The detaining Doctor accessed the required paperwork over the internet and erroneously completed the English version rendering the section invalid.

2.13 The third breaches applied to the same patient, who was detained on a general ward.

2.14 Following completion of the detention, paperwork was not receipted by the Hospital Managers by completion of a Form HO14 as is required.

2.15 Both of these incidents happened during the weekend and was identified the following Monday by the MHA Team. Contact was made with the detaining ward who informed the team that the patient had now been discharged.

2.16 The MHA team contacted the ward concerned to explain the protocol for receipt and scrutiny of statutory documentation under the MHA 1983, in line with CTMUHB's Scheme of Delegation.

2.17 Both the Liaison R.C and AMHP were asked to inform the MHA office (by email) of any detentions undertaken out of hours.

2.18 A communication brief (SBAR) has been circulated to the ILG Directors for awareness and action across the three ILG's

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

3.1 The number of minor errors fell by 24% from 41 to 31. The team continue to roll out the basic scrutiny checklists to further reduce this number

3.2. There have been 3 fundamental defective errors during this quarter

3.3 Due to the issue of the conflict of professional interest, a communication brief has been submitted to the Senior Medical Council for discussion and sharing to ensure that this error is not repeated.

3.4 Due to fundamental errors within the District general Hospital Wards, a communication brief has been circulated to the ILG Directors for action across the three ILG's

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 completed	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 Main Strategic Objective	To provide strong governance and assurance
Link to Main WBFG Act Objective	Work collaboratively with our public service partners and a broader range of partners to join up health and other services where this potentially represents better value for our residents and care users

5. RECOMMENDATION

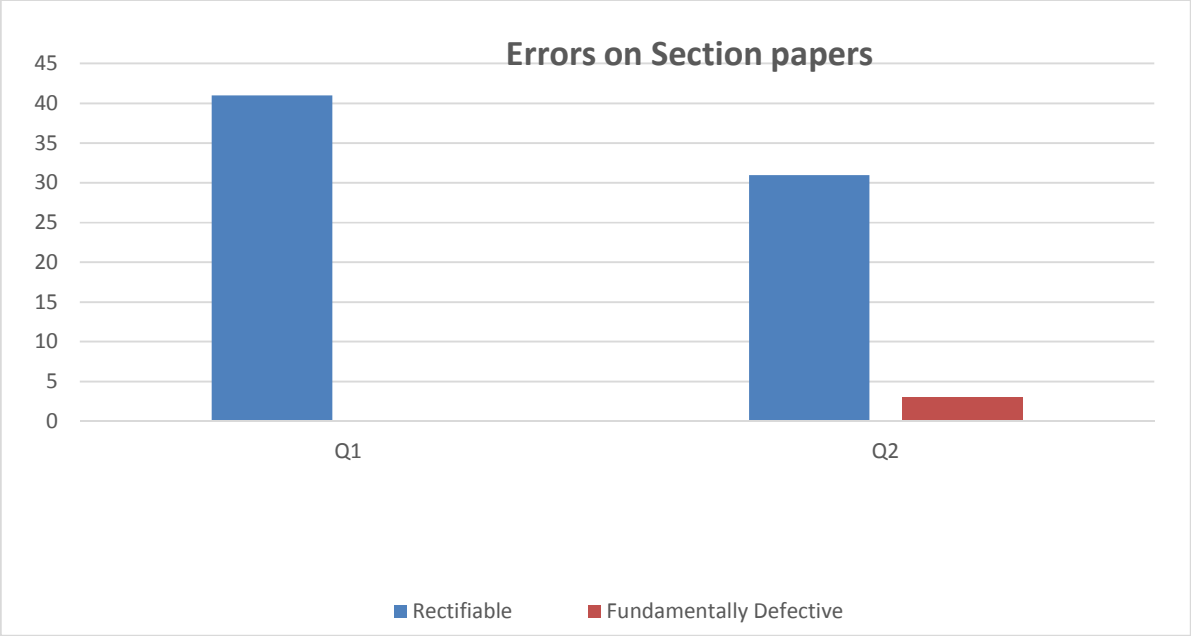
5.1 The MHA Monitoring Committee is asked to:

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

Quarterly Summary

During quarter 2 of 2020/21 the minor errors on section papers across all disciplines were rectified within the 14-day time limit. There were 3 breaches of the Act during this period.

Summary Table (July-September 2020)



Category	Q1	Q2
Rectifiable	41	31
Fundamentally Defective	0	3

Total detentions per locality with number of minor errors on section papers

(July-September 2020)