SPSO Scottish Public Services Ombudsman

The Scottish Public Services Ombudsman Act 2002

Investigation Report

UNDER SECTION 15(1)(a)

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Scottish Parliament Region: Central Scotland

Case ref: 201404087, Lanarkshire NHS Board
Sector: Health
Subject: Hospitals; clinical treatment; diagnosis

Summary
Miss C, who had a previous history of mental illness, had a psychotic episode and was taken by ambulance in the early hours of the morning to the emergency department at Wishaw General Hospital. An initial mental health assessment was carried out identifying that she was seriously unwell and should be assessed by a doctor as soon as possible. However, she was not assessed for over three hours. A junior doctor examined her, took blood tests and contacted the on-call psychiatrist for advice. The psychiatrist said that out-patient follow-up may be the best option and that they would review Miss C after her blood tests were done. A couple of hours later, Miss C's parents were told that she was being admitted to the hospital for assessment. However, Miss C was agitated, received sedation and was restrained by the police. Later that morning her parents were told that she had been detained under mental health legislation. She was transferred to Monklands Hospital as there were no beds available.

Miss C's mother (Mrs C) complained that if Miss C had initially been properly assessed by a psychiatrist and admitted to Wishaw General Hospital, then the police would not have become involved and she would not have been detained.

As part of my investigation of Mrs C's complaint, I obtained independent advice from advisers in emergency medicine and psychiatry. My adviser in emergency medicine considered that the triage nurse in the emergency department had appropriately assessed Miss C. He said that the delay in assessment by a doctor was not ideal but, unfortunately, was not unusual in a busy emergency department at night. My adviser found that the junior doctor's assessment was thorough and of a good standard, but that the junior doctor failed to recognise the severity of Miss C's illness. Due to a lack of detail in Miss C's records, my emergency medicine adviser could not state definitively that she required hospital admission but, in his opinion, it was highly likely that she did. He said that the junior doctor should have questioned the advice of the on-call psychiatrist and insisted on an urgent psychiatric assessment in the emergency department, escalating this to a consultant if the request was refused. He also

said that when Miss C's condition deteriorated and three doses of sedatives were required, she should have been thoroughly re-assessed.

My psychiatric adviser considered that Miss C's psychiatric assessment was unduly delayed and that her condition was allowed to deteriorate during this delay. He said that it had been unreasonable for the on-call psychiatrist to say that out-patient follow-up may be the best option for Miss C, and he also considered that the standard of note-keeping was inadequate. In view of all of these failings, I upheld this aspect of Mrs C's complaint and made recommendations.

Mrs C also complained that the board's handling of her complaint was inadequate. Having carefully considered their initial response to her complaint, I do not consider that it was an adequate response to the issues she had raised about Miss C's treatment, as they failed to show how these had been investigated. After this, Mrs C met staff from the board, then wrote to them. The board's response again did not acknowledge their failings or address all of Mrs C's concerns about Miss C's treatment in the emergency department. Therefore, I also upheld this aspect of the complaint.

Redress and recommendations

The Ombudsman recommends that the Board:	*Completion date*
(i) issue a written apology to Mrs C for the failure to provide reasonable care and treatment to Miss C in hospital on 18 September 2013;	18 December 2015
(ii) remind medical and nursing staff in the Emergency Department that acute mental health patients are high-risk patients;	18 December 2015
(iii) take steps to try to put a low threshold in place for the involvement of senior medical staff in decision-making regarding the discharge of such patients;	18 January 2016
(iv) take steps to ensure that the assessment and management of acute mental health presentations is discussed during the induction programme for new junior doctors in the Hospital's Emergency Department;	18 January 2016
(v) take steps to ensure that it is emphasised in the induction programme of junior on-call psychiatrists	18 January 2016

	that it should normally be the case that acute mental health patients attending the Emergency Department following an emergency should have a thorough psychiatric assessment;	
(vi)	remind relevant psychiatric staff that patients being considered for discharge directly from the Emergency Department should have their follow-up and circumstances taken into consideration;	18 December 2015
(vii)	consider if there should be a change to the process to allow the member of staff carrying out the triage to consider direct referral for psychiatric assessment in high-risk cases;	18 January 2016
(viii)	emphasise to relevant staff involved in the complaint the importance of keeping accurate records that would be fully adequate for the purposes of later scrutiny;	18 December 2015
(ix)	consider if there should be a protocol for emergency tranquilisation in the Emergency Department;	18 January 2016
(x)	issue a written apology to Mrs C for the failure to satisfactorily respond to her complaint; and	18 December 2015
(xi)	make the staff involved in the handling of Mrs C's complaint aware of our decision on this matter.	18 December 2015

Who we are

The Scottish Public Services Ombudsman (SPSO) investigates complaints about organisations providing public services in Scotland. We are the final stage for handling complaints about the National Health Service, councils, housing associations, prisons, the Scottish Government and its agencies and departments, the Scottish Parliamentary Corporate Body, water and sewerage providers, colleges and universities and most Scottish public authorities. We normally consider complaints only after they have been through the complaints procedure of the organisation concerned. Our service is independent, impartial and free. We aim not only to provide justice for the individual, but also to share the learning from our work in order to improve the delivery of public services in Scotland.

The role of the SPSO is set out in the Scottish Public Services Ombudsman Act 2002, and this report is published in terms of section 15(1) of the Act. The

Act says that, generally, reports of investigations should not name or identify individuals, so in the report the complainant is referred to as Mrs C and her daughter is referred to as Miss C. The terms used to describe other people in the report are explained as they arise and in Annex 1.

Introduction

1. Mrs C complained to the Ombudsman about the care and treatment her daughter (Miss C) received when she attended the Emergency Department at Wishaw General Hospital (the Hospital) on 18 September 2013. Miss C had a psychotic episode and was taken to the Hospital by ambulance. She arrived at 04:12, but Mrs C said that there was a delay before she was seen. Staff then telephoned Mrs C to say that she should come to the Hospital to take Miss C home, as there was nothing they could do for her. However, Mrs C said that she was then told at 09:15 that Miss C would be admitted for assessment. At 11:00, she was told that Miss C was being transferred to Monklands Hospital. Mrs C was then told that Miss C had been detained under the Mental Health (Care and Treatment) (Scotland) Act 2003. Mrs C said that if Miss C, who had a past history of psychosis, had initially been properly assessed by a psychiatrist and admitted to the Hospital, then the situation would not have escalated. She stated that the police would not have become involved to restrain her and she would not have been detained under mental health legislation.

2. The complaints from Mrs C I have investigated are that:

(a) Lanarkshire NHS Board (the Board) provided inadequate care and treatment to Miss C in the Hospital on 18 September 2013 (*upheld*); and

(b) the Board's handling of the complaint was inadequate (*upheld*).

Investigation

3. In order to investigate Mrs C's complaint, my complaints reviewer has reviewed the information received from Mrs C and the Board. He has also obtained detailed advice from a medical adviser (Adviser 1), who is an experienced Emergency Medicine Consultant and from an adviser (Adviser 2), who is an experienced psychiatrist. In this case, we have decided to issue a public report on Mrs C's complaint in view of the advice we received.

4. I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked. Mrs C and the Board were given an opportunity to comment on a draft of this report.

(a) The Board provided inadequate care and treatment to Miss C in the Hospital on 18 September 2013

Background

5. Miss C arrived at the Emergency Department in the Hospital at 04:12 on 18 September 2013. She had been taken there in an ambulance. An initial mental health assessment was carried out at 04:35. Miss C was given a triage category of two, which meant that she should be moved into the clinical area immediately and assessed as soon as possible. However, she was not assessed by a junior locum doctor in the Emergency Department (Doctor 1) until 07:45. Doctor 1 recorded that Miss C denied low mood or suicidal thoughts. She also recorded that she had had a discussion with psychiatry and that they would review Miss C after her blood tests had been done.

6. At 09:50, it was recorded that Miss C's agitation was continuing and she had to be restrained by the Police, as she was lashing out. She was given diazepam and lorazepam. She was subsequently detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 and was transferred to Monklands Hospital. Mrs C has told us that Miss C was subsequently charged by the Police.

The Board's response

7. On 5 February 2014, Mrs C sent an email to the Board to complain about the care and treatment provided to Miss C in the Emergency Department. She said that Miss C had been taken to the Hospital by ambulance on 18 September 2013 after suffering a psychotic episode. Mrs C said that she telephoned the Hospital at 06:00 and was told that Miss C was settled and was waiting to be seen, as staff were busy with an ill patient. Mrs C said that she telephoned the Hospital again at 06:45 and was told that Miss C was still waiting to be seen. She stated that a doctor then telephoned her at 07:15 and told her to come and collect Miss C, as they had spoken to a psychiatrist and there was nothing they could do for her. The doctor suggested that she telephone Miss C's Community Psychiatric Nurse (CPN) and she told them that Miss C did not have a CPN. Mrs C said that she then heard the doctor talking to Miss C. The doctor then said that they would telephone her back.

8. Mrs C said that her husband (Mr C) telephoned the Hospital at 09:15. Staff told Mr C that Doctor 1 had left and that Miss C was being admitted to the Hospital for assessment. She said that she then telephoned the Hospital again at 11:00. She was told that Miss C was being transferred to Monklands

Hospital, as there were no beds in the Hospital. A Mental Health Officer then telephoned Mrs C to say that Miss C had been detained under the Mental Health (Care and Treatment) (Scotland) Act 2003.

9. The Board acknowledged receipt of the email on the following day. They asked that Miss C complete a consent form for Mrs C to pursue the complaint. They also issued a letter to Miss C about this. They then received the consent form on 18 February 2014 and wrote to Mrs C to inform her of this on the same day. They said that they would do their best to respond within four weeks. The Board then issued a response to Mrs C on 13 March 2014. They said that Doctor 1 had not documented that she contacted Mrs C at home and they were unable to speak to her, as she was no longer employed by them. They stated that there was no other documentation to suggest that contact was made by another member of staff. They apologised for the way in which staff communicated to Mrs C and for the distress this caused to her and Mr C.

10. The Board also said that Miss C was then reviewed by a consultant in Emergency Medicine (the Consultant), as she was experiencing ongoing agitation. They said that she prescribed sedation to Miss C in an effort to calm her down. They also said that the doctor who attended from psychiatry (Doctor 2) had documented that formal assessment was initially not possible, as Miss C was being aggressive and uncooperative. He discussed this by telephone with the on-call psychiatrist, who suggested emergency detention. They said that the assessment was then carried out and the emergency detention papers were completed at 10:00. The Board apologised that staff had not contacted Mrs C to pass on this information and that she had to contact them again. They said that staff had been reminded of the importance of keeping relatives updated.

11. Mrs C wrote to the Board on 23 March 2014. She said that they were unhappy with the Board's reply and wanted a meeting. On 8 May 2014, the Board received an email from Doctor 1. In this, she said that she remembered telephoning psychiatry about Miss C and asking for their advice. She said that they advised her that outpatient follow-up may be the best option for Miss C. She said that it was difficult to be certain, but she thought that she then telephoned Mr and Mrs C to tell them this. She said that she could tell they were unhappy and she then obtained information from them about Miss C.

12. Mr and Mrs C then met staff from the Board on 21 May 2014. They raised concerns about the delay in assessing Miss C in the Emergency Department and in her being seen by a psychiatrist. They also explained the impact that Miss C's mental health had on their life. Mrs C then wrote to the Board again on 1 July 2014 and raised further concerns about Miss C's attendance at the Hospital on 18 September 2013.

13. The Board responded to Mrs C on 8 September 2014. They stated that Miss C had arrived in the Emergency Department at 04:12 and was seen by the triage nurse at 04:35. They said that she was later seen by Doctor 1 who contacted the on-call psychiatrist and was advised that outpatient follow-up may be the best option. They said that it would be normal practice to contact psychiatry for advice about patients presenting with mental health problems. They also said that Doctor 1 then contacted Mrs C to discuss the advice provided. They stated that she took on board Mrs C's concerns and the fact that Miss C's behaviour had deteriorated and then carried out a further detailed assessment.

14. In their response to Mrs C dated 8 September 2014, the Board said that when Miss C was triaged following her arrival at the Hospital, all of her observations were within normal limits, although she had a slightly increased heart rate. They said that Miss C did not require any medical management as her condition was related to mental health issues and she was awaiting review by psychiatry. They stated that when she became agitated and began lashing out at staff, she had to be restrained by police officers, although this did not change her management. They said that they were unable to comment on the advice and management provided by psychiatry and that Mrs C should contact Primary Care about this. Finally, they said that staff within the Emergency Department cannot demand that the on-call psychiatrist comes to the department.

Emergency Medicine Advice

15. We asked Adviser 1 if Miss C had been appropriately assessed by the triage nurse when she arrived in the Emergency Department in the Hospital. In his response to us, Adviser 1 said that the triage nurse had appropriately assessed Miss C. He commented that her vital signs were recorded as an initial screening process to exclude a physical cause for her mental state. The triage nurse also noted Miss C's past history of bipolar disease and that she was experiencing a psychotic episode at the time of presentation. He added

that the triage nurse had completed a mental health assessment scoring tool, which is normally used to assess the risk of self-harm. Adviser 1 also commented that the nurse allocated Miss C a triage category of two. This indicated that she regarded Miss C as being seriously unwell and that she required medical assessment as soon as possible.

16. We then asked Adviser 1 if it had been reasonable that Miss C had not been seen by a doctor until 07:45. In his response, Adviser 1 said that there was a considerable delay of over three hours before Miss C was assessed by Doctor 1, which was not ideal in the circumstances. However, he noted that the information provided by the Board mentioned that Doctor 1 had to deal with a seriously ill patient at the time. He commented that it is unfortunately not uncommon for patients to wait for prolonged periods in Emergency Departments for medical assessment due to the volume of patients needing to be seen, especially during the night when staffing levels are lower. He stated that this is a problem common to all large Emergency Departments and that when demand exceeds capacity, patients must by prioritised in terms of medical urgency.

17. We also asked Adviser 1 if Doctor 1 had carried out a satisfactory assessment of Miss C. In his response, Adviser 1 said that Doctor 1's initial assessment was thorough and of a good standard. He commented that she had taken and documented a comprehensive history from Miss C. This included a mental state examination and a physical examination. Blood tests were also taken to exclude a physical cause of Miss C's symptoms.

18. We then asked Adviser 1 if Doctor 1's documentation in relation to the examination of Miss C had been adequate. In his response, Adviser 1 said that Doctor 1's documentation of Miss C's history and examination had been adequate. However, he then stated that Doctor 1's overall assessment of Miss C's illness and its severity could have been more explicit. He said that Doctor 1 had not documented that the on-call psychiatrist may have initially said that Miss C did not require psychiatric assessment and that she should be sent home. She had also not documented the telephone conversation with Miss C's parents. In addition, the deterioration in Miss C's behaviour had not been documented, though it is possible that this occurred after Doctor 1's nightshift had finished.

19. We asked Adviser 1 if Doctor 1 should have admitted Miss C to hospital at that time. In his response, he said that there was insufficient information documented in order to state definitively that a hospital admission was required. However, he did comment that from the information that had been written, his opinion was that this was highly likely.

20. We asked Adviser 1 if staff in the Emergency Department should have asked a psychiatrist to come to the ward. In his response, he said that he considered that they should have. He stated that Mrs C had suggested that the on-call psychiatrist initially said that an assessment was not required and that Doctor 1 should discharge Miss C. He said that Mrs C's complaint and the email from Doctor 1 dated 8 May 2014 indicated that she attempted to follow this advice. Adviser 1 stated that this was an incorrect course of action. He said that Doctor 1 should have insisted on an urgent psychiatric assessment in the Emergency Department. If this was refused, she should have escalated the issue to her consultant.

21. We then asked Adviser 1 if it was reasonable that diazepam was administered to Miss C on two occasions and that lorazepam was then administered. In his response to us, Adviser 1 said that this was a reasonable course of action. He commented that it is arguably preferable to administer lorazepam rather than diazepam, but in the circumstances, this was not unreasonable. He said that guidance from the Scottish Intercollegiate Guidelines Network: Bipolar Affective Disorder (82) stated:

> 'Intramuscular injection of antipsychotics and/or benzodiazepines (lorazepam), should be used in emergency situations, in accordance with local protocols.
>
> Benzodiazepines may be used as adjunctive treatment in acute mania where sedation is a priority.'

22. Adviser 1 also stated that the Consultant's assessment and documentation regarding Miss C's deterioration was very brief. He said that with such a considerable change in behaviour and the fact that Miss C had previously only been assessed by a junior doctor should, in his opinion, have prompted a full re-assessment of her condition.

23. The Adviser then went on to say that he considered that there had been a number of shortcomings in Miss C's care and treatment:

- although Doctor 1 conducted a thorough assessment of Miss C, he failed to recognise the severity of her illness;
- the on-call psychiatrist apparently initially refused to see Miss C and advised that she be discharged without an agreed follow up plan. In view of her history and features at the time of presentation, this was not the correct course of action to take.
- when Doctor 1 was given this advice, she should have realised that it was inappropriate and unsafe and should have questioned it. She then should have escalated the situation to her consultant;
- if the nursing staff in the Emergency Department were aware of the plan to discharge Miss C, they should also have questioned this plan; and
- when Miss C's condition deteriorated, a thorough re-assessment of her condition should have been considered. He said that this was especially the case when three doses of sedatives were required.

Psychiatric Advice

24. We also obtained psychiatric advice on Mrs C's complaint from Adviser 2. We asked Adviser 2 if it had been unreasonable for the on-call psychiatrist to state that out-patient follow-up may be the best option for Miss C. Adviser 2 said that this had been unreasonable. He said that the circumstances of Miss C's attendance at the Emergency Department were not taken into account. He also said that there had been no communication with Miss C's parents to gain background information or to discuss further plans. He said that the on-call psychiatrist had not seen or examined the patient at that time. In addition, admission to hospital, on a voluntary or involuntary basis does not appear to have been contemplated.

25. We asked Adviser 2 if it was unreasonable for the on-call psychiatrist to say that they would assess Miss C after her blood test results were available. In his response to us, Adviser 2 said that this had been unreasonable. He stated that Miss C had been brought to the Emergency Department as a result of a 999 call. It had been identified that she had a previous history of mental illness. The initial mental health assessment form, which was completed at 04:35, highlighted several risks and categorised Miss C as, 'category 2 – High Risk'. He said that after waiting for over three hours, Miss C was seen by Doctor 1, who considered that psychiatric assessment was required. He said that it was unlikely that the blood results would have materially affected the

assessment and the psychiatric assessment could have been done while the blood results were awaited.

26. We then asked Adviser 2 if a psychiatrist should have attended the Emergency Department to assess Miss C prior to the deterioration in her condition. In his response, Adviser 2 said that a psychiatrist should have attended the Emergency Department as promptly as possible after the request from Doctor 1.

27. Adviser 2 also commented that the standard of note keeping was poor. He said that although Miss C was given diazepam at 08:40 and 09:20 and lorazepam at 10:00, there was no note of the circumstances of the first two injections. He also said that there was no reference to a protocol for the emergency use of tranquilisation. Finally, Adviser 2 said that there were no entries in the notes to indicate who might have done the psychiatric assessment or what the outcome was.

(a) Decision

28. The advice I have received is that Miss C was appropriately assessed by the triage nurse when she attended the Emergency Department. The triage nurse considered that Miss C required medical assessment as soon as possible. However, there was a delay of over three hours before Miss C was assessed by Doctor 1. The assessment that took place at that time was reasonable, however, Doctor 1 subsequently failed to fully document her assessment of Miss C's illness and its severity; her discussion with the on-call psychiatrist; and, her conversation with Mr and Mrs C.

29. Adviser 1 considered that although Doctor 1 had conducted a thorough assessment of Miss C, she failed to recognise the severity of her illness. He said that Doctor 1 should have insisted on an urgent psychiatric assessment in the Emergency Department. In addition, Adviser 1 said that staff in the Emergency Department should have questioned the on-call psychiatrist's decision that Miss C could be discharged. He also considered that a thorough re-assessment of Miss C's condition should have been considered when her condition deteriorated.

30. Turning to the psychiatric advice I received, Adviser 2 considered that the psychiatric assessment was unduly delayed and that Miss C's condition was allowed to deteriorate during the delay. He also said that it had been

unreasonable for the on-call psychiatrist to state that outpatient follow-up may be the best option for Miss C. In addition, he considered that the standard of note keeping was inadequate.

31. In view of all of these failings, I have upheld this aspect of Mrs C's complaint.

(a) Recommendations

32. I recommend that the Board:	*Completion date*
(i) issue a written apology to Mrs C for the failure to provide reasonable care and treatment to Miss C in hospital on 18 September 2013;	18 December 2015
(ii) remind medical and nursing staff in the Emergency Department that acute mental health patients are high risk patients;	18 December 2015
(iii) take steps to try to put a low threshold in place for the involvement of senior medial staff in decision-making regarding the discharge of such patients;	18 January 2016
(iv) take steps to ensure that the assessment and management of acute mental health presentations is discussed during the induction programme for new junior doctors in the Hospital's Emergency Department;	18 January 2016
(v) take steps to ensure that it is emphasised in the induction programme of junior on-call psychiatrists that it should normally be the case that acute mental health patients attending the Emergency Department following an emergency should have a thorough psychiatric assessment;	18 January 2016
(vi) remind relevant psychiatric staff that patients being considered for discharge directly from the Emergency Department should have their follow-up and circumstances taken into consideration;	18 December 2015
(vii) consider if there should be a change to the process to allow the member of staff carrying out the triage to consider direct referral for psychiatric assessment in high risk cases;	18 January 2016
(viii) emphasise to relevant staff involved in the	18 December 2015

	complaint the importance of keeping accurate records that would be fully adequate for the purposes of later scrutiny; and	
(ix)	consider if there should be a protocol for emergency tranquilisation in the Emergency Department.	18 January 2016

(b) The Board's handling of the complaint was inadequate

Background

33. See complaint (a) above.

The Board's Policy and Procedure for Handling and Learning from Feedback, Comments, Concerns and Complaints

34. The Board's complaints policy and procedure states that where it is not possible to respond within twenty working days, the complainant will be provided with an explanation as to why there is a delay and, where possible, a revised timetable. It states that once the Board's Feedback and Complaints Officer is satisfied that the investigation process has been completed and has fully investigated all the issues raised, a report of the investigation will be issued. It states that the report will include:

- the conclusions of the investigation;
- an explanation of any technical terms;
- an apology where things have gone wrong;
- details of any area of disagreement and an explanation as to why no further action can be taken;
- information as to any remedial action taken or proposed as a consequence of the complaint;
- details as to how the complainant can contact the SPSO if they are not satisfied with the outcome of the investigation; and
- contact details for a named member of staff if clarification is required.

(b) Decision

35. The Board received a consent form from Miss C in relation to the complaint on 18 February 2014 and issued a response within 20 working days of this being received. However, having carefully considered the Board's response to Mrs C's complaint, I do not consider that Mrs C received an adequate response to the issues she had raised. The Board's letter simply outlined what had been done when Miss C attended the Emergency

Department. Although they apologised for failing to communicate with Mrs C adequately, the Board failed to evidence that the concerns Mrs C had raised about Miss C's treatment had been investigated.

36. Mrs C then met staff from the Board on 21 May 2014. On 1 July 2014, she wrote to the Board again. However, the Board initially failed to acknowledge this letter and did not issue a response to her until 8 September 2014. Their response to Mrs C again failed to acknowledge the failings I have highlighted above. In addition, they said that they were unable to comment on the advice and management provided by psychiatry and that Mrs C should contact Primary Care about this. The Board's response should have addressed all of Mrs C's concerns in relation to the treatment Miss C received in the Emergency Department and the Board have told us that the manager who signed off this letter has been reminded of this. In view of all of this, I have also upheld this aspect of the complaint.

(b) Recommendations

37. I recommend that the Board: *Completion date*

(i)	issue a written apology to Mrs C for the failure to satisfactorily respond to her complaint; and	18 December 2015
(ii)	make the staff involved in the handling of Mrs C's complaint aware of our decision on this matter.	18 December 2015

38. The Board have accepted the recommendations and will act on them accordingly. We will follow-up on these recommendations. The Board are asked to inform us of the steps that have been taken to implement these recommendations by the date specified. We will expect evidence (including supporting documentation) that appropriate action has been taken before we can confirm that the recommendations have been implemented.

Annex 1

Explanation of abbreviations used

Mrs C	the complainant
Miss C	the aggrieved, Mrs C's daughter
the Hospital	Wishaw General Hospital
the Board	Lanarkshire NHS Board
Adviser 1	the Ombudsman's emergency medicine adviser
Adviser 2	the Ombudsman's psychiatric adviser
Doctor 1	the junior locum doctor who initially assessed Mr C in the Emergency Department
CPN	Community Psychiatric Nurse
Mr C	Mrs C's husband
the Consultant	the Emergency Medicine Consultant
Doctor 2	the doctor who attended from psychiatry

Annex 2

Glossary of terms

adjunctive treatment	additional treatment
benzodiazepine	drugs used to treat anxiety, insomnia, and a range of other conditions
diazepam	a medicine used to treat anxiety
lorazepam	another medicine used to treat anxiety

Annex 3

List of legislation and policies considered

Scottish Intercollegiate Guidelines Network (82): Bipolar Affective Disorder

Lanarkshire NHS Board's Policy and Procedure for Handling and Learning from Feedback, Comments, Concerns and Complaints

Mental Health (Care and Treatment) (Scotland) Act 2003