Partneriaeth Ranbarthol Gorllewin Morgannwg | West Glamorgan Regional Partnership

Adult Practice Review Report

West Glamorgan Safeguarding Adults Board
Concise Adult Practice Review

Re: WBA N1 2015

Brief outline of circumstances resulting in the Review

A concise adult practice review was commissioned by *the Western Bay Safeguarding Adults Board* on the recommendation of the Adult Practice Review Sub-Group in accordance with the Guidance for Multi Agency Adult Practice Reviews. The criteria for this review are met under Section 139 of the Social Services and Well-being (Wales) Act 2014*:*

*A Board must commission a concise adult practice review where an adult at risk who has **not,** on any date during the 6 months preceding the date of the event, been a person in respect of whom a local authority has determined to take action to protect them from abuse or neglect following an enquiry by a local authority, and has:*

- *Died, or*
- *Sustained potentially life threatening injury; or*
- *Sustained serious and permanent impairment of health.*

The timescale of the review is from 29th October 2014 to 19th January 2015.
Mr. A was referred by the Health Board (HB) Long Term Senior Nurse to the Western Bay Safeguarding Adult Board as he required care and support which the Senior Nurse felt had not been met. The focus of the review covers a period of two and a half months from the first hospital admission to transfer to a Neuropsychiatry Unit in England. During this time Mr. A's behaviour and cognitive ability fluctuated. Sedation was prescribed and administered to manage his periods of agitation.

On the 29th October 2014, Mr. A was found by his son at home in an unconscious state. Empty packets of Morphine Sulphate Tablets (MST) were present. He was taken to the local Emergency Department following a 999 call to the ambulance services. The family of Mr. A shared that 10 days prior to his admission he had taken increased doses of Oromorph to relieve chronic pain in his feet and shoulder. Mr. A was transferred to the Intensive Care Unit on the 31st October 2014.

Mr. A was 46 years old at the time and lived with his family, i.e. his wife, 15 year old son and two daughters both over 18 years of age. Mr. A was a known insulin dependent diabetic with a history of diabetic coma, seizures and renal problems. There is no record that Mr. A had a mental health condition prior to this time.

Within the two and a half month timescale of this review Mr. A was a hospital in–patient in acute medical and mental health wards for a total of 69 days. The list below also shows the times when Mr. A was discharged from hospital:

- Emergency admission to Emergency Department (29/10/14)
- Transferred to Intensive Care Unit (31/10/14)
- Transferred to acute Medical Ward 1 (05/11/14)
- Transferred to Private Residential Care Home X (02/12/14)
- Transferred to Private Residential Care Home Y (09/12/14 – did not arrive)
- Admitted to acute Mental Health Ward 1 as detained by the police under Section 136 of the Mental Health Act (09/12/14); remained on ward as an informal patient (09/12/14)
- Discharged home (13/12/14)
- Arrested by the police for Breach of the Peace at his home (16/12/14)
- Attended and discharged from the Magistrates Court (17/12/14)
- Second arrest by the police for Breach of the Peace at his home (17/12/14); remained in custody
- Admitted to acute Mental Health Ward 2 under Section 2 of the Mental Health Act (18/12/14)
- Transferred to acute Medical Ward 2 (19/12/14)
- Transferred to Psychiatric Intensive Care Unit (20/12/14)
- Transferred to Neuropsychiatry Unit in England (19/01/15).

Mr. A was discharged from hospital on two occasions. Firstly on a temporary basis to Private Residential Care Home X and secondly to his home. Mr. A demonstrated a variety of behaviour, i.e. inability to verbalise, threatening to discharge himself, absconding from the ward on two occasions, being aggressive towards staff and causing damage to hospital property. Due to his presenting behaviour a number of physical and mental health assessments were carried out by the Medical Team, Neurorehabilitation Consultant, Liaison Psychiatry and Consultant Psychiatrist. His condition escalated from the 22nd December 2014 whilst an in-patient in the Psychiatric Intensive Care Unit at the local general hospital where significant nursing resources were required to care for him.

Mr. A had complex care needs which were challenging for the multi-agencies to meet. This includes medical and nursing staff, police, social workers and the private care sector. Professionals applied Section 136, Section 5(2) and Section 2 of the Mental Health Act (see Glossary of Terms on page 13). The family confirmed that the chain of events was distressing for Mr. A and for them as they felt that his health and well-being needs were not met.

Neuropsychiatry assessed Mr. A on the 24th December 2014 resulting in a referral to the Neuropsychiatry Unit in England on the 7th January 2015. The Welsh Health Specialised Services Committee (WHSSC) agreed funding resulting in Mr. A's transfer on the 19th January to the Neuropsychiatry Unit in England. It is likely that

the Christmas holiday period would have played a part in the delay in the referral process and in securing his placement. At this time there were no neuropsychiatric beds in Wales available.

Practice and organisational learning

Learning from the multiagency review and learning events

It was necessary to hold two learning events as information became available after the first learning event which the Panel needed to explore further. The Panel requested that an independent representative attend the second learning event with a working knowledge of the Mental Health Act 1983, Mental Capacity Act 2005 and Deprivation of Liberty Safeguards 2007. There was difficulty in the Western Bay Business Unit appointing a suitable representative which led to a time delay in the second learning event taking place.

Family involvement

Mr. A's wife accepted the offer to meet the Chair and Reviewer towards the latter stages of the review process. The Chair and Reviewer met Mr. A, his wife, daughter and son at their home. Mr. A and his family welcomed the review as they were keen for improvements to be put in place which will help patients in the future who present in similar circumstances to that of Mr. A. The family commented that they were pleased with the care and support received by Mr. A at the Neuropsychiatry Unit in England. During the meeting, Mrs. A stated that during the time frame of this review she was informed that her husband had suffered a degree of "brain damage" during a previous hospital admission dating back a number of years. The family explained that Mr. A's physical health had deteriorated over the last year and that he required much assistance on a daily basis. Prior to his deteriorating health Mr. A had worked as an engineer.

Deprivation of Liberty Safeguarding application

On the 27th November 2014 whilst an in-patient on the acute Medical Ward 1 a mental health assessment by the Liaison Psychiatric Doctor found Mr. A not to have an underlying primary mental health condition but had evidence of significant cognitive impairment. This doctor stated that Mr. A lacked capacity to discharge himself against medical advice; he suggested a Deprivation of Liberty Safeguarding (DoLS) application when the Section 5(2) expired on the 29th November 2014 if his condition did not improve. The doctor also requested neuropsychology input to formally assess his level and nature of cognitive impairment. The doctor planned to review Mr. A the following day.

On the 28th November, Mr. A was reviewed by the medical consultant. At this time, Mr A was alert, talking normally and calm and requested increased pain relief. The plan was to await psychiatric input.

On the 28th November, Mr. A was again reviewed by the same Liaison Psychiatric Doctor (as the previous day) who documented:

> *"Patient assessed under the Mental Health Act (MHA). No further application under the MHA to be made. No evidence of psychiatric illness but patient does need to be detained for his own safety as he lacks capacity to discharge himself against medical advice. An application under DoLS would be appropriate and is recommended."*

On the 1st December 2014 Mr. A was assessed by the Consultant Neuropsychologist. The assessment showed that Mr. A did not demonstrate capacity regarding discharge destination. The Consultant Neuropsychologist noted that staff reported evidence of improvement and that Mr. A would benefit by being in a quieter environment with staff trained to de–escalate his agitation. Again, the Consultant Neuropsychologist suggested approaching the Neurorehabilitation Consultant for admission to the Neurorehabiltation Department; in the event that Mr. A's agitation persisted a referral could be made to the regional Neuropsychiatric Unit.

On the 1st December a DoLS urgent authorisation was put in place which was due to expire on the 8th December 2014. Mr. A was discharged on the 2nd December 2014. There was a one day interval (on a Sunday) from when the Section 5(2) expired and the DoLS urgent authorisation was put in place as the consultant was unaware that this can be processed on a weekend.

The Health Board provides a mandatory programme of training for the Mental Capacity Act (2005) and DoLS for all staff. Since the time frame of this review, it is acknowledged that there is widespread learning across organisations on the practice of the Mental Capacity Act (2005) and DoLS applications.

Referral to private residential home

On the 1st December 2014, Mr. A's medical condition did not require him to remain on the acute medical ward. The urgent need for acute medical beds within the hospital played a part in expediting Mr. A's discharge from hospital resulting in his transfer to private Residential Care Home X. This home provides care for adults with acquired brain injury or mental health conditions. This was on a temporary basis for four weeks. This arrangement had been agreed by the Locality Lead of the discharging hospital which was different to the locality of Mr. A's residence.

The Panel could not find evidence to support that there was effective communication between the hospital and Private Residential Care Home X with regard to the requirement to submit an urgent authorisation at the care home.

Mr. A's family felt that his discharge and transfer to Residential Care Home X was rushed and it was a move that Mr. A could not cope with and did not want. There had been reference to Mr. A's lack of capacity prior to his hospital discharge. Under the Mental Capacity Act 2005 Code of Practice there was a missed opportunity on the acute Medical Ward 1 to carry out a best interest meeting for Mr. A regarding his place of discharge. It is recorded in the medical notes that Mr. A was informed by the doctor that he was going to be discharged from hospital and

transferred to the neurorehabilitation housing the same afternoon. The doctor has documented that Mr. A did not take this information on board. There is no evidence in the medical notes that the doctor or nursing staff discussed this plan with Mr. A's family; the clinical entry shows that his family was informed of his transfer.

A question asked at the learning event was on what basis was Mr. A's referral accepted. The Clinical Nurse Manager (from Residential Care Home X) stated that he was aware of Mr A's behaviour prior to his assessment on the 1st December 2014 on the medical ward. At the time of his assessment the Clinical Nurse Manager believed Mr. A was suitable for short term care in Residential Care Home X. It is not clear whether a mental capacity assessment was completed at this time which the Adult Practice Review (APR) Panel agree should have been completed.

The review has identified that Mr. A's behaviour and cognitive ability fluctuated. This will have added to the difficulties encountered when developing an effective care plan. The Panel believe that prior to his discharge from the acute Medical Ward 1, had more time been made available to plan his discharge this may have prevented some of the events which followed.

Community Mental Health Team

The staff at Residential Care Home (X) stated that Mr. A settled into the care home without one to one care, was sociable and had capacity. After a period of three days his behaviour changed and concern was raised that he may be a threat to himself and others. Due to Mr. A's presenting behaviour, the nursing team from Residential Care Home (X) escorted Mr. A to an arranged appointment at the local Mental Health Community Service. At the second learning event, the mental health nurse stated that on Mr. A's arrival, she discussed Mr. A's case with a senior manager who advised that it was not appropriate to complete a mental health assessment for the following two reasons:

- A diagnosis of organic brain injury had recently been given
- Mr A was a resident in a different health locality.

The Panel questioned the decision of the mental health team in their management of Mr. A following referral from Residential Care Home X. The Panel agreed that a mental health assessment should have been completed at this time as Mr. A was demonstrating threatening behaviour. The Panel established that an organic brain injury does not equate to exclusion from a mental health assessment. In addition, the place of residence should have made no difference in the decision whether to complete a mental health assessment. Any on–going care required following a mental health assessment can be communicated to the appropriate locality team. The Panel also agreed that consideration should have been given to referring Mr. A to the Emergency Department to assess his physical condition given the fact that he was an insulin dependent diabetic. It is recognised that abnormal blood glucose levels can affect a person's behaviour.

Mr. A was returned to Residential Care Home X without a mental health assessment being completed. Mr. A's behaviour over the next few days gave increased concern to family and staff that he may be cause harm to himself or others. He was seen by the Health Board Nurse Assessor from the Long Term Care Team. The agreed plan of care between the Clinical Nurse Manager from

Residential Care Home X and the Health Board Long Term Care Team was to transfer Mr. A to Residential Care Home Y (the same care provider as Residential Care Home X, a distance of 15 miles). Residential Care Home Y provides care to adults over 18 years with a mental illness (functional) who have a primary diagnosis of acquired brain injury who require nursing care.

The Panel noted that there is no record that a mental capacity assessment or a risk assessment relating to transfer arrangements were completed prior to Mr. A's transfer.

On the 9th December Mr. A was transported to Residential Care Home Y with an escort. On the way, when the vehicle came to a stop, Mr. A got out of the vehicle and walked on a busy main road where he was at risk of serious injury from on - coming traffic. The police were called and detained Mr. A under Section 136 of the Mental Health Act and took him to a place of safety at the local general hospital where a mental health assessment was undertaken. Mr. A was admitted to acute Mental Health Ward 1. Mr. A agreed to remain in hospital as an informal patient on acute Mental Health Ward 1. The Health Board Locality Team cancelled the bed at Residential Care Home Y when they were informed of his admission to hospital. The APR Panel agreed that again there was lack of planning to ensure that Mr. A's needs would be met when discharged from hospital.

Mr. A remained as an informal patient on acute Mental Health Ward 1 for five days. During this time he received a mental health assessment from a Consultant Psychiatrist. This assessment determined that Mr. A did not have a mental illness so there was no indication to detain him under the Mental Health Act. Mr A was asking to go home. Again there is no record that the family were involved in the discharge arrangements. On the 13th December Mr. A was discharged and his daughter collected him from hospital.

During the first learning event, the lack of a discharge plan was discussed. The Panel could find no evidence of a discharge plan in the medical record.

On the 16th December Mr. A was arrested for Breach of the Peace following a domestic incident at his home. The custody nurse informed the Health Board's Locality Team of Mr. A's arrest. The Long Term Care Team arranged for Mr. A to see his GP although this consultation did not take place due to the next series of events. The following day, Mr. A was taken by the arresting police officer to the Magistrates Court.

Discharge from the Magistrates Court

On the 17th December Mr. A was discharged from the Magistrates Court and was given a bus ticket to get home. The police had requested for a Social Worker to attend the Court but unfortunately the case was withdrawn before the Social Worker arrived. Mr. A's wife was concerned for his safety so reported her husband as a missing person to the police. The weather conditions on this day were one of extremely heavy rain so family concern was heightened as he was not wearing a coat. Both Mr. A's wife and daughter left their home to search for him.

Mr. A managed to make his way home. The police attended the home and found him to be hostile and aggressive towards his family. The police were concerned for

the safety of the family and Mr A was therefore arrested for Breach of the Peace. Mr. A's wife informed the police that holding her husband in custody was not the appropriate place given the circumstances around his health and well-being to which the police agreed. The police were reluctant to arrest him but had no other option available to them at that time. They recognised the requirement for urgent action by the Health Board and Social Services to secure safe and appropriate accommodation for Mr. A as they wanted to avoid a repeat of what had just taken place, i.e. appearance at the Magistrates Court resulting in a discharge and attendance at the family home.

Given the recent history of the police detaining Mr. A under a Section 136 and arrest for Breach of the Peace, the action by the Court was called into question at the first learning event. It was acknowledged however at the learning event that at times Mr. A displayed a calm demeanour and that this may have been the case on this day. The Reviewer sent a letter of enquiry to the Magistrates Court requesting relevant information around this event which would inform the review. A written reply from a Court Solicitor confirmed that Mr. A's case was withdrawn. The Solicitor added that the reason the Court may not have waited for the Social Worker would be to ensure that people who are kept in custody by the police are not deprived of their liberty for any longer than is absolutely necessary. Breach of the Peace is considered a minor incident that the Court would look to deal with promptly in every case. Had Mr. A appeared on bail for an offence, it is more likely that the Court would have waited for a Social Worker to arrive. The Panel considered that the rationale described by the Solicitor for Mr. A's management at this time was reasonable.

Mental Health Assessments

Mr. A received mental health assessments by psychiatrists on the 27th November and 13th December which concluded that he did not have a mental health condition. It was stated that his behaviour was as a result of organic brain injury secondary to the reported overdose of query MST or insulin.

Social Services received a referral for Mr. A on the 16th December with a request for urgent allocation. A Social Worker from the Adult Physical Disability Team requested a mental health assessment be carried out by the Approved Mental Health Professional (AMHP) (Social Services). The AMHP at this time felt that the referral for a mental health re-assessment was not appropriate as the mental health assessment three days earlier on acute Mental Health Ward 1 identified that Mr. A did not have a mental health condition. Discussion at the second learning event agreed that the AMHP's decision at this time was appropriate.

On the 18th December, the behaviour of Mr. A whilst in custody deteriorated which resulted in the police contacting Social Services to request a mental health assessment. The outcome of the mental health re-assessment by the AMHP and two doctors (the same AMHP as above) was that Mr. A was detained under Section 2 of the Mental Health Act. The AHMP explained that given the recent history of Mr. A, he would benefit by transfer to an acute mental health ward where appropriate care and further re-assessment could be put in place. Mr. A was admitted to acute Mental Health Ward 2.

On the 19th December, Mr. A's physical condition suddenly deteriorated which resulted in his admission to acute Medical Ward 2. Mr. A promptly responded to medical treatment. Mr. A's behaviour again became threatening which resulted in his transfer on the 20th December to the Psychiatric Intensive Care Unit (PICU). The police were called to assist in this transfer. Mr. A remained in the PICU until his transfer on the 19th January 2015 to the Neuropsychiatry Unit in England.

Communication

Following Mr. A's discharge from acute Mental Health Ward 1 on the 13th December, the police representative on the Panel stated that it would have been good practice for the ward staff to have informed the police of his discharge for consideration of safeguarding options.

Referral to Regional Neuropsychiatric Regional Unit

There is no record that Mr. A was referred to the regional Neuropsychiatric Regional Unit as suggested by the Consultant Psychiatrist on the 30th November. It is possible that as a result of Mr. A's transfer to Residential Care Home X, this referral in effect became forgotten about as Mr. A had left the NHS environment for a period of time.

Police involvement

Due to Mr. A's pattern of behaviour the police services were called four times to attend. During the learning event, the police were keen to share that the scenario of a person presenting with a mental health condition and the practical difficulties encountered on how best to manage that person for the safest and effective care is not unusual. The police communicated that following Mr. A's second arrest for Breach of the Peace they readily recognised that holding Mr. A in custody was not the preferred option due to his presenting condition however no other option was available to them.

Improvement already in place

South Wales Police are currently piloting a nine month project in partnership with the three local Health Boards, bringing mental health practitioners into their public service centre. The mental health practitioners will triage cases at first point of contact to support access to appropriate crisis care and to provide more timely referrals to other health, social care and third sector services. They will make decisions around whether a Police response is required at all. It is hoped that this pilot will reduce the demand for the police and an improved service provision will be available for service users.

Safeguarding Children

The medical records contain an entry by a doctor making reference to the safeguarding of Mr. A's 15 year old son:

"To contact the child protection team at ….."

The doctor documents his request to make a children's safeguarding referral, but there is no evidence that a children's safeguarding referral had been received by the Local Authority.

Learning Point – Safeguarding Children

The doctor did not follow the All Wales Child Protection Procedures (2008) as he did not make a children's safeguarding referral when he identified a safeguarding concern. It is important that all professionals are aware of their accountability in making such a referral and that this must not be delegated to another professional. Given Mr. A's numerous contacts with other professionals and his presenting behaviour, there is no evidence to support that the other professionals involved in Mr. A's care considered a children safeguarding referral.

Best Interest Meeting

A consistent theme of this review is the difficulty multi-agency professionals encountered in their attempt to put in place an effective care plan to meet the complex needs of Mr. A. Contributing to this was Mr. A's fluctuating behaviour and mental capacity which resulted in his care needs changing on a frequent basis. At the learning event, discussion took place around care pathways with an expectation that there should be a designated lead to determine a care plan. Under the Mental Capacity Act 2005, the Code of Practice states that any decisions made or anything done for a person who lacks capacity must be in the person's best interests. The Panel agreed that a multidisciplinary /agency meeting should have been convened with a view to carrying out a Best Interest meeting with family involvement.

The Panel agreed that the numerous moves experienced by Mr. A since his initial admission would have had a detrimental effect on his emotional well-being and mental capacity. The Panel also noted the lack of family involvement during this time.

Improving Systems and Practice

The Panel agreed the following recommendations based on the learning points resulting from this Concise Adult Practice Review.

<u>Best Interest Assessment</u>

Learning point 1

The multi-disciplinary / agency team should comply with the Mental Capacity Act 2005 to ensure the best interests of a person are met when they lack capacity. Appropriate multidisciplinary/agency meetings with family involvement should be convened to ensure the best interests of the person. It is essential that the needs of the patient are considered and that the family are involved in these discussions.

Mental Capacity Act (2005) and Deprivation of Liberty Safeguards

Learning point 2

Multi-agency teams must continue to provide staff with mandatory training on the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards and support and monitor attendance. Measures must be put in place where compliance is not met.

Adult Safeguarding

Learning point 3

The Health Board should review the discharge planning documentation so that where there are safeguarding concerns, consideration can be given to communicate with the police prior to discharge.

Children Safeguarding

Learning point 4
Mandatory training on Children Safeguarding is a requirement for all professionals within multi-agencies. Multi-agency teams must continue to provide staff with training for staff on Children Safeguarding in line with the All Wales Child Protection Procedures (2008). Measures must be put in place where compliance is not met.

Risk assessment

Learning point 5
Multi-agencies must complete an appropriate risk assessment when transporting a patient in a vehicles to ensure the safety of the patient and others is maintained.

Statement by Reviewer(s)			
REVIEWER 1		**REVIEWER 2 *(as appropriate)***	
Statement of independence from the case *Quality Assurance statement of qualification*		**Statement of independence from the case** *Quality Assurance statement of qualification*	
I make the following statement that prior to my involvement with this learning review:- • I have not been directly concerned with the individual or family, or have given professional advice on the case • I have had no immediate line management of the practitioner(s) involved. • I have the appropriate recognised qualifications, knowledge and experience and training to undertake the review • The review was conducted appropriately and was rigorous in its analysis and evaluation of the issues as set out in the Terms of Reference		I make the following statement that prior to my involvement with this learning review:- • I have not been directly concerned with the individual or family, or have given professional advice on the case • I have had no immediate line management of the practitioner(s) involved. • I have the appropriate recognised qualifications, knowledge and experience and training to undertake the review • The review was conducted appropriately and was rigorous in its analysis and evaluation of the issues as set out in the Terms of Reference	
Reviewer 1 *(Signature)*	Wendy Sunderland - Evans	**Reviewer 2** *(Signature)*	N/A
Name *(Print)*	Wendy Sunderland Evans	**Name** *(Print)*	N/A
Date	16.05.19	**Date**	

Chair of Review Panel (Signature)	
Name *(Print)*	Terri Warrilow
Date	16.05.19

Appendix 1: Terms of reference
Appendix 2: Summary timeline

Glossary of Terms

Mental Capacity Act 2005
The Mental Capacity Act is designed to protect and empower people who may lack the mental capacity to make their own decisions about their care and treatment. This applies to people aged 16 years and over.

Neurorehabilitation
Neurorehabilitation aims to improve function, reduce symptoms and improve the wellbeing of people with diseases, trauma or disorders of the nervous system which include brain and spinal cord injury.

Neuropsychiatry
Neuropsychiatry is the assessment and treatment of patients with psychiatric illness or symptoms associated with brain abnormalities. Patients with these disorders often have serious problems with their intellectual abilities, memory, thought processes, interpersonal relationships and behaviour.

Deprivation of Liberty Safeguards (DoLS)
Deprivation of Liberty Safeguards provides a legal framework to protect vulnerable adults who may become or are being deprived of their liberty in a care home or hospital setting. This was introduced in 2009 as an amendment to the Mental Capacity Act 2005. If a hospital or care home needs to deprive a person of their liberty, in their best interests, a DoLS application needs to be completed. Following assessment by a Best Interest Assessor and a specially trained doctor, if appropriate, permission is granted to deprive a person of their liberty by granting a DoLS authorisation.

Section 136 – police power of arrest
Section 136 of the Mental Health Act is an emergency power which allows a person to be taken to a place of safety from a public place, if a police officer considers that person to be suffering from a mental disorder and in need of immediate care.

The purpose of removing the person to a place of safety is to enable an assessment of their mental health to be made by a doctor and an Approved Mental Health Professional (AMHP) in order for suitable arrangements to be made for the person's care and treatment. The person will be assessed as soon as possible.
A place of safety will usually be a NHS hospital or other health setting and only in exceptional circumstances a police station. A Section 136 lasts for a period of 24 hours with the possibility of a 12 hour extension under clearly defined circumstances.

Section 5(2) – Application in respect of a patient already in hospital
When a Section 5 (2) of the Mental Health act is applied, a patient can be kept in hospital because a doctor thinks that the patient has a mental health problem and is not well enough to leave. The patient can be kept in hospital for a maximum of 72 hours. During this time, the patient will have a mental health assessment by two doctors to decide if he/she needs to be kept in

hospital for longer. The patient will also be seen by an Approved Mental Health Professional (AMHP).

If it is agreed that the patient has a severe form of mental illness, the patient will then have a Section 2 (or a Section 3) applied if the Approved Mental Health Professional agrees with the doctors.

Section 2

Section 2 of the Mental Health Act allows a patient to be detained in hospital under a legal framework for an assessment and treatment of their mental disorder. When people have a severe form of mental illness they are sometimes so unwell they may not be able to accept that they may need to be admitted to hospital for their health, safety or protection of others. A Section 2 should end as soon as possible but can be in place for up to 28 days.

For Welsh Government use only

Date information received ……..

Date acknowledgment letter sent to SAB Chair ……

Date circulated to relevant inspectorates/Policy Leads …….

Agencies	Yes	No	Reason
CSSIW	☐	☐	
Estyn	☐	☐	
HIW	☐	☐	
HMI Constabulary	☐	☐	
HMI Probation	☐	☐	