mentalwelfare commission for scotland

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INVESTIGATION REPORT

The care and treatment of Mr EF

Contents

Our aim

We aim to ensure that care, treatment and support are lawful and respect the rights and promote the welfare of individuals with mental illness, learning disability and related conditions. We do this by empowering individuals and their carers and guiding and challenging service providers and policy makers.

Why we do this

Individuals may be vulnerable because they are less able to safeguard their own interests. They can have restrictions placed on them in order to receive care and treatment. When this happens, we make sure it is legal and ethical.

Who we are

We are an independent organisation set up by Parliament with a range of duties under mental health and incapacity law. We draw on our experience as health and social care staff, service users and carers.

Our values

We believe individuals with mental illness, learning disability and related conditions should be treated with the same respect for their equality and human rights as all other citizens. They have the right to:

- be treated with dignity and respect
- ethical and lawful treatment and to live free from abuse, neglect or discrimination
- care and treatment that best suit their needs
- recovery from mental illness
- lead as fulfilling a life as possible

What we do

Much of our work is at the complex interface between the individual's rights, the law and ethics and the care the person is receiving. We work across the continuum of health and social care.

- We find out whether individual care and treatment is in line with the law and good practice
- We challenge service providers to deliver best practice in mental health and learning disability care
- We follow up on individual cases where we have concerns and may investigate further
- We provide information, advice and guidance to individuals, carers and service providers
- We have a strong and influential voice in service policy and development
- We promote best practice in applying mental health and incapacity law to individuals' care and treatment.

Reason for investigation

Mr EF died on 19 September 2011 in Community Unit B. It was reported to the Procurator Fiscal as a sudden death. The cause of death was subsequently confirmed at post-mortem examination as being due to bacterial endocarditis secondary to valvular heart disease. Four days previously, he had been reviewed urgently at General Hospital 1 by a consultant acute physician and sent back to Community Unit B.

Mr EF's death was subject to a full and thorough internal review. We were made aware of Mr EF's death and received the internal review in October 2012. This was followed by a meeting between the Chief Executive and Chief Medical Officer of the Commission and the Medical Director of NHS Board A to discuss matters arising from the review.

This report outlines the main findings from this case and the steps taken by us and NHS Board A to address the issues raised by Mr EF's death. His parents expressed concern about Mr EF's death and were informed that an investigation would be taking place. Senior officers from the NHS Board met the parents, gave them the report of the internal investigation and explained the findings to them.

Background

Mr EF was known to have a learning disability. He also had congenital heart disease affecting his aortic valve. He had been under the care of cardiologists for this.

He had a history of minor offences relating to poor social judgement as a result of his learning disability. These included assault, breach of the peace and making nuisance telephone calls. He had episodic hospital treatment during the 1990s for this.

Mr EF was convicted of making threats to kill and was detained in the State Hospital in Scotland. He remained under a compulsion order with restriction order in terms of the Mental Health (Care and Treatment) (Scotland) Act 2003.

He was transferred in 2007 to Ward X at Psychiatric Hospital 1 and from there to Community Unit B to continue his rehabilitation. He remained in close contact with his parents throughout this time.

Timeline of relevant events

February – April 2011

Mr EF was examined by his dentist who found extensive decay and recommended that all upper teeth were removed. In view of his medical history, the dentist requested information from Psychiatric Hospital 1.

Over the next two months, there was further discussion about the risks of dental extraction given that Mr EF had disease of his heart valve. In this situation, there is a risk of developing infective endocarditis if bacteria enters the blood stream and infects the damaged heart valve.

In the past, it had been standard procedure for antibiotics to be given when significant dental work is undertaken. This is no longer standard procedure but it was advised that if Mr EF developed flu like symptoms after dental treatment, staff should consult his cardiologist or general practitioner. Staff were given a leaflet on infective endocarditis. Due to his poor dental hygiene, there was a risk of endocarditis with or without dental extractions. The dentist had full information about Mr EF's aortic valve disease.

20 June 2011

The dentist removed Mr EF's upper teeth. During this procedure Mr EF was sedated and he made an uneventful recovery.

The next day he went with a member of staff from Community Unit B to have a dental plate inserted. This proved difficult because it was quite painful. However, over the next few weeks, it was reported that the denture was comfortable. Mr EF was managing to wear it and eat with it during the day. His oral hygiene was still poor.

3 August 2011

Nurses reported some concerns about Mr EF's physical health. He appeared pale in colour and had vomited. Mr EF had no pain but felt shaky and had a mildly raised temperature at 37.5 degrees Celsius. Mood changes were also noted during this time. Mr EF appeared low in mood and his behaviour became unpredictable with verbal aggression at times.

18 August 2011

Mr EF was seen by a locum GP along with a member of nursing staff. A history of general tiredness, malaise, muscle aches and mild fever was noted. It was thought he had a viral illness but was advised to come back for review if it did not settle. There is no evidence that information about dental treatment was communicated to the GP.

25 August 2011

It was noted in Community Unit B that Mr EF was pale. He had lost a stone in weight and was referred back to the GP. Subsequent blood tests were taken: he had low haemoglobin, blood sodium was slightly low and they kept his physical health under review.

1 September 2011

He was not any better and if anything was more tired and lethargic. Blood tests were repeated, he had a further dental assessment a week later when it was noted that his teeth were very dirty.

Repeat blood samples received on 12 September 2011 showed that he was still somewhat anaemic that was reported as "likely anaemia of chronic disease".

15 September 2011

Due to ongoing concerns, medical staff at Community Unit B decided to send Mr EF to General Hospital 1 where he was initially examined by nursing staff and then by a consultant acute physician who thought he had a viral upper respiratory tract infection.

Mr EF and members of nursing staff were reassured and he was sent back to Community Unit B. He was seen the following day by his GP who noted that he had been at General Hospital 1 but had little information as to what had happened. The plan was to find out what the opinion was and review him in a week.

19 September 2011

On 19 September 2011, at 11am, he was found by a member of nursing staff on his bedroom floor. He had died, probably sometime earlier that morning.

On 22 September 2011, a post mortem carried out at the request of the Procurator Fiscal showed bacterial endocarditis and valvular heart disease.

Review of events

There were two significant concerns about Mr EF's death.

These were:

1) in the lead up to his attendance at General Hospital 1 on 15 September 2011, could or should anything have been done differently to either prevent or identify infective endocarditis, and

2) was his assessment and treatment on 15/09/11 appropriate and, in particular, would he have been treated differently had he not had a learning disability and been under the care of specialist services?

1) Could or should anything have been done differently prior to 15 September 2011?

Infective endocarditis is rare with an incidence of 1.7 to 6.2 cases per 100,000 patients per year. It carries a high mortality rate of around 10%. Had the diagnosis been made in August 2011 when Mr EF started to experience symptoms of ill health, antibiotic therapy would be likely to have helped. The internal review by NHS Board A looked in detail at opportunities to make this diagnosis at an early stage.

Questions they asked, and their findings relevant to those questions were

a) Should Mr EF have had antibiotics to prevent infective endocarditis when he had his dental extraction?

On previous visits to dentists, Mr EF had received antibiotics in accordance with advice from the cardiologist managing his case.

However, from 2008 onwards, this was no longer a standard practice. NICE guidance entitled "prophylaxis against infective endocarditis: antimicrobial prophylaxis against infective endocarditis in adults and children undergoing interventional procedures"[1] no longer recommended antibiotics before dental procedures.

Within the UK, and internationally, opinion is still split on this matter and it was recognised that bacteria could enter the bloodstream simply by brushing teeth in somebody with poor dental hygiene. The cardiologist, in view of recent guidelines, was very clear that he would no longer have recommended antibiotic therapy in this situation.

The review concluded that, while it may have been that bacteria entered Mr EF's bloodstream during his dental extraction, it could equally have happened at other times simply by brushing badly decayed teeth. It therefore said that the advice and treatment offered by the dental service was correct.

[1] http://www.nice.org.uk/nicemedia/pdf/cg64niceguidance.pdf

b) Could a diagnosis have been made by the GP at an earlier stage?

It is important to point out the nature of Community Unit B. While it is technically an NHS facility, it is actually a home for seven residents, all of whom have learning disability.

From 2006 onwards, it was decided that residents should be registered with and have a personal relationship with a GP in a way that members of the general population do. If there was a physical health problem, the resident would have an appointment made to see the GP and be accompanied to the surgery by a member of nursing staff. This was clearly what happened on several occasions during August 2011.

The internal review found good documentation in the GP records. They considered that the initial diagnosis of a viral illness was not unreasonable and that appropriate blood tests were undertaken. He was slightly anaemic but had a previous history of rectal bleeding and it was therefore appropriate the blood tests were repeated. The GP was concerned that there was "something going on" with Mr EF but did not consider infective endocarditis as a possibility. On receipt of the repeat blood tests, it was the GP's intention to refer Mr EF onto secondary care services for further investigation.

Nursing staff were aware that Mr EF was not physically well. One of the problems identified was the flow of information from the GP surgery to Community Unit B. The GP said that it can be challenging to identify the results for Community Unit B patients and then feed those results straight back to the unit. He relied on the unit, with a high staff to patient ratio, to phone the surgery to get results if required. Since this event, there has been improved flow of information from the practice to Community Unit B.

The same point was made about information going in the opposite direction. While the dentist gave verbal and written advice to Mr EF and the nurse about infective endocarditis in March, there was no evidence that this procedure and the advice were communicated from Community Unit B to the GP. The review states that, understandably, there was no one member of the nursing staff that attended all Mr EF's clinical appointments outwith the unit. This means it would have been difficult to ensure all necessary information was communicated between healthcare professionals. In the absence of this information, the review found that, even if the GP had made an earlier referral for investigation of anaemia, it was unlikely that a specialist review would have taken place until September, by which time events may have still have overtaken this referral.

2) Could or should anything have been done differently at General Hospital 1 on 15 September?

a) Assessment in Community Unit B

The consultant psychiatrist in Community Unit B reviewed Mr EF at the request of nursing staff on 15 September. The doctor undertook that review promptly, identified that Mr EF was unwell and recognised he needed further medical assessment. There was no immediate access to the most recent blood results and she had to call a doctor in the Psychiatric Hospital 1 to obtain the results. She had undertaken this task herself rather than contacting the GP, but she felt the situation was urgent and that hospital assessment and investigation were required. The drawback to this was that important background information was not made available because the GP surgery was not involved. The psychiatrist arranged an escort to travel with Mr EF, informed the Scottish Government of her decision (due to his restricted status) and telephoned General Hospital 1. However, she only spoke with a receptionist and not one of the doctors.

She wrote a referral letter with all the information she had available at the time but did omit important information about how long Mr EF had been unwell and the extent of his weight loss. She had no information about what had been happening in general practice and it was concluded that, with the benefit of hindsight a direct conversation with a senior doctor on duty at General Hospital 1 would have been better to relay real and genuine concerns about Mr EF's wellbeing.

It is likely that a senior doctor at General Hospital 1 would have agreed to review Mr EF that day or, at the very least, seen him as an outpatient the following day.

b) Assessment of Mr EF at General Hospital 1

The internal review noted that the diagnosis of bacterial endocarditis was missed and was not even considered as a diagnostic possibility by the consultant physician who examined Mr EF. There were different accounts as to the extent of the clinical examination performed. However, the review stated that there were features that could have raised alarm signals, i.e. fever, rapid pulse, known valvular heart disease, anaemia of a type found in infective endocarditis (but also in many other conditions) and a low serum albumin (essential blood protein). He did not have a chest x-ray, ECG or urine examination (the last of these might have found evidence of blood in the urine which could have increased the possibility of infective endocarditis as a diagnosis).

The consultant physician was concerned that further investigations might have caused Mr EF distress and led to deterioration of his behaviour. He also made the point that he had not been informed of the length of Mr EF's symptoms or the concerns of the psychiatric team about his overall wellbeing. He knew the GP was investigating his anaemia. The nurse who had accompanied Mr EF was aware of all these details.

We cannot comment on whether or not the diagnosis should have been made at this point. When this was reviewed by a cardiology specialist, he agreed that there were clear cut pointers to a diagnosis of infective endocarditis and that a consultant cardiologist would have made this diagnosis. In relation to a general physician, his conclusion was that "an excellent doctor would have picked that up; a middling doctor could have been forgiven for missing it".

Had the diagnosis been considered at that point, Mr EF would have been admitted to hospital. However, blood cultures would have had to be taken and further investigations arranged before antibiotic therapy could be started, this may not have occurred for at least two days. If surgery had been contemplated, Mr EF would have received at least five days of antibiotics before considering surgery.

It may have been that Mr EF's physical condition had deteriorated markedly and that, even if he was in hospital on 19 September, he would have still suffered a cardiac arrest and died.

However, our view was that at the very least he would have had the care and attention in a general hospital that would have given him the chance of survival rather than being sent back home to a unit where there was nowhere near the same access to physical investigation and monitoring.

Our concern was the consultant physician's assumption that "further investigations may have caused Mr EF distress and led to a deterioration of his behaviour". While this may have been the case, the Commission considers it unacceptable and a significant breach of equality duties that a person with learning disability was not afforded access to the same level of investigation and management to safeguard or promote his physical health as would be offered to a person without learning disability.

We consider that every effort should have been made in this case to provide Mr EF with the opportunity to benefit from such treatment, including specialist learning disability nursing care while he remained in the general hospital.

Conclusions of the Internal Review

We accepted many of the findings and recommendations from the Internal Review.

These were:

- There was no concern in relation to the assessment and treatment by the dental service. The decision not to give antibiotics was in line with local policy and NICE guidance.
- There were no concerns about the general practitioner. It would be very rare for a GP to see anybody with infective endocarditis, a rare condition whose early course mimics that of a non specific viral illness.
- The flow of information among healthcare professionals involved with Mr EF was not optimal. In particular, information on dental treatment was not communicated to the GP by the dentist or the Community Unit B staff. Also, nursing staff did not appreciate the significance of the information about infective endocarditis from the dentist. While this may not have altered the outcome in this case, it is a significant problem and could occur in other cases.
- The consultant psychiatrist in Community Unit B did not have all the necessary information about Mr EF's care and treatment as she did not have his primary care records. Also, there was no formal escalation policy within Community Unit B for the management of acute illness. The internal review concluded that it would have been more appropriate to request an urgent review by a doctor from the GP surgery rather than the consultant psychiatrist. Again, while perhaps not critical in this case, it could be critical in other cases.
- The assessment in General Hospital 1 lacked the rigour that might have been expected of a consultant in acute medicine in a major teaching hospital. This was due to the consultant's concerns about causing additional distress to a potentially dangerous individual, his lack of understanding of the concerns of the consultant psychiatrist and his judgement that Mr EF did not have a serious acute illness. However, the review also took note of the cardiologist's comment that a missed diagnosis of infective endocarditis would not be uncommon in an acute secondary care setting and that his outcome would not have been different event if he had been admitted to hospital that night.

Recommendations from Internal Review

The review recommended the following

1) All establishments such as Community Unit B (either learning disability or psychiatric units) where primary care offers primary medical services for inpatients should review their policies on the interaction between the services.

   Key issues to be addressed include:
   - Shared understanding between the general practice and the unit as to the nature, role and function of the unit.
   - Agreed escalation policies for managing acute and chronic physical health deterioration.
   - Increased understanding of individual patient issues of incapacity, need for advocacy and confidentiality requirements.
   - The sharing of appropriate important clinical information between the "carers" in the establishment and the primary physicians, taking into account the issues of confidentiality and privacy.

2) The other psychiatric units in NHS Board A that do not have primary care input should also develop and agree with their local acute hospitals escalation policies for managing acute physical health deterioration.

3) Primary and secondary clinical management teams should discuss and agree improvements in the communication between clinicians in situations where a patient may require urgent hospital assessment.

   Special consideration should be given to improving and advertising the need to have telephone discussions about patients about whom there are concerns. Consideration should also be given to improving the ability to convey written information from primary and secondary care at the time of acute hospital admission. To help achieve this, the acute medical consultant physician in the GP referral unit carries a mobile phone between 8am and 8pm. This phone number has been circulated to all GPs.

4) The consultant acute physician no longer works in the United Kingdom and returned to working abroad for reasons unrelated to the case. Had he remained in employment in NHS Board A, the panel would have recommended that he prepare a written reflection of his involvement in this case for discussion at his annual appraisal. The NHS Board has sent him a copy of the report and he has acknowledged receipt.

5) The panel discussed at length whether guidance on diagnosis of infective endocarditis should be circulated to GPs in Board A but this was not felt to be something that would materially alter outcomes or enhance the likelihood of diagnosis. Indeed there was concern from the professor of cardiology that such guidance might result in many more referrals to secondary care to exclude a diagnosis of endocarditis.

6) A senior representative of NHS Board A should meet with Mr EF's family to discuss the content of this report, its conclusions and recommendations. Officers from the NHS Board met Mr EF's parents to discuss their concerns. They provided the parents with a copy of the report.

Action by the Mental Welfare Commission

We noted and accepted the findings and recommendations from the Internal Review.

The issues discussed further between the Commission and NHS Board A were:

1) Increasing the index of suspicion for infective endocarditis in the cases of individuals with learning disability and congenital heart disease.

2) The safety of the practice of the medical practitioner who assessed Mr EF at General Hospital 1.

3) The possibility that there was inequality in the treatment of Mr EF when compared with a person who did not have a learning disability.

On the first point, there was agreement that improved information flow, notably improved attention to the information given by the dentist in such cases, would help to address this issue by making more members of the clinical team aware of the risks involved.

On the second point, while it was not for us to make a judgement on the practice of the consultant acute physician, we recommended that NHS Board A determine the doctor's current employer and relay any concerns about his practice to that employer.

Further discussion took place around the third point, i.e. the likelihood that Mr EF was not given the care and treatment that would be afforded to a person who did not have a learning disability. It was agreed between us and NHS Board A that there were further actions that the NHS Board could take. For example, the Commission considered that the consultant acute physician made a judgement based on a perception of Mr EF's likely behaviour. We felt the consultant acute physician did not attempt to discuss with the learning disability team what help, support and additional input might be available to support Mr EF during his stay in the general hospital. There are procedures for planned admissions for people with learning disability to give them extra help and support but they are less clear on how to react in an urgent situation.

Outcomes

We expressed our gratitude to NHS Board A for taking this incident extremely seriously and devising a number of actions to address the shortcomings that both organisations identified.

In relation to the main recommendations in the NHS Board A report, the lead clinician for the learning disability service reported that the following actions have either been taken or are being progressed.

These are:

Actions specific to the learning disability service

1) Communication

GPs will be provided, as a matter of routine, with summaries of the psychiatric histories of each patient. These summaries will include detention status and observation levels required for each patient and information regarding risk factors. It was agreed that GPs should be invited to attend annual reviews of all the patients in the unit with the relevant multi-disciplinary team although it was recognised that the current contract for the GP service would not include this.

All email correspondence from healthcare houses will be sent to the clinical practice mailbox, not individual GPs.

All GPs are aware of the contact details of the charge nurses of each unit. If important information needs to be passed on, they can contact the charge nurse. If nursing staff phone the general practice for an update, they need to be aware that the practice will insist on phoning back in order to ensure that patient confidentiality is maintained.

2) Investigations

GPs can request that nursing or learning disability medical staff take blood samples.

To assist with this, GPs should provide, practice printed, sticky labels for the blood sample tubes so that the results go back to the GP.

Learning disability nursing and medical staff will ensure that they can access the Board's IT system so that they can personally check results.

3) GP appointments

All patients will be accompanied by a registered learning disability nurse whenever possible. If in unusual circumstances this is not possible, the identified non registered nurse will be knowledgeable and aware of the patient's history and condition.

All patients attending the general practice must have the prescribing kardex with them.

In addition, the Board intends to ensure that all patients with learning disability will attend medical appointments with a "My important health information" document. The Board is currently developing these documents.

4) Out of hours arrangements

It was confirmed that all patients residing in healthcare houses and therefore registered with general practitioners should have access to NHS 24 out of hours for urgent healthcare matters. This also applies to those patients within the grounds of Psychiatric Hospital 1.

Due to lack of certainty expressed previously by staff at NHS 24 when contacted by nursing staff and healthcare houses within the Psychiatric Hospital 1 grounds, it will be confirmed to the medical director at NHS 24 that patients in Community Unit B and other houses have access to NHS 24.

It was agreed that in appropriate cases certain patients are registered with the unscheduled care service. In cases where this has happened, nursing staff have established good relationships with staff at the unscheduled care service. Important information will be available in electronic form for the unscheduled care service.

5) Management of physical health

It was agreed that the hospital cardiac arrest/medical emergency operation policy did not apply to the outlying healthcare houses because of the primary healthcare registration status of the patients. The appropriate response was to dial 999 on an outgoing number.

It was agreed that the learning disability service would adopt the Psychiatric Hospital 1 standardised early warning score (SEWS) escalation flowchart. This flowchart needs to be reviewed and adapted for the healthcare houses. All nursing staff will be trained in the use of the flowchart.

In non emergency, but urgent, cases involving the physical healthcare of patients during the day, the GP should be contacted in the first instance.

In order to record that the recommended basic minimum healthcare checks have been completed by clinical teams in relation to patients in learning disability services, the flow form to be completed by learning disability and nursing staff are a) on admission nursing healthcare check list and medical physical examination record b) on annual review annual nursing physical health monitoring form and medical annual review physical health monitoring form. It was agreed that this paperwork should be used as a matter of routine. It was also agreed that clinical judgement was required regarding some investigations, taking into account the patient's capacity to agree and the ability to comply balanced with the necessity of the investigation involved.

Actions across NHS Board A

Following our intervention, NHS Board A has undertaken further actions relating to general hospital services. These address the principles of equality for a wide range of patient groups who may be disadvantaged by difficulties in communication, potential behaviour challenges to services and stigma or prejudice. This would include individuals with a wide range of mental health conditions, people from different ethnic backgrounds or with language difficulties and people affected by substance misuse difficulties. The following actions are being undertaken by the NHS Board:

1) Education

a) Of all staff to ensure there is an understanding about how to communicate with patients who may have additional needs or learning disabilities.

b) Specifically to address knowledge about capacity to give consent for investigation and treatment in difficult circumstances.

c) Communication techniques.

2) Availability of information and advice in unusual or difficult circumstances

a) How to obtain advice for patients under restricted conditions or held under detention orders for staff who are not familiar with these.

b) How to make sure there is shared information about patients' symptoms between different services providing elements of care and that information about important factors is not lost between services.

3) Ensuring carers and families are involved

a) Encourage staff to ask carers for their views about a patient's condition and make sure information has been sought from them and given to them.

Some activities have already taken place in relation to these points. NHS Board A has undertaken a "values into action" exercise to reflect on its culture and values. In undergraduate medical education, the relevant department is incorporating scenarios relating to vulnerable adults within "situational judgement tests". This is being developed to include a scenario relating specifically to adults with a learning disability. Learning disability liaison nurse and medical representation on the vulnerable adults education group has been established and there are proposals for incorporating learning disability specific training into the foundation year teaching programme.

For permanent staff, NHS Board A will encourage all staff to reflect upon their development needs in communicating and caring for vulnerable adults. Teaching modules are available and appraisers will be looking for evidence that medical staff have addressed their educational needs in this area as part of the evidence to be submitted in appraisal building towards revalidation. Updated information about liaison mental health and learning disability services will be highlighted for all new staff. Mr EF's case was presented to a meeting of the "learning from serious adverse events" quarterly event run by NHS Board A. Quality improvement teams will also be reflecting on how they meet the needs of vulnerable adults.

This programme was scheduled to start in autumn 2013. The Commission will ask for updates on progress.

We have sent our report to Mr EF's parents in order to assure them that lessons have been learned.

Summary and Conclusion

While ultimately Mr EF had a rare but serious complication of valvular heart disease, there were better opportunities to share information among the healthcare professionals involved that might have increased the suspicion of this diagnosis at an earlier stage. We consider that there is a considerable risk of gaps in communication and coordination of medical care where individuals remain under the care of the consultant psychiatrist but their physical health care is provided by a general practitioner with whom they are registered. Shared care protocols may help to reduce this risk.

Also, when Mr EF attended general hospital as an emergency presentation, it is likely that he did not have the opportunity to benefit from acute hospital investigation and treatment that would have been afforded a person without learning disability. The Mental Welfare Commission and NHS Board A have agreed on a set of actions to address the recommendations made by the internal review and by us.

The Scottish Government's latest learning disability strategy, "The Keys to Life"[2] was launched in 2013. In relation to health, it states, *"Research tells us that people with learning disabilities have some of the poorest health of any group in Scotland. They are considerably more likely to die at an early age than the general population – on average 20 years before. Some of the causes of death are potentially preventable, and the main causes of death differ from those of the general population."* Our report on Mr EF emphasises the importance of this statement.

Other NHS Boards should examine this report carefully and ensure that they afford people with learning disability or other related conditions equal access wherever possible to appropriate physical health investigation, treatment and care.

[2] http://www.scotland.gov.uk/Publications/2013/06/1123/0


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