mental welfare
commission for scotland

When things go wrong

Responding to errors in the application of mental health legislation

Good practice guide

June 2026

Our mission and purpose

Our Mission

To be a leading and independent voice in promoting a society where people with mental illness, learning disabilities, dementia and related conditions are treated fairly, have their rights respected, and have appropriate support to live the life of their choice.

Our Purpose

We protect and promote the human rights of people with mental illness, learning disabilities, dementia and related conditions.

Our Priorities

To achieve our mission and purpose over the next three years we have identified four strategic priorities.

- To challenge and to promote change
- Focus on the most vulnerable
- Increase our impact (in the work that we do)
- Improve our efficiency and effectiveness

Our Activity

- Influencing and empowering
- Visiting individuals
- Monitoring the law
- Investigations and casework
- Information and advice

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Relevant legislation: Mental Health (Care and Treatment) (Scotland) Act 2003, Adults with Incapacity (Scotland) Act 2000

Intended audience:
Approved medical practitioners; responsible medical officers; mental health officers; clinicians utilising Part 5 of the Adults with Incapacity (Scotland) Act 2000; health board Mental Health Act administrators; nursing and medical staff involved in mental health act or incapacity act processes; chief officers; associate medical directors in mental health

Purpose of this guidance

The application of mental health legislation is complex. It requires the coordinated actions of clinicians, mental health officers, administrative staff and others, often under significant time pressure and within systems that are not designed with mental health statutory safeguards as their primary focus.

In this context, errors are not uncommon. They may arise from workload pressures, gaps in training or experience, weaknesses in systems of working, or the cumulative effect of small administrative failures rather than from individual failings or poor intent.

While many errors are minor and readily corrected, others have more serious implications. Some place the legal basis of detention, treatment or transfer in question and can result in people being subject to compulsory measures without lawful authority. Where this occurs, the impact on the rights of the individual can be significant, and public confidence in the operation of mental health legislation can be undermined.

The Mental Welfare Commission for Scotland regularly receives enquiries and notifications when it becomes apparent that something has gone wrong in the use of statutory powers. Historically, the Commission has responded to these situations on a case-by-case basis. Similar errors can prompt very different responses from practitioners and services, and the absence of a shared approach can make it harder to address underlying systemic issues or recurring gaps in practice.

This good practice guide has therefore been developed to support consistent, proportionate and rights-based responses when errors are identified. Its focus is not on attributing blame, but on ensuring that errors are recognised, reported and addressed in a way that protects the individual, restores lawful authority where required, and enables learning. Appropriate reporting and follow-up are essential, not only to resolve the immediate situation, but to identify patterns of failure, strengthen safeguards, and remedy training or system gaps before they recur.

The guidance is deliberately framed in broad terms. It does not seek to create a rigid classification of errors. Instead, it emphasises a practical approach based on the effect of an error on lawful authority and statutory safeguards, and sets out the actions the Commission would ordinarily expect in response.

This good practice guide is not a statement of law and does not replace the need for professional judgement or legal advice where appropriate. In cases of uncertainty, particularly where the legal effect of an error is unclear, services should seek appropriate legal advice. Nor is this guidance intended to operate as a disciplinary framework.

This guidance is issued in light of the Commission’s functions under section 10 of the Mental Health (Care and Treatment) (Scotland) Act 2003, including its duties to promote best practice in the operation of the Act and to safeguard the rights and welfare of individuals subject to its provisions.

The guidance applies to the Commission’s functions under the Mental Health (Care and Treatment) (Scotland) Act 2003 and, where relevant, the Adults with Incapacity (Scotland) Act 2000 and related legislation. It is intended for those exercising statutory functions, those responsible for overseeing that work, and Commission practitioners responding to concerns.

Scope of this guidance

This good practice guide applies to situations where an error is identified in the use of statutory powers under mental health and incapacity legislation in Scotland, and where that error may have implications for the lawfulness of detention, treatment or transfer, or for the safeguards intended to protect the rights of the individual.

The guidance is primarily concerned with the operation of the Mental Health (Care and Treatment) (Scotland) Act 2003. Where relevant, it also applies to the Adults with Incapacity (Scotland) Act 2000 and to related statutory frameworks that interact with those Acts, including provisions governing compulsory treatment, authority for medical treatment, and transfers between places of detention or care.

The types of decisions and processes in scope include, but are not limited to:

- the making, extension, variation or revocation of compulsory measures;
- the completion and submission of statutory forms and reports;
- the authorisation of medical treatment under statutory safeguards;
- the transfer of individuals between wards, hospitals or settings where legal authority is required;
- the roles and statutory status of professionals involved in these processes.

This guidance is intended to apply when an error is discovered at any stage, whether by frontline staff, managers, designated medical practitioners, mental health officers, or the Commission itself, either by our information management system, our casework officers or practitioner staff, as well as including errors identified through Tribunal proceedings, monitoring activity, or retrospective review.

The good practice guide is not limited to situations where an error has resulted in harm. It also applies where an error has the potential to affect rights, undermine safeguards, or expose an order or decision to challenge, even if no adverse outcome has occurred.

This guidance does not seek to cover every aspect of error in mental health services. It is not intended to address broader clinical quality issues, complaints about care unrelated to statutory decision-making, or matters that fall primarily within professional conduct or disciplinary processes.

Nor does this good practice guide provide legal advice on the validity of individual orders or decisions. In cases of uncertainty, particularly where detention or compulsory treatment may be unlawful, services should seek appropriate legal advice.

Core principles when an error is identified

Statutory principles under the Mental Health and Adults with Incapacity Acts

The Mental Health (Care and Treatment) (Scotland) Act 2003 and the Adults with Incapacity (Scotland) Act 2000 both place the rights, dignity and interests of the individual at the centre of decision-making.

Under the Mental Health Act, those exercising functions under the Act must have regard to principles including benefit, the least restrictive alternative, participation, respect for the patient's past and present wishes, and respect for dignity. These principles do not fall away when something goes wrong. On the contrary, they become especially important where an error affects detention, treatment or transfer.

Similarly, the Adults with Incapacity Act requires that any intervention must benefit the adult, be the least restrictive option, and take account of the adult's wishes and the views of relevant others. Where an error occurs in the use of powers under the AWI Act, the response must be assessed by reference to whether lawful authority exists and whether these statutory principles continue to be met.

A shared implication of both Acts is that compulsory measures and compulsory treatment require a clear and valid legal basis. Where an error casts doubt on that basis, the position must be clarified promptly and the person's legal status addressed as a priority.

Organisational duty of candour and Scottish Government policy

The organisational duty of candour is set out in the Health (Tobacco, Nicotine etc. and Care) (Scotland) Act 2016 and the Duty of Candour Procedure (Scotland) Regulations 2018. These impose legal duties on organisations providing health services, care services and social work services when an unintended or unexpected incident occurs in the provision of those services and results in, or could result in, death or harm, or where additional treatment is required to prevent such harm.

Where the statutory criteria are met, organisations must follow a defined procedure. This includes informing the relevant person that an incident has occurred, offering an apology, providing an explanation of what is known, inviting them to a meeting, reviewing what happened with a view to identifying improvement, and learning from the incident, taking account of the views of the person affected.

Not every error in the application of mental health legislation will meet the statutory threshold for activation of the organisational duty of candour procedure. However, the underlying principles of the duty – openness, explanation, learning and

improvement – are relevant to many of the situations addressed in this guidance, particularly where errors affect legal authority or statutory safeguards.

National governance and learning frameworks

Scottish Government policy and Healthcare Improvement Scotland's national framework for reviewing and learning from adverse events emphasise that errors should be identified, reported and reviewed in a way that supports learning and system improvement rather than blame.

These frameworks recognise that errors commonly arise from workload pressures, systems of working, assumptions, communication failures or training gaps, rather than from isolated individual failings. They also emphasise the importance of timely reporting, proportionate review, and feedback into organisational learning systems.

This approach is consistent with the Commission's experience of errors in the application of mental health legislation, which often reflect cumulative system weaknesses rather than a single point of failure.

Professional and regulatory expectations

Alongside organisational duties, health and social care professionals are subject to a professional duty of candour. This requires professionals to be open and honest with people in their care when something goes wrong with treatment or care and causes, or has the potential to cause, harm or distress.

Professional regulators, including the General Medical Council, Nursing and Midwifery Council and Health and Care Professions Council, also emphasise the need to act within the law, to recognise the limits of one's authority, to seek advice where there is uncertainty, and to reflect on errors through supervision, appraisal and continuing professional development.

In the context of mental health legislation, this means that professionals should not minimise or conceal errors, should not attempt to retrospectively legitimise actions taken without lawful authority, and should engage constructively with governance, learning and assurance processes.

Applying these principles when an error is identified

Taken together, these statutory, national and professional sources support a consistent approach when an error in the application of mental health legislation is identified:

- the rights, dignity and legal position of the individual must be the primary consideration;
- the response should be guided by the effect of the error on lawful authority and safeguards, rather than by labels or classifications;
- where lawful authority is unclear or absent, this should be addressed as a matter of urgency;
- correction should be prospective; retrospective validation is inappropriate;
- openness, explanation and support are essential where rights may have been affected;
- errors should be reported and reviewed to enable learning and system improvement;
- responsibility should be understood in both individual and system terms.

These principles underpin the remainder of this guidance and inform the Commission's expectations of services when errors in the application of mental health legislation come to light.

Understanding error in mental health law

Errors in the application of mental health legislation usually arise within complex systems rather than from a single act or omission. Statutory processes for detention, treatment and transfer involve multiple professionals, prescribed roles, formal documentation and strict timescales. While these safeguards are essential for protecting rights, they also create points where errors can occur, particularly under pressure.

The Commission's experience suggests that common contributory factors include workload pressures, unfamiliarity with infrequently used processes, gaps in training, reliance on templates or copied text, delays in documentation, and unclear responsibility for verification.

Consistent recognition and reporting of errors matters. How services respond can either mitigate harm and strengthen safeguards, or allow systemic weaknesses to persist. For the Commission, understanding both what went wrong and how it was addressed is central to its role in protecting rights and promoting good practice.

In practice, errors in statutory paperwork can have different legal consequences. Some errors are unlikely to be legally material at all, and do not affect the validity or robustness of the order; these are typically clerical or administrative in nature and can be corrected without legal consequence.

Other errors do not automatically invalidate the measure but render it vulnerable to challenge if tested before a court or tribunal. In such cases, the order or decision remains legally effective unless and until it is set aside, and should be treated as valid in the interim, albeit requiring prompt correction and replacement.

Finally, some errors are so fundamental that the document is incapable of performing its statutory function and may be treated as void *ab initio* – in effect, as if no lawful authority had ever been created. This may occur where mandatory statutory requirements are absent, or where the evidential content plainly does not relate to the person concerned.

Minor clerical or administrative errors

Some errors are clerical or administrative in nature and do not affect the validity of an order or decision, nor render it realistically open to challenge. These errors do not undermine statutory safeguards and do not affect whether lawful authority exists.

Such errors commonly include typographical mistakes, minor inaccuracies in dates or identifiers that do not create ambiguity about the person concerned, or mis-ticked boxes that are clearly inconsistent with an otherwise coherent and correct narrative. While these errors should not be ignored, they are unlikely to have legal consequences if corrected appropriately.

Example 1
A statutory form contains a typographical error in the patient's surname, or a transposed digit in a CHI number, but the remainder of the document clearly and consistently identifies the patient by name, date of birth, location and clinical narrative. The statutory tests are properly addressed and the professional signatories are correct.

Example 2: under-18 safeguard documentation error
In a case involving a patient under 18, either the RMO or the DMP must meet the relevant child specialist requirement for a T3. The DMP is a child specialist and the safeguard is therefore met, but the statutory form incorrectly records the RMO as the child specialist. The documentation is misleading and legally vulnerable, even though the substantive safeguard requirement has been satisfied.

Expected response and rationale

In these circumstances, the appropriate response is to correct the error promptly and transparently, ensuring there is a clear audit trail. This may involve a written correction or addendum attached to the original document rather than alteration of the original record.

Any corrections should be made in accordance with professional and organisational standards for record-keeping. Original entries should not be deleted or obscured. Amendments should be clearly dated, signed and attributable, with the original entry remaining legible, in line with guidance from professional regulators (for example the General Medical Council) and defence organisations such as Medical and Dental Defence Union of Scotland (MDDUS).

It will not usually be necessary to replace the order or certificate, nor to escalate the matter beyond local processes, unless similar errors are recurring or indicate wider weaknesses in documentation practice. Communication with the patient will often not be required unless the error has caused confusion, distress or loss of confidence.

The rationale for this approach is that statutory safeguards have been met in substance and lawful authority has not been affected. A disproportionate response risks obscuring the distinction between genuinely serious failures and routine administrative mistakes, and may undermine confidence rather than support learning.

More significant errors that do not invalidate an order but may give rise to challenge

Some errors do not of themselves invalidate an order or decision, but expose it to challenge if tested before a court or tribunal. In these situations, lawful authority is likely to remain in place unless and until the measure is set aside by a court or tribunal but the error should be addressed promptly to reduce risk and to maintain statutory safeguards.

In some cases, the challenge relates not to the validity of the order itself, but to treatment or actions taken under it.

These errors typically involve failures of process or timing, or documentation that is inaccurate, incomplete or lost in a way that matters, even though the core statutory requirements may have been met in substance.

Common examples include:

- delay in obtaining a required second opinion, resulting in a period where treatment requiring authorisation is given without a valid certificate;
- documentation that inaccurately records who met a statutory safeguard requirement, even though the requirement was met in practice;
- failure to follow prescribed timescales for renewal or review (other than those which result in automatic lapse), where the underlying criteria for compulsion are otherwise satisfied;
- missing paperwork.

Example 3: delay in treatment authorisation

A patient subject to compulsory measures initially consents to medication and a valid T2 certificate is in place. The patient subsequently withdraws consent to medication that requires authorisation under Part 16 of the Act. Treatment continues while arrangements are made for a Designated Medical Practitioner visit, and a T3 is completed several days later.

The compulsory order itself remains valid and is not rendered challengeable by the delay in authorisation. However, once consent was withdrawn, the T2 no longer provided lawful authority, and treatment administered prior to the T3 was given without lawful authority under the Act.

No T4 form is completed in respect of this period. Section 243 provides a limited exception to the requirement for prior authorisation, permitting urgent medical treatment only where it is necessary at the time for one of the statutory purposes, namely saving life, preventing serious deterioration, alleviating serious suffering, or preventing violence or danger. It applies only where the patient is detained in hospital.

This is not an error affecting the validity of the order, but an error affecting treatment provided under it. Such situations may give rise to complaint, governance review, duty of candour considerations, or legal challenge in relation to the treatment provided.

Example 4: Lapsed AMP status

A patient is subject to a compulsory treatment order granted by the Mental Health Tribunal for Scotland. After the order is in place, it comes to light that the medical practitioner who carried out the statutory examination and submitted the medical report believed they were an Approved Medical Practitioner (AMP), but their AMP approval had lapsed shortly before the examination. The lapse arose from an administrative oversight and was not recognised at the time by the practitioner or the service.

Here the statutory function was carried out by a practitioner who did not, at the relevant time, hold current approval to act as an AMP. This represents a failure of a mandatory statutory safeguard, but the error relates to the status of the practitioner rather than to the substantive clinical assessment itself. In these circumstances, the CTO is likely to be legally vulnerable and open to challenge if tested before a Tribunal or court. It would be open to a Tribunal or court to conclude that, due to the failure of a mandatory statutory safeguard, the CTO is unlawful. Unless and until it is set aside, the order may remain legally effective in the interim. Practitioners who believe that their AMP approval has lapsed should seek legal advice in relation to any statutory work they have undertaken.

Example 5: Missing SUS paperwork

A patient subject to a hospital-based compulsory treatment order has been granted suspension of detention (SUS) in the community. The patient fails to comply with the conditions of suspension and requires recall to hospital. When reviewing the file, it becomes apparent that the SUS form authorising suspension cannot be located within the clinical record. It is unclear whether the form was properly completed and signed at the time, or whether it was completed but not scanned or retained.

If a valid SUS form was completed and signed at the time, but is now missing from the record, the issue is one of record-keeping rather than absence of authority. The recall power is likely to remain lawfully exercisable.

However, if it cannot be evidenced that a SUS form was ever properly completed or signed, then it cannot be established that the patient was lawfully suspended from detention in the first place. In that case, the legal position is materially different. Practitioners should seek legal advice before proceeding where the position cannot be clearly established.

Expected response and rationale

Where an error of this nature is identified, the usual response should be to correct the position prospectively and transparently. This may involve completing a new certificate or order, issuing a written correction to the statutory record, or taking steps to ensure that the correct safeguard is clearly and accurately documented.

Where statutory documentation cannot be located, practitioners should treat the position as uncertain and take steps to clarify it promptly. This includes establishing, as far as possible, whether the statutory requirements were met at the time, seeking legal advice where there is uncertainty about the validity of the underlying authority, and reconstructing the record as far as possible using available evidence (for example contemporaneous entries, copies held elsewhere, or confirmation from signatories). Any reconstruction should be clearly identified as such, and where documentation cannot be located or confirmed, this should be explicitly recorded with a clear explanation of what is known and what cannot be established.

Where treatment has been given without valid authorisation, the responsible medical officer should inform the patient, as far as they are able to understand, explain what has occurred, and advise them of their rights to advocacy, legal advice and complaint. Relevant others, such as the named person, welfare attorney or guardian, and independent advocate, should also be informed where appropriate. The patient should ordinarily be informed both verbally and in writing.

These errors should be recorded through local incident reporting systems and notified to the Commission, particularly where they involve treatment without authority, under-18 safeguards, or repeated procedural failures. Depending on the circumstances, they may also engage professional or organisational duties of candour.

The rationale for this approach is that, although lawful authority may technically remain in place, the integrity of statutory safeguards has been compromised. Prompt correction, openness and learning are therefore required to protect rights, maintain confidence in the legal framework, and prevent recurrence.

Serious errors that invalidate detention or compulsion

Some errors are so fundamental that they invalidate the statutory measure relied upon and result in a person being detained and treated without lawful authority. These situations raise the most serious concerns for the individual's rights and require immediate attention.

Such errors arise where a statutory document or process is incapable of performing its legal function. This may occur where mandatory statutory requirements are absent, where the evidential content does not relate to the person concerned, or where an order has expired or otherwise ceased to have effect and no lawful replacement is in place.

In these circumstances, the issue is not simply that the measure is vulnerable to challenge. Rather, there may be no lawful authority at all for the detention or compulsory powers being exercised.

Example 6

A compulsory treatment order is extended using a CTO3a form. While the patient identifiers are correct, the evidential narrative sections of the form clearly relate to a different patient. The form is signed by the responsible medical officer and the mental health officer and treated locally as a valid extension. The defect is later identified at a Mental Health Tribunal hearing, which finds the extension invalid and revokes the CTO. The patient has been subject to compulsory powers for a period without lawful authority.

Expected response and rationale

Where an error of this nature is identified, the response must be immediate and proportionate to the seriousness of the rights breach.

The first priority is to clarify and address the person's current legal position. Immediate steps must be taken to ensure that detention or compulsion does not continue without lawful authority. Where statutory criteria are met, lawful authority may need to be restored prospectively through a fresh process. Retrospective validation is not appropriate.

Senior clinical, social work and organisational leadership should be informed without delay. The incident should be recorded through local governance systems and will ordinarily require a significant adverse event review, often involving both the health board and local authority where joint statutory responsibilities apply.

The scope of the error should be examined to identify whether other cases may be affected. This will usually require audit or sampling of statutory documentation and assurance that safe systems of working are in place.

The patient should be provided with a clear explanation of what has occurred, both verbally and in writing, and supported to access advocacy and legal advice. Relevant others, such as the named person, welfare guardian, advocate and legal representative, should also be informed as appropriate. In many cases, the organisational duty of candour procedure will be engaged.

The Commission would ordinarily expect to be notified promptly of such errors and to receive the outcome of the review and audit, including the actions taken to prevent recurrence.

The rationale for this approach is that detention or compulsion without lawful authority represents a serious failure of statutory safeguards. The response must therefore focus not only on correcting the individual case, but on restoring confidence in the integrity of the legal framework and ensuring that similar failures cannot recur.

Treatment without authority

Errors in the authorisation of medical treatment raise distinct but closely related issues to errors affecting detention. Treatment without lawful authority may occur even where detention itself is lawful. In such cases, the individual may be subjected to compulsory treatment without the statutory safeguards intended to protect their rights.

Under the Mental Health (Care and Treatment) (Scotland) Act 2003, certain medical treatments require specific legal authority under Part 16. Where medication is given as mental health treatment and a T2 or T3 certificate is required but is not in place, and the treatment is not given as urgent medical treatment under section 243 of the Act (which requires retrospective notification to the Commission via a T4), the treatment has been given outwith the authority of the Act.

A later certificate cannot retrospectively legitimise treatment given during a period when no valid authority existed. This applies regardless of whether the failure arose from delay, misunderstanding, workload pressures or administrative oversight.

Similarly, under the Adults with Incapacity (Scotland) Act 2000, some treatments require enhanced safeguards and independent scrutiny. Reliance on a general treatment authority is not sufficient where the legislation requires a specific process.

The Commission's approach to treatment without authority is rooted in the principle that Part 16 and Part 5 safeguards are core protections of patients' rights.

Example 7: late second opinion under Part 16

A patient subject to compulsory measures withdraws consent to medication that requires authorisation under Part 16 of the Mental Health Act. Treatment continues while arrangements are made for a designated medical practitioner visit. A T3 certificate is completed several days later.

Although the compulsory order itself remains valid, treatment during the intervening period was given without lawful authority.

Expected response and rationale

- treatment requiring authorisation should be reviewed immediately;
- the responsible medical officer should inform the patient, as far as they are able to understand, that treatment was given outwith the authority of the Act;
- the patient should be advised of their rights to consult a solicitor, access independent advocacy and make a complaint;
- the named person, welfare attorney or guardian, and independent advocate should be informed where applicable;
- the incident should be recorded through local governance systems and notified to the Commission.

The rationale is that delay does not suspend the requirement for statutory authorisation, and transparency is essential where safeguards have failed.

Example 8: T2 issued for a 16-year-old where the RMO is not a child specialist

A 16-year-old patient is subject to compulsory measures. The responsible medical officer completes a T2 certificate authorising treatment on the basis of the young person's consent. It later becomes apparent that the RMO does not meet the child specialist requirement.

For patients under 18, statutory safeguards require that the T2 must be completed by either an RMO or a DMP who is a child specialist and this safeguard has not been met.

Treatment given on the basis of that T2 has therefore been given out with the authority of the Act. The defect is not remedied by the young person's apparent consent, as the statutory requirement relates to the status of the practitioner rather than to the patient's capacity or agreement.

Expected response and rationale

- treatment requiring authorisation should be paused unless and until lawful authority is established;
- urgent steps should be taken to involve a child specialist and obtain valid authority;
- the young person should be informed in an age-appropriate way and supported to access independent advocacy;
- parents or carers, the named person and legal representatives should be informed as appropriate;
- the incident should be recorded and notified to the Commission.

The rationale is that child-specific safeguards are mandatory and exist to protect particularly vulnerable patients.

Example 9: anti-libidinal medication prescribed under section 47 without the correct AWI process

An adult subject to welfare guardianship order has a section 47 of the Adults with Incapacity (Scotland) Act 2000 completed for prescribed medication intended to reduce sex drive. The medication is commenced on the basis of the section 47 certificate and agreement from carers, without referral to the Commission for an independent second opinion under Part 5 of the AWI Act.

A section 47 certificate does not, of itself, provide lawful authority for medication given for the purpose of reducing sex drive. Under the Adults with Incapacity (Scotland) Act 2000, section 48 and the Adults with Incapacity (Specified Medical Treatment) (Scotland) Regulations 2002 provide that certain treatments cannot be authorised by a section 47 certificate alone and require additional safeguards, including independent scrutiny. Similarly under Part 16 of the Mental Health (Care and Treatment) (Scotland) Act 2003, and in particular section 240, such treatment is subject to enhanced safeguards and requires an independent second opinion. Reliance on a general treatment authority is not sufficient where the legislation requires this additional level of protection.

Expected response and rationale

- the medication should be reviewed immediately and not continued unless and until lawful authority is obtained;
- an urgent referral should be made to the Commission for an independent second opinion;
- the adult should be informed, as far as they are able to understand, of what has occurred and supported to access advocacy and legal advice;
- the welfare guardian and other relevant parties should be informed;
- the matter should be recorded, reviewed and notified to the Commission.

The rationale is that reliance on a general treatment authority is insufficient where the legislation requires enhanced safeguards.

Commission expectations

Where treatment without lawful authority is identified, the Commission would ordinarily expect:

- prompt action to restore lawful authority prospectively or to stop treatment;
- openness and explanation to the patient and relevant others;
- notification to the Commission;
- recording and review through local governance systems;
- learning to prevent recurrence.

Treatment without authority represents a failure of statutory safeguards. Addressing it promptly and transparently is essential to protect individual rights and maintain confidence in the operation of mental health and incapacity legislation.

Transfer without authority

Transfers under the Mental Health (Care and Treatment) (Scotland) Act 2003 are not purely operational decisions. They engage statutory safeguards intended to protect the rights of the patient and those who support them. In particular, the Act distinguishes between hospital-to-hospital transfers under section 124 and transfers between hospital units within the same hospital under section 124A. This distinction matters because it affects the patient's rights to information, support and, in section 124 cases, appeal.

A transfer may be "without authority" in different senses. In some cases, the problem is that the statutory power to transfer was not properly exercised at all. More commonly, the transfer takes place under a valid statutory power (for example because the receiving hospital managers consented), but statutory safeguards around notice, information and Commission notification have not been complied with. These failures may not automatically invalidate the underlying compulsory order, but they can undermine patient rights and, in an appropriate case, affect Tribunal decision-making at review.

Example 10: mischaracterisation of transfers between geographically separate hospital sites

A Tribunal review considered a determination to extend a hospital-based compulsory treatment order originally granted in 2019 specifying Hospital A as the place of detention. In 2019, the patient was moved from Hospital A to Hospital B and remained detained there. Subsequent renewal documentation described the place of detention using a generic "umbrella" hospital descriptor, with Hospital B described as the ward or unit.

The Tribunal required clarification of the legal status of Hospital B and the statutory steps required for the 2019 move. Evidence was given that, following management changes and service reconfiguration in the mid-2010s, a number of geographically separate sites linked historically to a single larger hospital campus fell to be regarded as hospitals in their own right for the purposes of Part 7, Chapter 6 of the Act. On that basis, the move from Hospital A to Hospital B was a section 124 hospital-to-hospital transfer.

The Tribunal set out the section 124 regime in detail, including:

- the requirement for written notice (at least 7 days in advance unless urgency applies, and subject to the statutory consent exception);
- the continuing requirement to give notice as soon as practicable where "urgency" is relied upon;
- the duty to notify the Commission within 7 days of transfer;
- the right of appeal to the Tribunal under section 125;
- the effect of section 124(14), which deems the compulsory order to specify the receiving hospital once the transfer occurs.

The Tribunal identified evidence suggesting that notice to the Commission was not timeous and that "urgency" was relied upon in documentation with an explanation related to bed availability. The section of the transfer paperwork intended to record when notice was actually given to the patient and others was not completed. The Tribunal emphasised that the notice and information provisions are particularly important from the perspective of patient rights, including participation and reciprocity, and that "urgency" should not be treated as a general operational bypass. It noted that the Code of Practice refers to "strong clinical reasons" in this context.

However, the Tribunal did not conclude that failures in notice and/or Commission notification invalidated the transfer or the compulsory order. It reasoned that section 124(14) operates upon transfer and is dependent on the consent of the receiving hospital managers rather than on full compliance with the notification steps. The Tribunal therefore confirmed the determination to extend the compulsory order, while making clear that repeated failures to meet notice requirements could, in an appropriate case, justify refusal to confirm a determination at review.

Why this matters

This example illustrates three recurring risks:

- mischaracterising transfers between geographically separate hospital sites as internal "unit" moves, leading to the wrong statutory route being used;
- over-reliance on generic hospital descriptors that obscure where detention is actually authorised;
- treating notice, information and Commission notification as procedural extras rather than statutory safeguards connected to participation, advocacy, appeal rights and reciprocity.

Expected response and rationale

Where a transfer concern of this kind is identified, the Commission would ordinarily expect the following.

Clarification of the correct legal route

- confirm whether the move is properly a section 124 hospital transfer or a section 124A unit transfer, based on the status of the sites involved;
- ensure services do not rely on historic assumptions where management and organisational arrangements have changed.

Immediate rights-focused remediation where safeguards were not met

- ensure the patient (and, where relevant, the named person and primary carer) receives written information explaining the transfer position and rights, including appeal rights where section 124 applies;
- ensure that section 260 duties are met, including informing the patient of independent advocacy and taking steps to support its use, recognising that notice of a proposed transfer is one of the occasions on which section 260 duties arise through the prescribed information regulations.

Commission notification and record clarity

- ensure the Commission is notified in accordance with section 124(12) (or equivalent provision) and that records clearly identify the hospital in which detention is authorised, not merely a generic umbrella descriptor;
- where local paperwork has used generic hospital descriptors inconsistently, take steps to correct the record and prevent confusion in future Tribunal scrutiny.

Governance and system learning

- record the issue through local governance systems and review why the wrong transfer route was used or why notice requirements were not met;
- review local understanding of “urgency” and ensure it is not applied so widely that it routinely defeats statutory safeguards;
- provide assurance that transfer processes will comply with the correct statutory route going forward, particularly where the issue appears to be systemic rather than case-specific.

The rationale is that even where a compulsory order remains legally operative, failures in transfer safeguards can deprive the patient of information, advocacy support and appeal rights. These are not technicalities; they are core elements of lawful, rights-based compulsion.

The role of the designated medical practitioner when things go wrong

Designated medical practitioners (DMPs) perform a statutory safeguard function. Their role is to provide independent scrutiny of proposed medical treatment under Part 16 of the Mental Health (Care and Treatment) (Scotland) Act 2003 (and, where relevant, to contribute to scrutiny under the Adults with Incapacity (Scotland) Act 2000 through Commission processes). When errors are identified, the DMP's actions can be critical in preventing further unlawful treatment and in restoring the integrity of statutory safeguards.

DMP responsibilities where an error is identified

When a DMP becomes aware of an error—whether before, during or after a visit—the DMP should focus on the effect of the error on lawful authority and safeguards, rather than on how the error arose.

In particular, the DMP should consider:

- whether there is lawful authority in place for the treatment proposed or being given at the time of assessment;
- whether a mandatory safeguard (for example, child specialist status, eligibility, timing or scope) has not been met;
- whether treatment may already have been given outwith statutory authority.

A critical distinction must be maintained between correcting documentation and authorising treatment.

Where the statutory safeguard has been met in substance, but the documentation is inaccurate or misleading (for example, mis-recording which clinician meets a child specialist requirement), the DMP may correct the record through an appropriate written correction or addendum attached to the statutory paperwork.

Where the safeguard has not been met, the DMP cannot "correct" the position by authorising treatment. Authorisation can only operate prospectively and cannot retrospectively legitimise treatment already given without authority. In such cases, the DMP should withhold authorisation until the correct statutory requirements are met and should inform the Commission.

Where a DMP identifies that treatment has already been given outwith statutory authority, the DMP's role is not to regularise the past. Instead, the DMP should:

- ensure the current legal position is clarified;
- advise that treatment requiring authorisation should not continue unless and until lawful authority is established;
- inform the Commission promptly;
- record clearly the basis on which authorisation is withheld or deferred.

The responsibility for informing the patient, named person and others rests with the responsible medical officer, but the DMP should ensure that this expectation is clear.

In cases involving patients under 18, DMPs should be particularly alert to statutory requirements relating to child specialist status. Where neither the RMO nor the DMP meets the required criteria, authorisation cannot be given. Where the DMP meets the requirement, it is essential that this is accurately recorded.

DMPs should not assume that apparent consent by a young person cures defects in statutory safeguards. Where safeguards have not been met, treatment given on that basis is not lawfully authorised.

The DMP safeguard is central to maintaining confidence in compulsory treatment processes. When errors are identified, careful distinction between correction and authorisation, prompt escalation where authority is absent, and clear documentation are essential to protect patient rights and uphold the integrity of the statutory framework.

What the Commission will usually expect when notified of an error

When the Mental Welfare Commission for Scotland is notified of an error in the application of mental health legislation, its primary concern is the protection of the individual's rights and the restoration of lawful practice. The Commission's response will be proportionate to the nature and effect of the error, but there are common expectations that apply across most situations.

On notification of an error, the Commission will usually seek sufficient information to understand:

- the nature of the error and how it was identified;
- the current legal position of the individual, including whether there is lawful authority for detention, treatment or restriction;
- the period, if any, during which authority may have been absent or unclear;
- the steps taken to address the position prospectively.

The Commission does not expect a full investigation to have been completed before notification. Early contact is encouraged where there is uncertainty, particularly where detention or compulsory treatment may be unlawful.

The Commission will ordinarily expect services to have addressed, or to be actively addressing, the following priorities:

- clarification of the person's current legal status;
- cessation or correction of any ongoing detention, treatment or restriction that lacks lawful authority;
- restoration of lawful authority prospectively where statutory criteria are met;
- appropriate senior clinical and managerial oversight.

Where lawful authority is unclear, the Commission would expect services to treat the situation as urgent until resolved.

The Commission will ordinarily expect that the person affected has been informed, as far as they are able to understand, of what has occurred and what will happen next. This includes:

- a clear explanation of the issue in accessible language;
- advice about rights to advocacy, legal advice and complaint;
- involvement of the named person, welfare guardian or attorney, and independent advocate where applicable.

Where the circumstances meet the statutory threshold for organisational duty of candour, the Commission would expect the relevant procedure to be activated and followed.

Errors should be recorded through local governance systems and reviewed in a manner proportionate to their seriousness. Depending on the nature of the error, this may range from a local review of documentation practices to a significant adverse event review involving both health board and local authority partners.

The Commission will usually expect to be informed of:

- the outcome of any review or audit;
- whether other cases were affected and what action was taken;
- the measures put in place to prevent recurrence.

Where similar errors arise repeatedly, or where a single error suggests wider system weaknesses, the Commission may seek broader assurance. This may include:

- sampling or audit of comparable cases;
- review of local policies, templates or training;
- clarification of roles and responsibilities across services.

The Commission's interest in these circumstances is not limited to the individual case, but extends to the effectiveness of safeguards more generally.

The Commission's role is to safeguard the rights and welfare of people subject to mental health and incapacity legislation and to promote good practice. It does not replace local management, legal advice or professional regulatory processes, nor does it act as a disciplinary body.

Preventing recurrence: strengthening systems and safeguards

Responding appropriately when an error occurs is essential, but it is not sufficient. Preventing recurrence requires attention to the systems, assumptions and working practices that allowed the error to arise in the first place. The Commission's experience is that many serious errors in the application of mental health legislation are foreseeable and preventable, particularly where similar issues recur across cases or services.

Following an error, assurances that it was "a one-off" or due to individual oversight are rarely adequate on their own. Where an error has affected lawful authority or statutory safeguards, the Commission would ordinarily expect services to demonstrate how systems have been strengthened to reduce the risk of repetition.

Effective prevention focuses on how work is organised, checked and overseen, rather than relying solely on individual vigilance.

Errors affecting detention, treatment or transfer should normally be recorded through local incident reporting systems, such as Datix, in line with health board and local authority governance arrangements.

The purpose of recording such incidents is not simply compliance or escalation, but to ensure that:

- the error is visible within organisational governance structures;
- appropriate review and oversight are triggered;
- patterns of similar error can be identified;
- learning is captured and acted upon.

The Commission would generally expect Datix (or equivalent) reporting where:

- treatment has been given without lawful authority;
- detention or restriction may have occurred without lawful authority;
- statutory safeguards (for example under-18 or Part 16 requirements) have failed;
- similar errors have occurred more than once.

Reporting should be in line with local organisational policies and governance arrangements, including those of health boards, local authorities, and integration joint boards (health and social care partnerships), and independent or private providers, as applicable.

Not every minor clerical error requires incident reporting. Proportionality remains important. However, failure to record more serious errors risks allowing systemic weaknesses to persist unrecognised.

Datix reporting should link to appropriate local governance routes, which may include clinical governance groups, mental health governance forums, or joint health board / local authority review arrangements where statutory responsibilities are shared.

Errors often arise where it is unclear who is responsible for checking legal authority at key points. Services should be able to identify:

- who is responsible for verifying statutory authority before detention, treatment or transfer proceeds;
- how responsibility is shared between clinical, social work and administrative staff;
- how out-of-hours and cross-team working is managed.

Clear ownership reduces reliance on assumptions that “someone else has checked”.

Targeted training and refresher activity is particularly important for statutory processes that are used infrequently or that involve enhanced safeguards, such as under-18 cases, treatment under Part 16, or transfers between hospitals.

Single errors may be unavoidable in complex systems, but patterns should be treated as warning signs. Services should monitor for:

- repeated late or defective statutory paperwork;
- recurring misunderstandings about legal routes (for example transfer provisions);
- frequent reliance on “urgency” exceptions;
- discrepancies between records and actual practice.

Datix and other governance data should be used proactively as an early warning system, rather than retrospectively after harm has occurred.

Preventing recurrence is an integral part of protecting patient rights. Effective use of local governance arrangements, including Datix, supports learning, accountability and improvement. The Commission would ordinarily expect services to maintain a rolling programme of audit to provide local assurance and demonstrate to the Commission the lawfulness of their activities pursuant to mental health legislation. Robust systems, clear responsibility and shared learning reduce the likelihood that individuals will again be detained, treated or transferred without lawful authority, and strengthen confidence in the operation of mental health legislation.

Summary and key messages

Errors in the application of mental health legislation are an unfortunate but predictable feature of complex statutory systems operating under pressure. Most arise not from ill intent, but from the interaction of workload, systems of working, training gaps and assumptions about where responsibility lies. What matters most is not that errors occur, but how they are recognised, addressed and learned from.

This guidance emphasises that responses should be shaped by its impact on lawful authority and statutory safeguards. Minor clerical errors may require correction only. More serious errors may render an order vulnerable to challenge. The most serious failures result in detention, treatment or transfer without lawful authority and require urgent action.

Across all scenarios, several consistent messages emerge:

- the rights, dignity and legal position of the individual must be the primary consideration;
- where lawful authority is unclear or absent, this should be treated as urgent until resolved;
- correction must be prospective; retrospective validation is inappropriate;
- openness, explanation and access to advocacy and legal advice are essential where rights may have been affected;
- errors should be recorded, reported and reviewed through local governance arrangements, including Datix where appropriate;
- learning should address system weaknesses as well as individual practice;
- activities pursuant to mental health legislation should be subject to a rolling programme of local audit to assure health boards/Private providers and demonstrate to the Commission the lawfulness of their activity.

The Mental Welfare Commission for Scotland's role is to safeguard the rights and welfare of people subject to mental health and incapacity legislation and to promote good practice in its use. Early engagement with the Commission when an error is identified is encouraged, particularly where there is uncertainty about legal authority or the appropriate response.

The appropriate response to errors can strengthen systems, improve understanding of statutory safeguards, and reinforce a culture of openness and learning. Handled poorly, they risk compounding harm, undermining trust, and weakening confidence in the legal framework designed to protect some of the most vulnerable people in society.

Links

Mental Welfare Commission

Medical treatment under Part 16 of the Mental Health Act (2026, PDF)

Consent to treatment (2025, PDF)

Not properly authorised (monitoring report on Part 16 compliance) (2011, PDF)

Healthcare Improvement Scotland (HIS) adverse events and learning frameworks

A national framework for reviewing and learning from adverse events in NHS Scotland (February 2025, PDF)

HIS adverse events toolkit (April 2025)

HIS "Learning from adverse events" programme page (overview and links)

Scottish Government duty of candour (organisational) and legislation

Organisational Duty of Candour: non-statutory guidance (revised March 2025) (publication page)

Organisational Duty of Candour guidance (revised March 2025) (direct PDF)

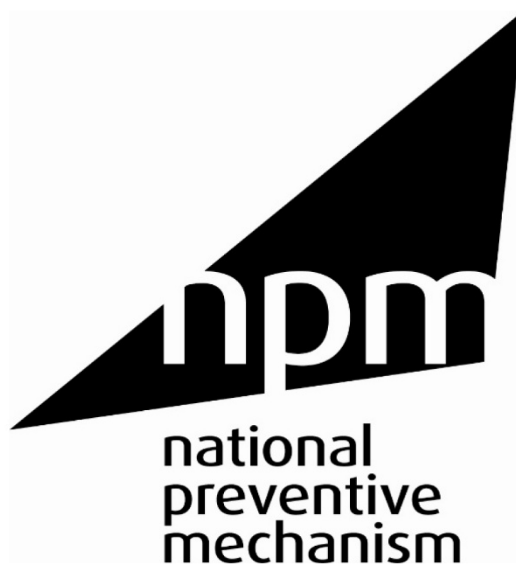
Health (Tobacco, Nicotine etc. and Care) (Scotland) Act 2016 (legislation.gov.uk)

Duty of Candour Procedure (Scotland) Regulations 2018 (SSI 2018/57) (legislation.gov.uk) Right Decisions

GMC duty of candour guidance (GMC)

Medical and Dental Defence Union of Scotland

Risk Alert: Altering patient notes (MDDUS)



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