Scottish Parliament Region: Lothian

Case 201200953: Lothian NHS Board

Summary of Investigation

Category

Health: Prison; records; medication

Overview

The complainant (Mr C) raised concerns about the loss of his clinical records and about the prescription of on-going medication for glaucoma by Lothian NHS Board (the Board)'s services delivered through the prison healthcare centre (the Healthcare Centre) at HMP Edinburgh (the Prison).

Specific complaint and conclusion

The complaint which has been investigated is that it was unreasonable that the Healthcare Centre lost Mr C's clinical records and did not prescribe his on-going medication (*upheld*).

Redress and recommendations

The Ombudsman recommends that the Board:	*Completion date*
(i) issue a full apology to Mr C for the loss of his clinical records, for the potential impact that his lack of medication may have had on his eyesight, and for the poor handling of his complaints;	8 May 2013
(ii) confirms that the healthcare centre now uses electronic clinical records which include lists of prescribed drugs for prisoners, and the date this was implemented;	8 May 2013
(iii) confirms their review of the process of transferring clinical records from establishment to establishment, which they referenced in a letter to Mr C;	8 May 2013
(iv) confirms the scope and findings of the NHS LEAN review of the pharmacy process, and if this is not yet complete, what the timescales for the review are; and	22 May 2013

(v)	provides evidence that they have reviewed their complaints handling procedure in relation to complaints about their prison healthcare service, to ensure a proactive approach is taken and to ensure they receive complaints timeously.	12 June 2013

Main Investigation Report

Introduction

1. Mr C suffers from glaucoma, which requires daily medication to prevent a significant, permanent deterioration in his eye sight. He was transferred to HMP Edinburgh (the Prison) on 15 February 2012, and his complaints relate to the handling of his clinical records and repeat medication requests in March and April 2012.

2. Having been seen by a prison medical officer and given his medication shortly after arrival at the Prison, Mr C then requested repeat medication. He made this request four times but was not issued with further medication. It also became evident when he saw the prison medical officer again on 22 March 2012 that his clinical records could not be located by staff at the Prison healthcare centre (the Healthcare Centre).

3. Mr C complained to Healthcare Centre staff and then to Lothian NHS Board (the Board). When he complained to the Board the issue was raised again with Healthcare Centre staff, and Mr C was issued with his repeat prescription. During investigation it became apparent that the notes were not in the Healthcare Centre, and were assumed to be in another prison health centre. Mr C was informed of this. Following on from my office's investigations following Mr C bringing his complaints to us, this subsequently turned out to be erroneous, and Mr C's clinical records are still missing.

4. The complaint from Mr C which I have investigated is that it was unreasonable that the Healthcare Centre lost Mr C's clinical records and did not prescribe his on-going medication.

Investigation

5. In writing this report, my complaints reviewer has considered the complaints correspondence between Mr C and the Board, as well as made further enquiries of the Board. My complaints reviewer also sought clinical advice from one of the Ombudsman's medical advisers (the Adviser).

6. I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked. Mr C and the Board were given an opportunity to comment on a draft of this report.

Complaint: It was unreasonable that the Healthcare Centre lost Mr C's clinical records and did not prescribe his on-going medication

7. Mr C was transferred to the Prison on 15 February 2012. Shortly after his arrival at the Prison, Mr C was seen by a prison medical officer at the Healthcare Centre, and was prescribed his medication for glaucoma (Timolol 0.5 percent, daily eyedrops) along with painkillers (Ibuprofen 400 milligrams) to counter the side effects of Timolol, both of which he had been taking for several years. These were issued to Mr C on 16 February 2012.

8. Mr C submitted a repeat prescription form to get new supplies of his medication on 10 March 2012, and subsequently submitted a further three forms without any medication being issued. He saw a prison medical officer at the Healthcare Centre on 22 March 2012, at which time he was told that his clinical records could not be located.

9. On 27 March 2012 Mr C submitted a 'feedback, comments or concerns' form to the Healthcare Centre, expressing concern at his lack of medication, in particular noting he had submitted four repeat prescription forms, and the fact his clinical records had gone missing. He was given a brief, generic response on 28 March 2012, which did not address the concerns raised. It claimed that his clinical records were 'safe and secure', and that he should wait for his medication as it took four days from request to delivery.

10. Mr C was not satisfied by this response, and wrote to the Board to formally complain about his medical care on 4 April 2012 (received by the Board on 10 April 2012). Mr C subsequently had an appointment with a prison medical officer on 13 April 2012; he was issued with a replacement kardex (a paper file listing a patient's medication, required for a patient to receive any prescription) as his original kardex had also gone missing along with his clinical records. He was prescribed the required medication on 13 and 14 April 2012 respectively. The Board's response on 7 May 2012 indicated that the Healthcare Centre had not taken any steps to address his lack of medication or to retrieve Mr C's notes until the formal complaint was received, despite the issue becoming apparent following the appointment of 22 March 2012 and the contents of the feedback form submitted by Mr C on 27 March 2012.

11. Following their investigation into the complaint, the Board said they were advised by another prison healthcare centre that they had Mr C's records, which

they said had been located within another prisoner's clinical records, who had the same surname and initial, and a similar prisoner number, as Mr C. The other prisoner had recently been transferred from the Prison to the other prison. The Board said they asked the other prison healthcare centre to send the records back to the Prison by courier.

12. However, Mr C's clinical records were not returned. In their response of 7 May 2012, the Board apologised to Mr C 'for the problems he had recently experienced in receiving his mediation'. However, they did not inform him that his clinical records were still missing.

13. Mr C remained dissatisfied by the Board's actions and wrote to my office to complain on 7 June 2012. The Board initially responded to my office's enquiries about this complaint on 8 August 2012. However, it was not until my complaints reviewer considered the information provided by the Board and made further enquiries that it became apparent or was otherwise revealed by the Board that Mr C's clinical records were still missing. In a further response to my office on 13 September 2012, the Board said that the information located in the other prisoner's records had in fact been found to be 'other pertinent prison information relating to Mr C'. They advised that the Healthcare Centre Manager wrote to Mr C on 6 September 2012 to inform him of the loss and to apologise for giving him inaccurate information in the response of 7 May 2012, ie that his clinical records had been transferred with another prisoner, with the suggestion, therefore, being at that time that his clinical records were to be returned imminently.

14. To date Mr C's clinical records have still not been found, despite thorough searches. In commenting on this report, the Board advised that every prison healthcare department in Scotland had been asked to check their medical files for Mr C's clinical records on numerous occasions.

15. It was not possible to say exactly how long Mr C had been without his medication, due to the kardex, which would have provided the list of prescriptions and dosages, also having gone missing. Assuming the prescription Mr C got on 16 February 2012 was his normal monthly supply, this would have lasted him until mid-March 2012. This is consistent with Mr C's initial complaint to the health centre, dated 27 March 2012, which states that he has been without medication for 10 days. He did not receive any more

medication until 14 April 2012. This would suggest that he was without medication for just under a month.

16. My complaints reviewer asked the Adviser to provide advice on the impact of withdrawal of glaucoma medication for this period. The Adviser explained that glaucoma is a condition whereby the pressure inside the eye increases; without treatment, a patient would eventually lose the sight in the affected eye. The Adviser said that, without medication, Mr C's glaucoma would eventually lead to the permanent deterioration in his eyesight, as the eye pressure would increase and the peripheral vision would deteriorate. However, the speed of deterioration would depend on the degree and severity of the glaucoma. It was the Adviser's opinion that a month without medication would probably not have had any permanent impact on Mr C's eyesight, but that nonetheless it was certainly not optimal treatment for Mr C to be without medication for this period of time.

17. The Adviser said his main concern was the systemic failure with regards to dealing with Mr C's clinical records. He said the system in use at the time was 'antiquated,' and electronic records would allow for immediate transfer of notes and would include a list of prescribing drugs.

18. The Board advised my office that the Healthcare Centre had now implemented a new electronic medical records system called Vision, which would prevent similar situations arising in the future. They said that the full pharmacy process had been reviewed via the NHS 'Lean' process (a formal learning network to accelerate the spread of good practice by system mapping and data capture required before embarking on a major organisational commitment to change), and they were currently looking at amending and changing some of those processes. They also advised they had arranged for Mr C to be referred to an optician.

Conclusion

19. In investigating Mr C's complaint, a number of concerning matters have been identified, in particular with regards to how the Board investigated Mr C's complaint. First, Mr C attended the Healthcare Centre for an appointment on 22 March 2012, at which time it was clear his clinical records were missing. It is also clear from the evidence I have seen that Mr C advised the Board he was not receiving the medication he required on 27 March 2012, as well as highlighting again that his clinical records were missing. The Board have

insisted, however, that they were not aware of either issue until 10 April 2012, even whilst it is clear a member of the Healthcare Centre staff had responded to the 27 March 2012 feedback form the following day. Furthermore, this response did not in any way attempt to properly address the issues. For these reasons it is not acceptable that the Board continue to state they were not aware of the problems until 10 April 2012.

20. When the Board did investigate following Mr C's formal complaint, their response did not acknowledge that the information provided by the Healthcare Centre on 28 March 2012 was incorrect, it did not acknowledge or address the clinical impact of Mr C being without his medication for a period of approximately five weeks (ie 10 March 2012 until 13 April 2012), and it did not address his allegation that he had submitted four repeat prescriptions, none of which had been responded to.

21. The handling of Mr C's clinical records in this manner is evidence of maladministration. I am concerned that, had Mr C not raised this matter with my office and my complaints reviewer not made further enquiries of the Board, the issue would have remained having not been investigated fully and properly, as it only became apparent following further enquiry that the records located within another prisoner's clinical records were not, in fact, Mr C's clinical records at all but other 'pertinent information'. Whilst I acknowledge the Board undertook searches to locate Mr C's records, I remain dissatisfied with their overall handling of this and in particular their failure to investigate this fully when it was originally raised with them by Mr C. However, I do note the steps the Board have advised me they have taken in order to address the administrative failings here.

22. In relation to the on-going prescription of Mr C's medication, my investigation has identified a service failure in the timeous provision of medication for a degenerative health condition. I note the advice given to me that a prolonged period without medication for this condition would have a serious impact upon the patient. Whilst I accept the period during which Mr C did not receive his medication did not necessarily have any permanent impact upon his eyesight, it is nevertheless entirely unacceptable this occurred. This has never been acknowledged by the Board.

23. In all the circumstances I uphold this complaint.

Recommendations

24. I recommend that the Board:	*Completion date*
(i) issue a full apology to Mr C for the loss of his clinical records, for the potential impact that his lack of medication may have had on his eyesight, and for the poor handling of his complaints;	8 May 2013
(ii) confirms that the healthcare centre now uses electronic clinical records which include lists of prescribed drugs for prisoners, and the date this was implemented;	8 May 2013
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(v) provides evidence that they have reviewed their complaints handling procedure in relation to complaints about their prison healthcare service, to ensure a proactive approach is taken and to ensure they receive complaints timeously.	12 June 2013

25. The Ombudsman asks that the Board notify him when the recommendations have been implemented.

Annex 1

Explanation of abbreviations used

Mr C	The complainant
The Prison	HMP Edinburgh
The Healthcare Centre	The healthcare centre at HMP Edinburgh
The Board	Lothian NHS Board
The Adviser	The Ombudsman's medical adviser
The Healthcare Centre Manager	The manager at the healthcare centre