Scottish Public Services Ombudsman
February 2017
Evidence to the Health and Sport Committee Inquiry: Healthcare in Prisons

Introduction

Nine of the 14 regional health boards in Scotland have responsibility for the healthcare of prisoners. This responsibility moved to them from the Scottish Prison Service in 2011, and since then we have been the final stage for prisoners with complaints about their healthcare in prison.

This briefing relates only to complaints where people have contacted SPSO. Each board with responsibility for prison healthcare (Ayrshire & Arran, Dumfries & Galloway, Forth Valley, Grampian, Greater Glasgow & Clyde, Highland, Lanarkshire, Lothian and Tayside) will record their own statistics on prison healthcare complaints.

As in non-prisoner health complaints, most of the issues we received and dealt with last year (2015-16) were about clinical treatment and diagnosis.

Case numbers

In 2015-16, the SPSO determined 138 cases about prison healthcare.

Of these:

- 84 (60.9%) were closed at our advice stage.
- 18 (13%) were closed at our early resolution stage.
- 36 (26.1%) were closed at our investigation stage.

Further details relating to the subject matter of these complaints is below.

Early closures / premature complaints

At the early stages of our process, cases are tested to check whether they are premature (the person making the complaint had not completed the Board’s complaints process before coming to us) or ‘out of jurisdiction’ (we can only investigate where we have the legal power to do so). We may also determine cases at this stage because we are unable to take the matter further because the complainant didn’t provide us with enough information, withdrew the complaint, or wanted an outcome we could not achieve for them.

In 2015-16, 49 cases were premature, a premature rate of 35.5%. The premature rate recorded by us for the whole health sector in that year was 23.5%.

A further 44 cases were not duly made or withdrawn.
Cases investigated by SPSO 2015-16 (by NHS board)

Of the 36 cases we investigated:

<table>
<thead>
<tr>
<th>Board*</th>
<th>Case outcome</th>
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<th>Totals</th>
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<td>Upheld</td>
<td>Not upheld</td>
<td>Withdrawn</td>
<td></td>
<td></td>
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<td><strong>Total Cases</strong></td>
<td><strong>12</strong></td>
<td><strong>21</strong></td>
<td><strong>3</strong></td>
<td><strong>36</strong></td>
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* We did not handle any prison healthcare cases at our Investigation stage for Highland NHS Board in 2015-16, so they have been excluded from this table.
** In each of these cases, the prisoner making the complaint was released before the end of our investigation and left no forwarding address for us to contact them.

The uphold rate for prison healthcare cases we investigated was 33%. In 2015-16, our overall uphold rate across all health complaints we investigated was 56%.

[Clerks note; For information the SPSO has confirmed the following numbers;]

Prison healthcare closed at Advice: 84/138 = 60.9%
Total health sector closed at Advice 2015-16: 671/1508 = 44.5%
Prison healthcare closed at Early Resolution: 18/138= 13%
Total health sector closed at Early Resolution 2015-16: 317/1508 = 21%*

Note on NHS Boards / naming prisons

We do not provide a breakdown of prison healthcare complaints by prison establishment as the complaint is against the NHS Board responsible for the service.

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* Please note that our prison healthcare statistics form part of our overall health statistics so each of these total ‘overall health sector’ rates (including the upholds already in the paper) include prison healthcare cases within them.
**Cases investigated by SPSO 2015-16 (by subject matter)**

<table>
<thead>
<tr>
<th>Subject</th>
<th>Upheld</th>
<th>Not upheld</th>
<th>Withdrawn</th>
<th>Totals</th>
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<td>Complaints handling</td>
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<td>1</td>
<td>2</td>
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<tr>
<td>Nurses / Nursing care</td>
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<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td><strong>Totals</strong></td>
<td><strong>12</strong></td>
<td><strong>21</strong></td>
<td><strong>3</strong></td>
<td><strong>36</strong></td>
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* This relates to the primary subject of the complaint. Within each complaint, there could be secondary complaints, for example a primary complaint about the clinical treatment and diagnosis may also include a secondary complaint about complaints handling.

The Annex to this report contains the summaries of all prison healthcare cases investigated in 2015/16.
Appendix 1: Case studies, 2015-16

Arranged alphabetically by NHS Board.

201406516  Ayrshire and Arran NHS Board  Not upheld

Mr C complained because he said an addictions caseworker inappropriately shared information about him at an integrated case management (ICM) meeting. The board told Mr C that he had consented to information about him to be shared because he had signed a consent form. Mr C disputed that he had given consent.

We obtained a copy of the information sharing protocol (ISP) agreement drawn up between the Scottish Prison Service and the NHS. That document was prepared to support the regular sharing of personal information for patients who are in prison with a view to supporting their care and case management in prisons and their transition in and out of prison. The ISP confirms that the information being shared will be used to facilitate operational prison management, including ICM, and the ongoing management and review of a prisoner’s health and social care. It confirms the information that can be shared includes clinical information and also states that, for the purposes of the protocol and the processes described in it, no consent will be required from service users. We also obtained a copy of the consent form Mr C signed which confirmed that he consented to participating in the ICM process and understood what the process involved and how the information gathered would be used and stored.

In light of the information available, we concluded that the caseworker shared information about Mr C in line with the ISP. In addition, Mr C signed a consent form. Therefore, we did not uphold the complaint.

201407002  Ayrshire and Arran NHS Board  Not upheld

Mr C complained about the medical care he had received while in prison. This related to the medication he was receiving for an old wound, and he also said that the board failed to provide appropriate follow-up treatment after an operation he had. Mr C also complained that the board failed to provide him with appropriate treatment for his depression, anxiety, post-traumatic stress and for his lack of sleep.

During our investigation, we took independent advice from a medical adviser, who is a GP. The complaint was investigated and showed that the treatment given to Mr C was reasonable and appropriate. The advice we received was that the management of his pain from the old wound was of a reasonable standard, entailed using appropriate evidence-based treatments, and that there was a regular review of his medical condition. In addition, the advice we received was that Mr C received reasonable follow-up care after his operation, and that he was receiving reasonable treatment and assessment of his mental health problems. Finally, we found no evidence that the board failed to provide appropriate treatment for his sleep difficulties.

201500679  Dumfries and Galloway NHS Board  Not upheld

Mr C complained to the board about the care and treatment he received from a prison health centre for on-going back pain. He was unhappy that the doctor had not done enough to manage his pain or deal with the cause of it. The pain relief medication and physiotherapy were not helping, and he wanted another back operation.

We took independent advice from a GP adviser. We found that the doctor had followed Scottish guidance on the management of back pain, and prescribing painkillers and physiotherapy was appropriate given his symptoms. When Mr C reported that his pain was not improving with these
measures, the doctor then referred him for surgical review. We concluded that the care and treatment was reasonable.

201503391 Forth Valley NHS Board Not duly made or withdrawn
Ms C made a complaint about health care she received whilst in prison. During our investigation, Ms C was released. We made attempts to trace Ms C but were unable to establish contact with her. As such, we did not issue a decision on Ms C's case.

201405660 Forth Valley NHS Board Fully upheld
Mr C complained that a nurse at his prison health centre gave his medication to a prison officer to administer.

We looked at Mr C's medical records and the board's file on Mr C's complaint, and we took independent advice from one of our nursing advisers. We found that the board took Mr C's complaint seriously, and the nurse was managed in line with the board's medication safety policy. We concluded this was appropriate action to take. However, this was a serious incident which the board should have acknowledged in their response to Mr C's complaint, and for which they should have offered him an apology. We upheld Mr C's complaint.

We recommended that the board:
- apologise to Mr C for the error made in the administration of his medication;
- explain to us what steps have been put in place to prevent such an incident from occurring again; and
- provide us with a copy of a drug recording sheet.

201404280 Forth Valley NHS Board Fully upheld
Mr C complained that the board required him to post a complaint to their patient relations team, rather than allowing him to submit a complaint to his prison health centre. Mr C felt this was unfair as he only had access to one second class stamp each week.

The board explained that in order to meet the national 20 working day target for dealing with complaints, they had asked prisoners to post their complaints directly to the patient relations team. In the board's view, this helped to remove any unnecessary delays in complaints being passed from the prison health centre to the patient relations team. The board also felt this approach was in line with the national complaints guidance 'Can I Help You' (CIHY).

We decided that the board's approach was not in line with CIHY, as the guidance does not specify to whom complaints should be made, only that the board must accept written or verbal complaints. This means complaints can be made to any member of board staff, including prison health centre staff. It is for the board to resolve any internal problems that might delay complaints being passed from the prison health centre to the patient relations team, and we would expect the board to deal with this without requiring prisoners to post a written complaint to the patient relations team. We upheld Mr C's complaint.

We recommended that the board:
- apologise to Mr C for requiring him to post his complaint;
- reimburse Mr C for the cost of a second class stamp;
- revise their process so that prisoners can submit complaints to their prison health centre; and
- put in place internal arrangements to expedite the transfer of complaints from prison health centres to the patient relations team.
201503407  Forth Valley NHS Board  Fully upheld

Mr C complained to the board about the treatment they offered him for an injury he suffered to his knee. He had originally attended a GP at the prison health centre and received an x-ray which showed no problems. It was therefore decided that he should attempt physiotherapy and return if the pain persisted. However, when he requested a further appointment to see the GP because he felt he should have a scan, his request was triaged by a nurse who advised that as his x-ray had been normal, he did not need an appointment or a scan.

We took independent advice from two advisers, one a GP and one a nurse. We found that Mr C's records showed that after the x-ray, his GP mentioned that a scan may be required if problems persisted. The advisers confirmed that the nurse in question should have consulted a GP and that, in line with national guidelines for the management of knee pain, further investigation would have been appropriate in the circumstances. As such, we upheld the complaint.

We recommended that the board:
- bring the failings to the attention of relevant staff;
- review their clinical decision-making in light of the relevant guideline;
- review the triage system to ensure that decision-making is made appropriately within the clinician's scope of expertise;
- apologise to Mr C for the failings identified; and
- arrange for a further GP assessment of Mr C's knee, if this has not happened already.

201406639  Forth Valley NHS Board  Fully upheld

Mr C complained that the prison health centre failed to provide appropriate treatment for the injury to his knee. After injuring his knee, Mr C attended the health centre and was prescribed pain medication. Mr C saw the doctor again a few days later because of the pain in his knee and also because the pain medication had given him a rash. The doctor prescribed a different pain medication and referred Mr C for physiotherapy and an x-ray. Mr C said his pain medication was not working but was advised that the doctor would review his medication after the x-ray results were received. The result confirmed Mr C had fluid and a loose fragment in his knee and the health centre referred him to an orthopaedic consultant.

NHS Scotland’s national guidelines for the management of knee pain indicates that if a patient presents with a significant knee injury then they should be referred to A&E, a minor injuries unit or to an orthopaedic specialist which would allow for imaging of the knee to be carried out by x-ray or MRI scan. We took independent advice from one of our GP advisers about the treatment Mr C received and they confirmed that the correct referral protocol – as outlined in the guidelines – was not followed by the health centre when Mr C presented with his knee injury.

In light of the evidence available, and given our adviser’s view which we accepted, we concluded that the health centre failed to provide appropriate treatment for the injury to Mr C’s knee because they did not refer him to A&E for further assessment when he first presented with the injury. Therefore, we upheld Mr C's complaint.

We recommended that the board:
- apologise to Mr C for the failures we found with the treatment he received;
- ensure relevant health centre staff familiarise themselves with the NHS Scotland guidelines; and
- reflect on Mr C's case and feed back any learning to us.
Mr C complained that the board failed to provide him with the necessary preparation in advance of a procedure to examine his bowel (colonoscopy). The board acknowledged that Mr C was not given the necessary preparation, which he should have received three days in advance of the procedure, and they apologised to him. We took independent medical advice from a GP. They noted that the hospital had sent clear instructions to the prison health centre regarding the preparation for the procedure and the adviser therefore considered it unreasonable that this was not carried out.

The hospital subsequently recorded that Mr C had refused to attend his appointment and he complained about this as he did not consider that the fault for this lay with him. The board apologised to Mr C for inaccurately recording that he had refused to attend. The GP adviser considered that this incorrect recording was unreasonable as it could have resulted in Mr C not receiving a follow-up appointment when the investigation was important to rule out a potential underlying cancer diagnosis.

As it happened, the prison doctor re-referred Mr C for a colonoscopy but this was vetoed by the hospital and the procedure was changed to an examination of only the lower part of his bowel (flexible sigmoidoscopy). Mr C complained that this change of procedure was not explained to him. We were advised that it would have been reasonable for the sigmoidoscopy procedure to be explained to Mr C on the day of the procedure and the records indicated that this happened. However, we could not see any evidence of the reasons for the change in procedure being explained to him.

Mr C also complained about the time the board took to respond to his complaint and for their failure to answer his questions. The board acknowledged that there were inconsistencies in their responses and that they had not answered all of Mr C’s specific questions. They also acknowledged that they had taken too long to respond to Mr C’s final letter. It had taken them six months to respond to this and we concluded that this was an unreasonable timescale.

We upheld all the complaints.

We recommended that the board:
- reflect on the process failings that have occurred in this case and inform us of the steps they have taken to ensure that similar future failings do not occur;
- remind staff to ensure that relevant information is shared with a patient when a procedure is changed and that this is documented;
- remind complaints handling staff of the importance of responding to complaints in a full, accurate and timely manner; and
- apologise to Mr C for the failings this investigation identified in their handling of his complaint.

Mr C complained that a prison health centre failed to refer him to a plastic surgery clinic for scar revision. This was in relation to scars on his abdomen which were causing him pain and discomfort. We took independent advice on the complaint from a GP. We were informed that the prison health centre had sent a referral to the plastic surgery clinic but it was subsequently decided that revision surgery was not appropriate, as Mr C was continuing to self-harm at the time. We were advised that the decision not to progress the referral in such circumstances was reasonable and in line with relevant guidelines. We accepted this advice and did not uphold this aspect of the complaint.

Mr C also complained about the way his complaints were handled by both the prison health centre and the board. He noted that he had asked specific questions in his complaints and that these had not been answered. We agreed that the prison health centre had only formally addressed one of the
two points raised with them and the board’s formal response omitted a reply to one of the four points raised with them. We, therefore, upheld this part of the complaint.

We recommended that the board:
- issue a written apology to Mr C for failing to fully respond to his feedback and complaint forms; and
- make the relevant complaints handling staff aware of our findings.

201403308  Forth Valley NHS Board  Fully upheld

Mr C complained that the board had contributed to the decision that he no longer needed to be managed under the Scottish Prison Service’s process for prisoners at risk of suicide or self-harm (the ACT 2 Care process). Mr C had been managed under this process for a number of days, as he had carried out acts of self-harm. During that period, two medical reports had been obtained identifying that he was at risk of further self-harm, and successive case conferences had also reached the decision that he was at risk of this. However, a further case conference decided that Mr C was not at risk. A mental health nurse was a participant at this case conference and agreed with the decision reached. Mr C carried out a further act of self-harm and was put back on the process.

We took independent medical advice from our mental health nurse adviser. Our adviser said that Mr C was removed from the process on the basis that he was not suicidal, however, as it is also a strategy for minimising the risk of self-harm this was not a reasonable decision. We found that the risk of life-threatening self-harm had not been sufficiently taken into account when the board contributed to the decision to remove Mr C from the process. The adviser also said that an entry that had been made in Mr C’s healthcare record was unreasonable in both tone and clinical approach to self-harming behaviour. We also upheld a second complaint that Mr C made about the board’s failure to provide him with a legible copy of his completed complaint form.

We recommended that the board:
- issue a written apology to Mr C for their role in the decision to remove him from the ACT 2 Care process at the meeting in question, and also for the inappropriate entry made in his healthcare record;
- ensure all relevant staff are aware of the ACT 2 Care approach to self-harm;
- make the mental health nurse involved in this case aware of the adviser’s comments and ensure that this is included for discussion at their next appraisal; and
- issue Mr C with a legible copy of the complaint form.

201402462  Forth Valley NHS Board  Not upheld

Mr C complained that the board failed to prescribe him specific medication for his drug addiction, and that his drug worker did not listen to his concerns.

We looked at Mr C’s medical records, and we took independent advice from one of our medical advisers. We found that the prison health centre kept detailed records of consultations with Mr C, and that they took his state of health into account when deciding not to prescribe him the specific medication he wanted. The records confirmed that assessments carried out by Mr C’s drug worker were appropriate. We concluded that the prison health centre’s actions were reasonable in the circumstances, and that the care provided by them was of a reasonable standard. We did not uphold Mr C’s complaint.
Mr C complained that the decision to stop his prescription for co-codamol was unreasonable. He said he had been prescribed the medication for around two years for arthritis but the doctor stopped it without explaining why.

We reviewed Mr C's medical records and we took independent advice from a medical adviser who is a GP. We found that the prison health centre doctor took the decision to stop Mr C's prescription for co-codamol because there was no medical evidence available to indicate that he had arthritis. The adviser told us that the doctor's decision was reasonable. They also confirmed that the doctor prescribed another suitable medication for Mr C's muscular and bone pain.

In light of this information, we did not uphold Mr C's complaint.

Mr C complained about the decision taken by the prison health centre to stop his medication for nerve pain. He said he was told that the medication had been stopped because he was on methadone. In response to his complaint, the board said the prison health centre decided to stop his prescription because they did not think he needed the medication.

We sought independent medical advice from a GP adviser. She reviewed the evidence available and confirmed that Mr C had a history of past and current drug misuse including using a combination of drugs. She said the prison doctor had a responsibility to ensure they were prescribing medication to Mr C safely and responsibly. Our adviser considered that in view of Mr C's drug misuse (including misusing the medication for nerve pain) and the increased risk of addiction, it was appropriate for the prison doctor to try less harmful, alternative drugs for him. The adviser noted that Mr C had been started on an appropriate alternative medication. She said the actions taken by the prison health centre were consistent with General Medical Council guidance and, in her view, the care and treatment provided to Mr C was reasonable.

In light of the evidence available, we did not uphold Mr C's complaint.

Mr C complained that the prison health centre's handling of his pain medication was unreasonable. He had been prescribed a medicated patch for nerve pain for a trial period of one month. Mr C said that the doctor did not review his treatment throughout the trial period or when the prescription ended. Because of that, he said he was left in pain. The information available confirmed that Mr C did not raise any concerns with healthcare staff about pain whilst receiving the treatment or after the treatment ended. We took independent advice from one of our GP advisers who noted that Mr C's mental health at the time the medication was being trialled was unstable and he did have episodes of self harm which involved him creating more damage to his wound. Because of that, our adviser considered that a routine review of Mr C's treatment for pain was not feasible at that time, and management of his acute and unpredictable mental health was the priority. In addition, our adviser noted that it was not practicable or common practice for doctors to contact patients routinely to enquire whether their prescribed medication was sufficient. Therefore, we did not uphold Mr C's complaint.

Mr C also complained that the board failed to respond appropriately to his complaint but we did not agree.

Mr C complained to us about the care and treatment he had received from the board at a prison health centre in relation to his stomach pains. We took independent advice from a medical adviser.
We found that the care provided to Mr C in relation to his stomach pains had been of a reasonable standard and we did not uphold the complaint.

Mr C also complained that the board failed to provide a reasonable response to his complaints about this. We were satisfied that the board had acted in line with their complaints procedure and that they had issued a reasonable response to Mr C's concerns. In view of this, we did not uphold this aspect of Mr C's complaint.

201400695  Forth Valley NHS Board  Not upheld

Mr C complained that the board’s prison health centre doctor unreasonably stopped his pain medication for a long-term knee injury, on the basis of alleged intelligence that Mr C misused another pain relief medication he had previously been prescribed. Mr C was concerned that the doctors at the health centre would not give him painkillers because of someone else’s say so, with no concrete proof or evidence and that in the meantime he had been left without effective medication.

We obtained independent medical advice on Mr C’s complaint from a GP. We also sought advice from the office of the Chief Medical Officer (CMO) on disclosure of information/confidentiality.

Our adviser noted that Mr C’s records indicated that the decision to stop his co-dydramol and not replace it with co-codamol was made, at least in part due to reported information regarding past drug misuse. However, our adviser explained that the pain guideline followed by the board suggested that there was no evidence for the continued prescribing of opioid based drugs such as tramadol, co-codamol and co-dydramol in patients with unexplained or persistent pain. Our adviser said it was, therefore, not unreasonable for the board to reduce and then stop Mr C’s tramadol or to stop his co-dydramol and not prescribe co-codamol in its place. Our adviser noted that the doctor prescribed appropriate alternative pain relief treatment for Mr C. We were satisfied that Mr C’s pain relief was appropriately managed by the doctor and the medication prescribed was appropriate for Mr C’s condition.

In terms of the disclosure of the information about past drug misuse, the doctor confirmed he did not disclose the information to Mr C at the time he made the decision to stop his opioid based medication. Based on the advice received from the office of the CMO, we were not critical of the prison health centre’s actions in this regard.

201404089  Forth Valley NHS Board  Not upheld

Mr C complained to us that the board had unreasonably refused to give him braces when he entered prison. The prison dentist originally told Mr C that he could not have braces because his oral hygiene was poor. He gave Mr C advice about improving this. When Mr C's oral hygiene had sufficiently improved, the dentist took impressions of Mr C's teeth for study models in order that the models could be scored for the Index of Orthodontic Treatment Need (IOTN). However, both the dentist and an orthodontist considered that Mr C did not achieve the minimum score for orthodontic treatment on the IOTN and that he did not meet the criteria for NHS orthodontic treatment.

We took independent advice on the complaint from a dental adviser with experience in orthodontics. We found that if Mr C’s oral hygiene had remained poor during orthodontic treatment, there would have been a risk of the development of decay and further damage to his teeth around the brace. Mr C was also given reasonable advice and the opportunity to improve his oral hygiene. Mr C’s oral hygiene had subsequently improved, however, the impressions that were taken showed that he did not meet the criteria for NHS orthodontic treatment, as he did not achieve the minimum score for orthodontic treatment on the IOTN. Consequently, we found that it had been reasonable for the board not to give Mr C braces and we did not uphold his complaint.
Mr C had some of his medications reduced and stopped soon after entering prison (although he was still on one medication). He was then transferred to a different prison, where he raised concerns about his medication and asked to be put back on his original medication. The board arranged for Mr C to see his psychiatrist from the community (who had prescribed his initial medication). The psychiatrist increased Mr C's current medication, but did not return him to his previous medications. Mr C complained about the board's failure to return him to his previous medication, and their handling of his complaint.

After taking independent advice from an experienced psychiatrist, we did not uphold Mr C's complaint about medication. We found there was no clinical reason to restart Mr C's previous medications, particularly as several of these medications are addictive and not for long-term use. We also noted that Mr C's psychiatrist from the community had reviewed his medication and agreed with this.

In relation to the board's complaints handling, we found the board had taken appropriate action in response to Mr C's complaints by arranging review by his psychiatrist from the community. However, on two occasions the board did not respond to Mr C's complaint to confirm what was happening and check that he was satisfied with this, as required by their complaints procedure. Therefore, we upheld this complaint.

We recommended that the board:

- apologise to Mr C for the failings our investigation found; and
- remind relevant staff of the need to acknowledge or respond to all complaints within a three working day timeframe.

Mr C complained that the prison health centre unreasonably refused to prescribe him detoxification medication. The board advised that a nurse carried out a number of assessments on Mr C which confirmed that he was not showing signs of withdrawal from drugs. Therefore, it was decided there was no medical need for him to be prescribed detoxification medication. We took independent advice from one of our GP advisers who confirmed that the care provided to Mr C appeared to be appropriate. Therefore, we did not uphold his complaint.

Mr C complained that the prison health centre's handling of his medication for nerve pain was unreasonable. He said he had been prescribed pain medication but when he was admitted to the prison, his prescription was stopped.

Mr C complained that the treatment provided to him for his shoulder injury was unreasonable. In particular, he said the health centre had only prescribed him pain relief, and had not arranged for him to have a scan or referred him for physiotherapy.

We found that Mr C had been assessed by a doctor several times due to his shoulder pain, and that medication for his pain had been prescribed. We took independent advice from a GP adviser on whether the treatment provided to Mr C was reasonable. The adviser noted that Mr C had indicated he had muscle pain but there were no concerns about swelling, bruising or restricted movement. The adviser explained that symptoms like these would have indicated trauma or a fracture. As Mr C
did not have those symptoms, the adviser considered it was reasonable for the doctor to treat Mr C's shoulder pain with painkillers. The adviser also said that referral to a physiotherapist was not necessary because Mr C had a full range of movement in his shoulder joint. The adviser also said a scan was not necessary because Mr C did not have symptoms to suggest he had a fracture.

In light of the evidence available, we did not uphold Mr C's complaint.

201301743  Greater Glasgow and Clyde NHS Board  Not upheld

Mr C, who was diagnosed with a personality disorder, had some of his medications reduced and stopped soon after entering prison (although he was still on one anti-psychotic medication). He was then transferred to a different prison, where he raised concerns about his medication and asked to be put back on his original medication. Mr C's lawyers also wrote to the prison and his psychiatrist, asking for him to be returned to this medication. Mr C complained about the board’s failure to return him to his previous medication.

The board said that Mr C’s medication had been assessed on several occasions, including by his psychiatrist from the community (who had prescribed his previous medications), and his medication was prescribed and reviewed as recommended by the psychiatrists.

After taking independent advice from an experienced psychiatrist, we did not uphold Mr C's complaint. We found that Mr C’s medication had been appropriately reviewed by psychiatrists, and there was no clinical reason to restart Mr C's previous medications, particularly as several of these medications were addictive and not for long-term use. We also found that Mr C’s psychiatrist from the community had reviewed Mr C while he was in a previous prison, and was in agreement with his current medication.

201405560  Greater Glasgow and Clyde NHS Board  Not upheld

Mr C complained that his pain medication was stopped unreasonably following a medication spot check (a check carried out by prison staff to ensure a prisoner has the correct type and amount of medication prescribed to them). Mr C also complained he had not been provided with reasonable alternative medication.

We took independent advice from one of our GP advisers. The adviser was satisfied that as Mr C had failed the medication spot check it was reasonable to have removed and stopped the prescription of the medication. The adviser was also satisfied the alternative medication provided was appropriate. For these reasons, we did not uphold Mr C's complaints.

201504628  Greater Glasgow and Clyde NHS Board  Not upheld

Mr C entered into a patient contract with the NHS about the prescription of substitute medication used to help patients to stop the use of heroin. A nurse gave Mr C a dose of the medication, but it was suspected that he had diverted the medication. The nurse checked his mouth and found no sign of it. Mr C said he had broken the medication so it could be taken quicker. However, the board decided to withdraw the medication. Mr C told us that taking the medication was the only option for him to lead a normal life and that the decision to stop it has affected adversely his mental health and confidence.

We took independent advice from a medical adviser who said the board's decision was reasonable. We found that the patient contract was very specific about the way in which the medication should be taken and that the medication could be withdrawn on the basis of suspicion of misuse.
201405741 Lanarkshire NHS Board Not upheld
Mr C complained that his prison health centre revealed information about his health to Scottish Prison Service (SPS) staff. Mr C also complained about the board’s response to his complaint.

We looked at the board’s investigation, and at an SPS investigation that was carried out in partnership with the board. The investigations concluded that no member of board staff was involved in revealing information about Mr C and, in the absence of any evidence to the contrary, it was not possible to dispute this. We found that the board’s investigation of, and response to, Mr C’s complaint were reasonable in the circumstances. We did not uphold Mr C’s complaints.

201404111 Lothian NHS Board Fully upheld
Mr C complained that he was not given his prescribed medications on his first days in prison, and that all his medications were stopped soon after entering prison. Mr C also complained that the board did not investigate when he complained about this.

The board said Mr C’s medications were stopped in accordance with his signed medications agreement after he was found concealing suboxone (a medication used to manage addictions) and after he refused to open his mouth to let staff check that he had taken his medication. The board said that, as Mr C had raised these issues with healthcare staff rather than complaining to complaints handling staff, they had treated this as a ‘concern’ rather than a ‘complaint’. They also said that, in any case, they had responded to Mr C’s verbal complaints reasonably, by discussing the complaints with him directly on each occasion.

After taking independent advice from a psychiatrist, we upheld Mr C’s complaints. We found there was no evidence the health centre had given Mr C his prescribed medication on his first days in prison, aside from one drug, for which there were two conflicting prescriptions (and he had been given one of these). We also found Mr C had been given incorrect medication on several other occasions. However, we found that it was reasonable for the health centre to decide to stop Mr C’s medications when they did. Two medications were stopped or reduced soon after Mr C arrived in prison, and the adviser said this was appropriate, as these medications were addictive and not intended for long term use. Mr C’s suboxone was stopped after he was found concealing this, and we found this was reasonable, as suboxone is used for addictions management, and there is a risk of overdose or harm if it is taken other than as directed. However, we were critical that the health centre were not able to show that Mr C had been warned about the consequences of concealing medications, as he had been asked to sign the wrong medications agreement (for ‘in possession’ medications, rather than ‘supervised’ medications). Mr C’s remaining medications were stopped when he refused to comply with instructions to open his mouth. We found this was reasonable, as these medications were not essential for Mr C’s condition and there is a risk of harm when medications are taken other than as directed.

We found that the board did not investigate Mr C’s complaints appropriately. Although we found it was reasonable for the board to treat these issues as a ‘concern’ when Mr C initially raised them, when Mr C continued to raise these issues, and was not satisfied with the board’s response, they should have been fully investigated.

We recommended that the board:
- remind nursing staff of the need to take care when administering medications (particularly where there are multiple prescriptions);
- review the processes for issuing prescriptions for incoming patients to the prison to ensure that existing prescriptions (from the community and/or time in custody) are continued or amended without delay, and the patient’s agreement is obtained to the applicable medication process (‘supervised’ or ‘in possession’);
- apologise to Mr C for the failings our investigation found; and
• take steps to ensure that complaints raised verbally with healthcare staff at the prison are appropriately handled and reported in accordance with the ‘Can I help you?’ guidance.

201505426  Lothian NHS Board  Not duly made or withdrawn
Mr C complained that his prison's medical health centre unreasonably stopped his medication. However, before we could reach a decision on his complaint, he was released from prison and gave us no forwarding address. We therefore closed his complaint without making a decision.

201401774  Lothian NHS Board  Some upheld
Mr C complained about the medical treatment he had received in prison and, in particular, about delays he had faced in getting medication. We took independent advice from one of our medical advisers, who is an experienced GP. Although there was no evidence that there was a three-week delay in prescribing his medication when he first arrived in the prison, the doctor failed to discuss with Mr C his decision at that time not to prescribe medication Mr C had previously been receiving on repeat prescription before entering prison. We found that this had been unreasonable, although, the doctor did subsequently decide to prescribe the relevant medication to Mr C. However, there were then delays in giving Mr C some of his medication due to staff shortages. Mr C was subsequently found to be stockpiling the medication. We found that it had been reasonable for staff to remove Mr C's stockpile of the medication, however, it was unreasonable that this medication was then stopped without a discussion about putting an alternative in place. In view of these failings, we upheld this aspect of Mr C's complaint.

Mr C also complained that the prison health centre had failed to appropriately maintain his medical records. We found that his records had been well-maintained and we did not uphold this aspect of his complaint.

In addition, Mr C said that the board's response had failed to address his complaint appropriately. We found that the board's response failed to indicate that an adequate investigation had taken place and that it failed to address the issues Mr C had raised. We also upheld this aspect of his complaint.

We recommended that the board:
• review the prison's processes for repeat prescriptions in order to try to ensure that all patients receive their repeat prescriptions in a timely fashion;
• remind the GP in the prison health centre that he should discuss changes in prescriptions directly with patients;
• provide evidence to confirm that steps have been taken to ensure that complaints from prisoners are investigated and responded to in line with the Scottish Government's guidance; and
• issue a written apology to Mr C for the failings identified.

201403402  Lothian NHS Board  Some upheld
Mr C complained about the care and treatment he received from a prison health centre in relation to his eye condition. He was concerned that he received various different medications, none of which helped and some of which appeared to worsen his condition. He, therefore, felt that he had been inaccurately diagnosed, and he complained that he was not referred to an eye specialist sooner.

We took independent advice from one of our medical advisers, who observed that Mr C had been seen on a number of occasions by healthcare staff and examined repeatedly. Our adviser noted that examinations did not reveal any serious underlying problems and that this mirrored the
subsequent findings of the eye specialist. As such, she did not consider there to have been an earlier indication for a referral to a specialist. We fully accepted this advice and did not uphold this aspect of the complaint.

Mr C also raised concerns about the way his complaint was handled. We noted that he submitted multiple complaint forms on the issue, and the prison health centre continued to try to resolve these informally. The guidance only allows a three-day window for informal resolution, following which the complaint should be formally acknowledged and investigated. This did not happen for several weeks and, seemingly, only upon Mr C’s prompting. We identified other failings to follow due process, such as an initial failure to inform Mr C of his right to approach this office. In the circumstances, we upheld this part of the complaint.

We recommended that the board:
- review their handling of this case with a view to making improvements and ensuring compliance with their statutory responsibilities, as set out in the ‘Can I help you?’ guidance; and
- apologise to Mr C for the identified failings in their handling of his complaint.

201407111    Lothian NHS Board               Not upheld

Mr C complained that the prison health centre unreasonably failed to prescribe him with appropriate pain medication. We reviewed his clinical records and we took independent advice from a GP adviser. The information available confirmed that Mr C was caught concealing his medication and because of that, the decision was taken to stop his pain medication. However, he was prescribed an alternative and referred to the pain clinic. The adviser said the decision to stop his pain medication was reasonable given that Mr C was caught concealing his medication. The adviser also confirmed that, in their view, Mr C had been prescribed an appropriate alternative medication for his pain.

Mr C also complained that there was an unreasonable delay in the health centre removing an item from his ear. In their response to his complaint, the board said they checked Mr C’s records and they could not see anything about him raising concerns about something being stuck in his ear. Following our review of Mr C’s record, it appeared that the board’s response was incorrect. We noted that a nurse had recorded in Mr C’s clinical record that he had approached her about having something stuck in his ear. The nurse also recorded that she successfully removed the item the same day as Mr C reported it to her by flushing his ear. In light of this information, we did not uphold Mr C’s complaint, but we did make a recommendation relating to the way the board responded to his complaint.

201401646    Tayside NHS Board                Some upheld

Mr C complained that the board unreasonably advised the Scottish Prison Service (SPS) that it was safe for him to be subject to metal detecting equipment, although he has an implantable cardioverter defibrillator (ICD) (a device that regulates irregular heart rhythms). Mr C also complained about the board’s handling of his medication. He said that staff altered his medication inappropriately, and made mistakes in administration. He also said that there was no reason for his medication to be supervised (taken in front of prison staff, rather than given into the patient’s keeping), as it was degrading to be required to open his mouth to show he had taken the medication, and this supervision resulted in him being harassed and bullied for his medication.

After investigating Mr C’s complaints and taking independent medical advice from several specialists, we upheld Mr C’s complaint about the administration of his medication. We found that, although a doctor decided to stop Mr C’s naproxen (a drug used for pain relief and anti-inflammation, which can contribute to poor kidney function), Mr C’s prescription record (kardex) was not updated to reflect this. This was because the kardex had to be recalled from the prison halls,
and a different doctor was on duty when the kardex was returned to the health centre. As a result, Mr C was inappropriately given a further dose of naproxen in the next weekly medications. We also found that it was unreasonable for a hospital doctor to decide to restart Mr C’s naproxen, although his clinical history showed that this had been stopped due to poor kidney function. Finally, we found that Mr C had been given incorrect dosages of medications on one occasion.

We did not uphold Mr C’s complaint about security screening. Although health centre staff gave slightly different advice about this to prison staff at different times, we found that all of the advice given was reasonable. We also did not uphold Mr C’s complaint about supervision of some of his medications (dihydrocodeine and tramadol – both prescribed for pain relief). In relation to dihydrocodeine, we found the board had complied with their local process for administering medication to prisoners who had recently arrived at the prison. In relation to tramadol, we found that the board’s decision to administer this as supervised was reasonable, as tramadol is an abusable drug and the medication was supervised for Mr C’s own safety and for general prison safety. We also found that it was reasonable for nurses to ask Mr C to open his mouth to show that he had taken the medication, as they needed to ensure that he took his prescribed medication and that this was not diverted, and the nurses were supported by prison staff who are able to request this kind of search under the prison rules.

We recommended that the board:

- issue a written apology to Mr C for the failings our investigation found;
- remind nursing staff of the need for care to be taken in administering and recording medications correctly;
- ensure there are clear and robust procedures for updating prescriptions to reflect GP decisions, including where kardexes need to be recalled from halls and/or where a different GP may need to amend the prescription; and
- raise our findings in relation to the restarting of naproxen to the attention of the relevant doctor for reflection as part of his next annual appraisal.

**201402360 Tayside NHS Board**

Mr C sustained an injury to his right hip/leg, which he said was caused when he fell off a chair. Mr C attended the prison health centre regarding his injury on several occasions. Mr C complained that the prison health centre failed to provide him with appropriate care and treatment. He said there was an unreasonable delay in the prison health centre carrying out an x-ray of his hip. He also said the prison doctor inappropriately failed to see him at a scheduled appointment.

We obtained independent medical advice on the complaint from one of our advisers who is a GP. The evidence showed that Mr C had seven consultations with medical staff at the prison health centre over a four week period following his injury. Our adviser said that Mr C’s assessment and management by the health centre staff was of a reasonable standard. She explained that Mr C’s symptoms and risk factors were not consistent with a hip or pelvis fracture. She said an x-ray was not clinically necessary in Mr C’s case and instead seemed to have been arranged after his request, rather than because of clinical suspicion of fracture. As such, she did not consider that Mr C’s x-ray should have been done more quickly.

The board said Mr C’s scheduled appointment with the prison doctor was cancelled because of security and health and safety reasons. Our adviser explained that health and safety decisions were taken in the best interests of both prisoners and staff and the prison health centre’s actions were reasonable.
201405328  Tayside NHS Board  Not upheld
Mr C complained about the way in which his pain relief medication was handled by the prison health centre. Mr C has osteoporosis (a condition causing weakness of the bones) and had been prescribed tramadol (a strong opioid painkiller). He was unhappy that there was little discussion or information about why it was being stopped. He was also unhappy that the board failed to provide relevant information in their response to his complaint.

We took independent advice from a medical adviser who is a GP. We found that, when reviewing Mr C’s medication, the health centre acted in line with Scottish national guidelines on the management of chronic pain and on prescribing. Tramadol was not the only type of painkiller that could be used to treat Mr C’s pain, and there is a lack of evidence for the long-term use of opioids for chronic pain. We considered it reasonable that the health centre tried alternative painkillers on the basis that further review took place.

We concluded that reasonable attempts were made by the health centre, and in the board's complaint response, to explain why the medication was being reduced and then stopped.

201500055  Tayside NHS Board  Not upheld
Mr C complained because he felt the care and treatment he received from the prison health centre was unreasonable. In particular, Mr C said that since taking his prescribed methadone he had been feeling ill. Mr C said a doctor concluded that he should not be prescribed methadone and made arrangements for an alternative medication to be prescribed. However, before that happened, Mr C was reviewed by another doctor who decided that the prescription for methadone should continue. Mr C was unhappy with that decision because he felt he was allergic to the medication.

The board explained to Mr C that, following review, the doctor considered the symptoms he had were not because of the methadone and there were other potential causes that needed to be excluded. The doctor suggested Mr C undergo further assessment with the mental health team, and offered treatment to reduce the symptoms he was suffering, which Mr C declined. In addition, the doctor concluded that Mr C's symptoms were not severe enough to justify changing treatment.

We took independent advice from one of our GP advisers and asked for their view on whether the care and treatment provided to Mr C had been reasonable. Our adviser considered that Mr C had been thoroughly assessed by the doctor. She also reviewed Mr C's medical records and noted he had a long history of multiple drug misuse. Our adviser commented that, in her view, with Mr C's history of multiple drug misuse and then stopping all drugs in favour of methadone, his symptoms could reasonably be interpreted by the doctor as having been related to drug withdrawal. As such, she said that the options offered to him – mental health assessment and a trial of allergy medication – and the reasons for not prescribing the alternative medication were reasonable. Our adviser commented that she could see no evidence that Mr C was not adequately assessed by an appropriate professional or that the treatment offered was inappropriate.

In light of the evidence available in Mr C's case and our adviser's view, which we accepted, we did not uphold the complaint.

201502164  Tayside NHS Board  Not duly made or withdrawn
Mr C complained because he said the board failed to respond appropriately to his complaint about scheduled appointments with the pain clinic. In particular, Mr C said the board had responded to his complaint saying that there was nothing documented about planned appointments with the pain clinic. However, before receiving the board's response, Mr C said a nurse gave him a written note.
The note showed that his medical record had been checked and noted that he was due to attend pain clinic appointments.

We made enquiries with the board but before finalising our investigation, Mr C was freed from prison. We tried contacting Mr C to confirm his new contact details but he did not respond to us. Therefore, we closed his complaint without reaching a finding.