SPSO decision report

Case: **201806499, Tayside NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Decision: some upheld, recommendations

Summary

Mr C complained about the actions of the prison health care service. Following a medication spot check, Mr C was found to be short of antidepressant tablets, and as a result his medications were stopped with immediate effect. Mr C explained that his medication count was short as his medication safe was broken into recently and everything was taken. In response to his complaint, the board explained they would not reinstate Mr C's medication. They also stated they had made enquiries with the Scottish Prison Service (SPS) and were informed that Mr C had not reported his safe being broken into.

Mr C complained to us about his medication being stopped and about the enquiries the board made into whether or not he had reported his safe being broken into.

In respect of the complaint about Mr C's medication being stopped, we took independent advice from an GP adviser. We noted that, ideally, a GP would not withdraw anti-depressant medication suddenly. However, we found that this may not be the case if there is poor compliance with the requirements of the medication. We also highlighted guidance about prescribing medication in a prison setting and noted that Mr C had signed a medical agreement treatment form that acknowledged his medication may be stopped if not appropriately managed. After reviewing Mr C's medical records, we noted that an early entry had suggested potential drug misuse. Based on the review of the information available, we concluded that healthcare staff's decision to stop Mr C's medication was appropriate and their actions reasonable. Therefore, we did not uphold this complaint.

In respect of the second complaint, the board acknowledged that they had not appropriately described their enquiries in their responses to Mr C. The board had spoken with SPS staff and stated that SPS had confirmed Mr C had not reported his safe being broken into. However, Mr C had, in fact, reported his safe as being broken into to SPS staff. The board accepted this error had caused Mr C further concern and apologised for this. We considered this likely to be a case of miscommunication rather than any attempt by the board or SPS staff to mislead. However, although we considered the enquiries made by the board to be in good faith, we concluded that they could have been clearer and taken into account the content of Mr C's complaint more closely. Furthermore, the outcome of the enquiries could have been relayed to Mr C more accurately. On this basis, we upheld this aspect of Mr C's complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to Mr C for failing to make reasonable enquiries to the SPS about what happened to his medication and whether his safe had been broken into. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/leaflets-and-guidance.

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.