National Assembly for Wales

Health and Social Care Committee

The work of the Healthcare Inspectorate Wales

Evidence from Mental Health Act Department, Abertawe Bro Morgannwg University Health Board – HIW 02

Dear Sir/Madam,

The following observations are being submitted by the Mental Health Act Department, ABMU Health Board, 71 Quarella Road, Bridgend. CF31 1JS

On the effectiveness of HIW in undertaking its main functions and statutory responsibilities:

1. We are still experiencing long delays in the arrival of a second opinion appointed doctor (SOAD) to complete treatment forms for detained patients who require medication or ECT.

2. SOAD Request Forms are not being processed due to being "lost" in the system; this is causing delays in the SOAD visit to the patient.

3. Completed SOAD certificates have been rendered invalid due to one of the statutory consultee not being consulted, or the SOAD not informing a staff member that they are being questioned as part of the consultation process on the day of the visit.

4. On occasion, completed SOAD certificates have been sent to the incorrect Mental Health Act Team. There have also been long delays in the form arriving at the hospital, further delaying the treatment for the patient.

5. There is no system whereby the Mental Health Act Department can monitor when visits by the SOAD have taken place. At one point HIW would sent out a weekly list to update staff, however, this function is no longer available.

6. It is difficult to obtain advice from HIW on issues relating to the length of time before the SOAD certificate should be reviewed. We are informed that this is a matter for the clinician to decide, however, HIW Reviewers can be critical of forms that are in use for long periods.

7. No feedback from a query raised to staff in HIW concerning the recording of a death of a patient subject to a guardianship order. The "Death of a Patient Liable to be Detained" states on the form that "*There are separate forms to record the death of a community patient (ie subject to supervised community treatment) or a guardianship patient".* Yet the HIW website does not contain a form to record the death of a guardianship patient and HIW could not provide a clear explanation of who needed to be informed.

8. There are concerns at the length of time between visits by HIW to mental health units and receiving the report from HIW, which have resulted in many of the issues raised by the report being resolved before the action plan is submitted to HIW.

9. The decision by HIW not to monitor patients subject to community treatment orders has raised concerns, as these represent a large portion of detained patients (68) in ABMU Health Board and they should be subject to the same inspection of their statutory documents under the Mental Health Act 1983 as other detained patients, to ensure that their rights and legal requirements are being adhered to.

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