SPSO decision report

Case: **201701043, Grampian NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Decision: some upheld, recommendations

Summary

Mr C complained about the care and treatment his daughter (Mrs A) received at Royal Cornhill Hospital. In particular, he complained that the board had failed to carry out appropriate risk assessments for Mrs A.

We took independent advice from a consultant psychiatrist. We found that Mrs A had been been provided with reasonable care and treatment and that regular risk assessments were carried out. We also noted that Mrs A had been appropriately assessed on her return to the ward after absconding from the hospital. However, we were concerned that, when Mrs A first went missing from the hospital, the board did not follow their missing persons policy. We found that there was a delay in the board contacting the police and that their missing persons policy did not specify a time period within which to initiate the actions to be followed when an in-patient goes missing from care. We were also concerned that the nursing records did not state when the first ward check was carried out after Mrs A went missing, and that there was no record of the actions taken by the board between the first check and a later check at 21:30. Therefore, we upheld this complaint.

Mr C also complained that Mrs A had not been provided with appropriate medication. We found that the board's approach to medication treatment was appropriate and reasonable and in line with relevant guidelines. Therefore, we did not uphold this complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to Mr C and Mrs A for failing to follow the missing persons policy. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/leaflets-and-guidance.

What we said should change to put things right in future:

- The times of ward checks should be documented.
- When an in-patient goes missing from care, the missing persons policy should be followed in relation to police contact.
- There should be clear guidance in place in relation to the timescales for taking action when an in-patient goes missing from care.

We have asked the organisation to provide us with evidence that they have implemented the recommendations we have made on this case by the deadline we set.