mental welfare commission for scotland

Closure report

Investigation into the care and treatment of Mr D prior to his death (2023)

November 2025

Our mission and purpose

Closure report

Investigation into the care and treatment of Mr D prior to his death (2023)

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Investigation team:
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Date of executive leadership team approval of investigation:
20 July 2021

Date of commencement of investigation:
Letter sent to leaders of Health and Social Care Partnership A and Health and Social Care Partnership B to advise of decision to investigate 28 August 2021

Date of publication of investigation report:
21 September 2023

Date of closure report:
9 October 2025 (completed outwith the 15-month Commission Key Performance Indicator standard)

Purpose of a closure report
The purpose of a closure report is to assess whether the Commission has achieved its objectives (including outcomes, learning, quality and impact) and completed all deliverables on time and as planned. The report must summarise the findings and recommendations made in the themed visit/investigation report and identify the organisations and individuals to whom the recommendations were made. The report should also identify the follow up actions and activities of the Commission in gathering in responses to the recommendations, and once in, identify how these responses were evidenced, assessed for impact and their success measured. The report should assess whether the activity was worthwhile in terms of impact, resource commitment and outcomes and met organisational standards and expectations.

Summary of recommendations made in the investigation report and the organisations and the individuals asked to respond

The investigation into the care and treatment of Mr D was conducted under section 11 of the Mental Health (Care and Treatment) (Scotland) Act 2003. Section 11 gives the Commission the authority to carry out investigations and make recommendations as it considers appropriate, including where an individual with mental illness, learning disability or related condition may be, or may have been, subject to ill treatment, neglect or some other deficiency in care and treatment.

Mr D was an 18-year-old man who died in December 2018 from the consequences of water intoxication as a result of ingesting an excessive quantity of water. This occurred while he was an inpatient in an acute adult mental health services (AMHS) ward where he had been admitted on an urgent basis under a short-term detention certificate (STDC) of the Mental Health (Care and Treatment) (Scotland) Act 2003 (the 2003 Act).

Prior to this, Mr D had been receiving care and treatment in a community setting from a different health board. Our investigation set out to look at the detail around this support, the transition from a Child and Adolescent Mental Health Services (CAMHS) service to adult services and the engagement with his family.

Mr D's case was brought to the Commission's attention by his family but we were also notified by services.

This investigation sought to identify what lessons could be learned from the experience of Mr D and his family by the Scottish Government, all of Scotland's health boards and health and social care partnerships, NHS Education (NES) and the Royal College of Psychiatrists, as well as those organisations directly involved in Mr D's care.

Recommendations for NHS A

1. NHS A must complete their responsibilities under organisational duty of candour to offer an explanation for Mr D's unexpected death and an apology where indicated, and ensure local policies fully reflect Scottish Government's non-statutory guidance.

   Our report highlighted some issues with duty of candour especially as Mr D's care and treatment was delivered across two health board areas. The organisational duty of candour non-statutory guidance published by Scottish Government makes clear that although it is the legal responsibility of the board in which an incident occurred to fulfil the legal responsibilities, it is not unusual for more than one organisation to be involved in the provision of healthcare, therefore:
   "All parties are expected to co-operate fully throughout the duty of candour procedure and share lessons learned and necessary actions identified by the procedure."[1]

   While we recognise that the joint Significant Adverse Event Report (SAER) was well conducted and contact and liaison maintained with family members, our investigation team assessed that this should have been followed by a robust response from both boards to Mr D's family under their organisational duty of candour responsibilities. This would have enabled Mr D's family to have had more confidence in the boards' commitment to learn from the findings of the SAER at that time.
   We have been advised that apology letters were sent to the family by both boards in line with our recommendation.

2. NHS A should audit their compliance with the now established Principles of Transition in Scotland in the care of child and adolescent patients with a diagnosis of psychosis who require ongoing treatment and transition to adult mental health services and demonstrate that robust and clear processes are in place.

   The investigation report highlights that services took a staged approach to transition for CAMHS to adult services for Mr D and wished to proceed at his pace. However, at the point of eight months, Mr D's situation was deteriorating and there was no contingency on how this would be managed across both services. We wanted to be confident that the service involved had improved upon this and was adhering to the Scottish government guidance.

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[1] Organisational Duty of Candour Guidance (2018), Scottish Government, p.17 [ARCHIVED CONTENT]. It should be noted that the Scottish Government revised the duty of candour guidance in March 2025 and strengthens the position of multiple organisations cooperating with each other Organisational Duty of Candour Guidance - 2025.

Unfortunately, we noted a delay to this response in September 2024 and we followed up with the service to address this issue. We were updated in October and December 2024 and confirmation was given that the audit had been completed with a further update on outcomes received in early 2025. NHS A advised us that they had expanded the scope of our recommendation and included all young people on the CAMHS caseload about to transition to adult services and not just those with a diagnosis of psychosis. The audit had particular emphasis on:

- timelines for referrals and appointments;
- acceptance of referrals by the adult service;
- any additional vulnerabilities that may impact on the transition;
- evidence of any conflict or confusion during the process and adherence to the principles themselves.

Although the service was able to detail some positive practice, they have advised us that referrals continued to be delayed in 20% of cases and disagreement or confusion around transition was evident in 50% of cases with no case displaying a clearly documented transition date which had been agreed by all parties. In some instances, prescribed Scottish government paperwork was not being used by the CAMHS service.

The service has taken immediate steps to remedy this position, and further detail is recorded under sections 2. (See below)

3. NHS A to ensure staff are fully aware of and supported during the process of a SAER involving their care area or the treatment of patients under their care.

We have commented that the significant adverse event process in this case was well conducted with an attempt made by both boards to work jointly. This worked, to a certain degree, and reflection by both boards following the review and our own investigation indicated that there was still learning to be gained (see section 6 of Mr D report). NHS A in particular had processes in place but awareness of these and dissemination of learning appeared to be limited in relation to some of the staff we spoke to. This was in contrast to what we heard from staff involved with NHS B.

NHS A has now introduced a number of changes to its process including the development of a patient safety action and experience group (PSAEG) with regular meetings that discusses all adverse events. This meeting has also produced a briefing template that

includes a summary on staff support along with an information leaflet for staff on impact of adverse events on staff and pathways on how they can find support.

Recommendations for NHS/HSCP B

1. NHS B must complete their responsibilities under organisational duty of candour to offer an explanation for Mr D's unexpected death and an apology where indicated, and ensure local policies fully reflect Scottish Government's non-statutory guidance.

   Please see above point 1 for NHS/HSCP A.

Recommendations for all NHS/HSCPs

1. Mental health service managers should ensure they have robust local procedures in place for the acute or planned transfer of patients between services and between health boards, staff are aware of the local requirements and safeguards required and audit their implementation.

   We received a number of responses to this recommendation providing examples including.
   - a digital solution to sharing data between Boards. To enable audit, amendments to current procedures have been revised to require creation of a Datix record of immediate harm if admission not accommodated locally.
   - an NHS board introduced a local adaptation of the National Guidance on Transitions paperwork for individuals moving from CAMHS to adult service along with a process audited for compliance and future monitoring.
   - A transfer checklist is in use and monitored at ward level as directed by Board-wide Admissions and Discharge Policy.
   - A patient transfer protocol created building on transfer risk assessment document – applicable across all MH and LD services and auditable.

2. Uncommon acute physical health scenarios can occur in patients in mental health inpatient services. To reduce the risk of harm, mental health service managers should ensure staff have information on recognising and responding to uncommon acute physical health scenarios including polydipsia and water intoxication. This may take the form of alerting staff to Continuing Professional Development (CPD) opportunities to build and maintain competence and should be auditable.

We received a number of responses to this recommendation providing examples including:

- CPD audit and sessions;
- Mental health training day to include uncommon physical illness, specifically including polydipsia;
- Ongoing information and learning events re uncommon physical illness in mental health;
- Establishment of regular physical health and mental health group;
- Intention to use Mr D report in undergraduate teaching programme for medical staff, specific to specific polydipsia;
- Grampian Health Board, in particular, has developed specific learning/information tool in respect of polydipsia/polyuria.

3. All health boards must raise awareness among staff of the organisation's obligations under duty of candour and related local policies. This should include a focus on organisational duty of candour when training staff to undertake SAERs and especially the requirement for a full apology (which is not the same as an admission of liability or blame).

   Examples from a range of responses include:

   - Information and training confirmed within modules such as 'Adverse event management policy', SAER training, and SAER Leads induction.
   - Availability of relevant TURAS Learn modules disseminated across staff via professional leads.
   - Quality assurance team audited adherence to Duty of Candour processes within board area.
   - Staff net page devoted to Duty of Candour with links to TURAS and NES Learnpro modules.
   - Approach highlighted at adverse event management training delivered by clinical governance team.

Recommendation for NHS Education Scotland (NES)
In partnership with stakeholders, NES should support educational and workforce developments on the recognition of uncommon acute physical health scenarios which occur in psychiatric inpatients including polydipsia and water intoxication and make this available nationally.

NES responded to this recommendation to advise that further discussions with medicine and pharmacy colleagues in NES and with external partners resulted in a general view that from an education perspective, the scale and scope of the recommendation is too broad to implement as stated. The number and type of possible physical health scenarios which could potentially occur is difficult to determine, particularly if the focus is on those that are uncommon. NES advised that, in consultation with medical colleagues, physical health in the context of psychiatric inpatient settings is an area which is already covered in core curricula. However to ensure as far as possible that the uncommon acute physical scenarios are highlighted in relevant education areas, NES is committed to ensuring that physical health is included in any future nursing, midwifery and allied health professionals' (NMAHP) mental health resources, including any related to acute psychiatric settings.

Recommendation for Royal College of Psychiatrists CAMHS Faculty
The Royal College of Psychiatrists CAMHS faculty (RCPsychiS CaAF) should explore with its members whether barriers exist to the use of clozapine in young people who meet established clinical criteria for its use.

Following Mr D and this recommendation the Royal College of Psychiatry progressed a research paper which was published in medical journal Plos One, 'Survey on barriers to psychiatrists' use of clozapine for young people in Scotland and suggestions for reducing these'. The research involved a cross-sectional survey of psychiatrists working in CAMHS across Scotland. The research paper findings were presented at the RCPsychiS CaAF Executive Committee meeting, and committee members have had time to consider and discuss the findings. This was further presented to the Mental Welfare Commission and the RCPsychiS CaAF annual conference, both taking place in November 2024. In addition, the Royal College commenced liaison with NHS Education for Scotland and the Royal College of Psychiatrists eLearning Hub around the possibility of creating a learning package focusing on clozapine prescription in CAMHS. This is a work in progress.

The research undertaken has identified a number of barriers within this area including confidence in prescribing, issues over diagnostic uncertainty and the availability of clinical resources in line with blood monitoring, staffing and clinic facilities.

Recommendations to the Scottish Government

Considering the different digital record systems across mental health services in NHS Scotland, the Scottish Government should set standards within the next six months for the safe transfer to, or management of patients who present from other health boards, including minimum standards for information sharing and use of a standardised form.

The government responded via the Minister for Mental Health, Social Care and Sport advising that they are looking at improving integrated data sharing on a national basis with a range of digital programmes, they have also set out a series of mental health standards which include person centred planning.

Summary of responses (including decision as to whether they are satisfactory and how this decision was evidenced and measured)

The Commission received responses from NHS A & NHS B, NHS Education Scotland, the Royal College of Psychiatry and the Scottish Government. Not all of responses were received within the agreed timelines, however work has been ongoing and reached a satisfactory conclusion in the majority of recommendations.

The responses were scrutinised by the Commission's investigation team and where required, additional information and evidence was sought in relation to action plans. Services, once alerted to any gaps, were responsive and able to provide updates.
In relation to **recommendation 2 for NHS A** they have outlined to us plans for improvement which have been put into effect, and we will continue to monitor this.

Recommendations for service enhancement include:

- All CAMHS teams adopting the Scottish government transition paperwork.
- Barriers to transition planning to be explored with clinicians with the aim of transition planning beginning at least six months prior to 18th birthday, wherever feasible.
- Consideration given as to how adult mental health teams can learn from the good practice in other parts of the service.
- Proposal that all adult mental health teams have a named transition lead, responsible for discussing referrals from CAMHS and arranging professional meetings and joint reviews.

We also received a response from the Royal College of Psychiatry detailing the work they had undertaken within the CAMHS faculty on barriers to prescribing clozapine in younger people, which had been identified in the Mr D report. The findings were presented to staff at a Commission learning event and detailed a number of issues. The barriers included the community nature of CAMHS services who do not have clinic / blood monitoring facilities, limited resources, diagnostic uncertainty in some young people. Discussion is taking place as to whether this could lead to prepared guidance outlining how to overcome such barriers.

Summary of Commission follow up activity and actions (including dates)

The Commission has continued to follow up recommendations from the report. These involved recommendations to 2 different health boards, NES, Royal College of Psychiatrists and Scottish Government. Wider recommendations were made national both to NHS boards and mental health service managers.

In addition, the Commission has been involved in further actions to promote national learning including:

- Liaising with Scottish government in relation to revised duty of candour guidance.
  (The Scottish Government published the revised duty of candour guidance in March 2025.)
- Presentation of report and its findings at a Commission learning event in September 2023.
- Participated in NHS B development session in relation to significant adverse events with reference to learning identified from Mr D report.
- Presentation of Royal College of Psychiatry (CAMHS faculty) survey and outcomes at Commission learning event autumn 2024.

The findings of Mr D's case were reflected on in end of year meetings with all HSCPs at the end of 2023.

Summary of the impact of the investigation report with particular reference to media as at 30 November 2023

This report was published with an easy read version and a news release on 21 September 2023

Media

This report was published anonymously with a news release on Thursday 21 September 2023. It was the third of the Death in Detention/Homicide Review project reports to be published. The report gained good coverage from Scottish and UK media, including 16 local news outlets across the UK; much of the coverage came from Press Association's copy.

Social Media

Twitter (aka 'X')

The original post received 136 engagements (meaning it was liked, reposted, clicked on, or otherwise interacted with). 97 users clicked on the link to the news story, four users liked the post, and eight posted it directly to their own followers. This was the second-most-successful post of the month.

Website

In the seven days following publication, the news story on the report was viewed 288 times, by 3.74% of users, making it the 7th most popular page in that time (the most popular being the home page, with 1161 views, or 15.08% of users). This is above average compared to our other reports and publications.

Mailing list

We sent the report to all 1,358 subscribers on our mailing list. It was opened 194 times in the first week, an open rate of 21.87%. Subscribers clicked through to the report 53 times, or 27.3% of those people who opened it, a slightly-above-average rate which is similar to our other reports (such as local visits).

Conclusion

The investigation concluded there were aspects of the care and treatment delivered by NHS A and NHS B that had they been conducted differently might have prevented Mr D's death while detained under the 2003 Act.

A more assertive approach to the treatment of Mr D's psychotic illness in the two years before his death was warranted. The failure to impart key clinical details to the treating ward staff during Mr D's final admission, both in the provision of all relevant casefiles and the creation of an informed and updated risk assessment and care plan, meant Mr D was able to engage in risky and ultimately fatal psychosis-driven behaviour (the consumption of excessive amounts of water) without mitigations having been put in place.

The Commission's investigation team and Mr D's family were keen to look at the care and treatment across both health boards and in community and hospital-based settings. We wanted to focus on areas that had not been looked at in the original SAER and we found a number of key issues that did impact on this tragic outcome for Mr D and his family.

For example, poor team dynamics where staff were not always able to communicate well, over reliance on family members as opposed to professional oversight and the transfer of an unwell young man to a differing area. We feel that these examples, while routine for mental health services, will be recognised and reflected upon with a clear line to improvement.

If you have any comments or feedback on this publication, please contact us:

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