# SPSO decision report

SPSO Scottish Public Services Ombudsman

**Case:** **201400511, Lothian NHS Board**
**Sector:** health
**Subject:** clinical treatment / diagnosis
**Outcome:** some upheld, recommendations

## Summary

Mr C complained that the board unreasonably refused to prescribe him a specific type of medication, that his prescription was stopped without him seeing the prison doctor, and that the board had failed to respond to his complaints appropriately.

Mr C had fallen one evening and cut his head, which resulted in him attending hospital for stitches. When nursing staff attended his cell, Mr C had fewer tablets of his prescribed medication than he should have had but he said this was because the remaining tablets were in a safe in his friend's cell. Mr C said he had previously had his medication stolen and, to try to prevent this from happening again, his friend kept some tablets for him. Mr C provided the remaining tablets the next morning but said he was then told his medication would be stopped. Mr C felt this was unfair.

As part of our investigation we took independent medical advice from one of our GP advisers. They said if the board had a policy about concealment of medication or patients not keeping their own medication - and Mr C had been made aware of it - then they could not say refusing to prescribe the medication was unreasonable. The board provided a copy of a contract Mr C had signed and it said he would neither give his medication to anyone else nor keep another person's medication in his possession. It also said if Mr C breached its terms then his medication would be reviewed and possibly stopped. Although Mr C outlined his concerns about his medication possibly being stolen, we considered the contract clear that he should not have given it to someone else. We did not uphold this complaint.

Despite this, our adviser said they would have expected additional records relating to the decision to have stopped Mr C's medication. They were concerned Mr C had to seek the reason for it being stopped (rather than him being told directly) and pointed to some inaccuracies in one of the prison health centre's responses to Mr C's complaint. That letter had said Mr C was admitted to hospital with a suspected overdose, yet there was no other record of this. We also took independent advice from our nursing adviser, who also saw no evidence that Mr C had been to hospital with an overdose. Although we did not consider these errors automatically meant medical staff had considered inaccurate information when reviewing Mr C's medication – his medical records did not mention a suspected overdose - the advice we received was that it was unreasonable Mr C had to seek the reason for the change to his prescription. We upheld Mr C's second complaint.

Finally, Mr C's complaints should have been acknowledged in three working days. The board's internal records were unclear as to whether this had happened and, as above, one response from the health centre contained factual inaccuracies. The board's responses were almost identical to each other, which we found particularly concerning in light of the apparent errors in the health centre's response. We felt that did little to evidence the thoroughness of the board's investigation and we upheld this complaint.

## Recommendations

We recommended that the board:

- ensure that clinical staff are reminded of the relevant General Medical Council guidance for prescribing medication in terms of patient communication;
- review the matter so the prescribing GP, if inaccurate information influenced his decision to stop Mr C's medication (such as him having been admitted to hospital with an overdose), revisits that decision;
- ensure the health centre team reflect on the inaccuracies identified in their handwritten response to Mr C's complaint and take steps to prevent this happening again; and
- conduct a review of their handling of Mr C's complaints and confirm to us any areas for improvement identified for future complaints handling.