

**Case:** 201104064, Tayside NHS Board  
**Sector:** health  
**Subject:** policy/administration  
**Outcome:** upheld, action taken by body to remedy, recommendations

### Summary

Mr C complained on behalf of his brother (Mr A), an adult with a mental health condition. Mr A had permission to leave the mental health unit where he lived to visit his own home for a few days. However, at the end of that time, no one came to collect and return him to the unit. As he did not return, the unit told his family and the police. The police found Mr A at his home and damaged his door to gain entry. They removed him from his home and took him back to the unit. Mr C complained about the trauma that the whole incident would have caused his brother.

When Mr C complained to the board, they acknowledged immediately that there had been a communication breakdown regarding the arrangements for collecting Mr A at the end of his home visit. They described the steps they were taking to help prevent the same thing from happening again.

Mr C remained dissatisfied and complained to us. As the board had acknowledged a shortcoming, we upheld the complaint. We considered that the action the board had taken in response to the event was good but did not go quite far enough as it would not necessarily prevent a recurrence.

### Recommendation

We recommended that the board:

- put in place a written policy or guideline for staff, in relation to patients who are using a pass, for example for a home visit.