

December 2011

The SPSO laid six investigation reports before the Scottish Parliament today. Five are about health and one is about a university. We also laid a report about 50 decisions about all the sectors under our remit. All of the reports can be read on the 'Our findings' section of our website.

Case numbers

Last month (in November) in addition to the six full reports laid before the Parliament we determined 351 complaints and handled 44 enquiries. Taking complaints alone, we:

- > gave advice on 253 complaints
- > resolved 54 in our early resolution team
- > resolved 44 by detailed consideration
- > made a total of 62 recommendations in decision letters.

Ombudsman's Overview

Vulnerable people


In my last Commentary, I highlighted failures in the care and treatment of vulnerable people. Vulnerability is the main theme of my *Overview* this month.

In November, I published a report (201003775) that identified problems in the care and assessment of a young person who attempted suicide. Two health reports published this month also highlight failures in the mental health care and assessment of two vulnerable men under two different health boards. The failures in each of these cases, whilst unique in their own circumstances, have had a devastating impact on the individuals concerned and their families. In both cases it is clear that an assessment of the individual and their risk of self-harm was absent. Also evident is the need for family inclusion in the care pathway of vulnerable individuals. I am sensitive to the challenges to clinical staff in providing care and treatment to a vulnerable patient and equally, I recognise the importance of confidentiality in the clinical setting. However, the reports I highlight today clearly demonstrate the importance of including an individual's family, not only during their care, but also when reviewing any adverse event.

Of this month's reports, I am particularly concerned about the case of a young man (201003783) who committed suicide despite being regularly assessed by staff. My investigation identified significant failings in his care. Mr A, who was 20, had attempted suicide on three previous occasions. He had attended a number of sessions with a psychiatric nurse and was seen by other members of staff. After a third overdose, he was given information about independent providers of mental health care in the community and discharged from hospital. No other follow-up was arranged. Mr A took his own life two weeks later.

Although my medical adviser said that, in this case, it would have been difficult to predict Mr A's suicide, I found that his risk of potential self-harm or suicide was never properly assessed. I also found that there was a failure to produce any written plan for Mr A's treatment. These are serious failings on the part of the Board, and go against national guidelines.

On investigating this complaint, I was concerned to discover that the Board did not produce all the relevant documents until after my draft report was issued to them. The documents that were not seen were crucial to the case, relating to the Board's response to Mr A's suicide, and displayed further failings by the Board in their handling of the case. One of the documents was a root cause analysis of events, which seemed to take place after a further three persons had committed suicide while in the Board's care. Authorities are required by law to provide all relevant information to me on request. I am disappointed that in this case the Board did not provide all the relevant information to me at the beginning of my investigation.



This month's findings

Clinical treatment; diagnosis; record keeping
A Medical Practice, Lanarkshire NHS Board (201003835)

District nurse care; communication; record-keeping; complaints handling
Grampian NHS Board (201004359)

Removal from Practice list; policy/administration; communication
A Dentist, Highland NHS Board (201005321)

Mental health assessment; clinical treatment; hospital transfer; staff attitude
Ayrshire and Arran NHS Board (201005047)

Mental health assessment; clinical treatment; policy/administration; communication
Tayside NHS Board (201003783)

Admissions; policy/administration; communication
The Robert Gordon University (201003198)

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The second case (201005047) raising similar issues, is of a man (also referred to as Mr A) who attempted suicide while at his mother's home. After admission to hospital, hours after self-harming and expressing paranoid thoughts, Mr A was able to self-harm again while on a general medical ward. Despite his condition on admission to hospital, staff did not appear to attach any urgency to the need for him to be psychiatrically assessed. As in the previous case I have described, no proper assessment was made of the risk to him. I found, in this case, that the Board had taken steps to address the matters they identified when looking at the complaint. I made recommendations to address the failings found by my investigation.

Communication

Many of the findings published this month, both in decision and investigation reports, point to problems in communication either within an organisation or with a service user. In total, five reports I laid today relate to lack of communication. One of the reports (201004359) involves a young child with diabetes, who was allowed to self-inject insulin without his mother's knowledge. Another (201003198) concerns a student with a possible learning disability who was not kept informed and whose needs were not assessed by the university, despite a request from her lecturer. A third (201005321) was about a family being de-registered by a dental practice without providing an explanation for their removal.

I see a high volume of complaints that hinge wholly or partly on a lack of communication, whether that is verbal or written. Good and open communication is essential to the efficient delivery of public services including complaints handling. It can prevent complaints arising or escalating and minimise distress to members of the public; it can also save bodies time and money. It is particularly important when dealing with families of vulnerable

individuals or when communicating bad news and I encourage bodies to support staff in improving communication.

Complaints Standards Authority update

Housing

We are continuing to work with the housing sector to develop a draft complaints handling procedure (CHP) that meets the needs of customers, housing providers and other stakeholders. Since our last update we have had extensive engagement with this sector. We delivered a presentation on using complaints as a self-assessment at the Chartered Institute of Housing's Conference on 24 November 2011. At the end of last month, we presented an early draft model CHP for the housing sector and have been gathering feedback on it from key stakeholders such as the Scottish Federation of Housing Associations and the Glasgow and West of Scotland Forum of Housing Associations to ensure it is user friendly and robust. We will continue to work with the sector towards our target deadline for introducing this model early in the new business year.

Local Government

In December, we attended SOLACE's meeting of local government chief executives to present and discuss the proposed model CHP for local authorities. The model CHP, which was developed by a working group of sector representatives, was received positively. Compliance with the model CHP will be monitored by Audit Scotland as part of their existing annual audit processes.

The CSA team is happy to provide further information on the two emerging model CHPs and can be contacted at CSA@spsso.org.uk. See the CSA website for more information: www.valuingcomplaints.org.uk

Annual letters

I recently issued my annual letter to every chief executive and council leader of Scotland's local authorities and published these on our website. You can read the letters and supporting statistical information at <http://www.spsso.org.uk/statistics>. My letters provide summary information about the complaints that I received and considered, and the decisions that I reached last year (2010 –11).

My letters also draw attention to current relevant issues. This year I remind authorities of the introduction of model CHPs in 2012 and of their statutory requirements for compliance with these. I ask them to remind their complaints handling staff of the importance of meeting the deadlines we set for them to provide my staff with information about complaints made to me. I also ask that when responding to our enquiries into complaints that they provide us with a single point of contact to avoid any delays or confusion. I urge all authorities under my jurisdiction to take note of these points so that we can work more productively.

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Case Summaries

Health

Clinical treatment, diagnosis; record-keeping

A Medical Practice, Lanarkshire
NHS Board (201003835)

Ms C raised concerns about the care and treatment provided by her GP Practice over a two-year period. Ms C went to the Practice complaining of abnormal sensations in her left arm. These became progressively worse and increased in frequency and severity. At first, the Practice diagnosed Ms C with nerve impingement then, a year later, with disc degeneration and nerve entrapment. Physiotherapy did not help, and after further visits to the Practice Ms C was referred to an orthopaedic specialist and a neurology specialist. More than two years after she first complained about the abnormal sensations, Ms C had an MRI scan and was diagnosed with a brain tumour. She complained to my office that the Practice failed to act on 'red flag' symptoms of a brain tumour and to diagnose this, and said that they should have referred her to a specialist sooner. Ms C now has several disabilities, including postoperative epilepsy, which affect her everyday life and she believes that these might have been avoided had she had been referred before the tumour had a chance to grow so large.

The Practice said that this diagnosis was very unexpected and that Ms C's symptoms were consistently indicative of nerve impingement. They felt they had referred Ms C as early as possible after symptoms of a brain tumour appeared. After taking advice from my medical adviser, however, I upheld Ms C's complaints that the Practice did not properly investigate her symptoms within a reasonable time and that their failure to diagnose her condition was not reasonable. I took the view that this meant that she had to suffer these symptoms far longer than she might have done had she been referred earlier. My medical adviser pointed out that Ms C had persistent and changing symptoms that were not indicative of the nerve issues that the Practice had diagnosed. It appeared that the Practice missed opportunities to refer Ms C earlier. My adviser also said that record keeping was inadequate and the Practice's actions were contrary to professional guidance on good medical practice, in that Ms C's condition was not adequately assessed, she was not referred at an appropriate time, and when a referral was made, it was a routine referral without the necessary degree of urgency.

As a result of my investigation, I recommended that the Practice apologise to Ms C for the failures described in my report. I asked them to review their practices to ensure they refer for specialist advice within a reasonable time, ensure that their record-keeping complies with GMC guidance and update their knowledge of the diagnosis and management of persistent upper limb symptoms.

District nurse care; communication; record-keeping; complaints handling

Grampian NHS Board (201004359)

Mrs C complained about the support given to her five-year old son (Master A) by a District Nursing Team (DNT). She said that they gave him instructions on self-administering insulin without her consent or knowledge, or that of his Paediatric Diabetes Care Team (PDCT). She was also unhappy with the Board's handling of her complaint, and the length of time it took the Board to send her a copy of her son's care plan.

Master A has Type 1 diabetes and a history of asthma, allergies and eczema. He needs to have regular injections using an insulin pen. Mrs C said that when a care plan was put in place for her son, it was agreed that DNT staff were to attend his school each lunchtime to administer his insulin. Mrs C later discovered that Master A was regularly self-administering these injections, supervised by a member of DNT staff and a school auxiliary. She was concerned about this, both because she did not know it was happening and because a health professional had told her that her son should not self-administer insulin at his age and stage of development. The Board were of the view that she had been informed from the start of the intention of involving Master A in his own care.

I upheld Mrs C's complaints. Having taken advice from my professional nursing adviser, I found that the evidence shows that a nurse from the DNT took the decision to allow Master A to become more involved in his own care. However, there was no record in the care plan of any agreement between Mrs C, the PDCT and the DNT about self-administering insulin, which my adviser said is particularly important when care is shared between agencies. In addition, a failure of communication between the DNT and Mrs C meant that she did not know about the decision. This is of particular concern, given Master A's age. I found that the DNT's record-keeping was poor, including the care plan itself and records of their communication with Mrs C. This led to misunderstanding and confusion at the Board over Mrs C's apparent acceptance of Master A self-administering insulin. Although the records also showed a positive approach to Master A's needs, the care plan should have recorded the relevant details. I consider that the care plan should have been signed off by the relevant parties, including Mrs C, who should have specifically been asked for her consent. I recommended that the Board apologise to Mrs C for the misunderstanding and confusion caused by this poor record-keeping. I also recommended that they in future obtain signed consent from the parent/carer in such situations, and that they look into having a single named point of contact for the parent/carer in relation to all of a child's diabetes care and treatment.

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I agreed that there were some delays in complaints handling. I found that the Board did not provide Mrs C with a copy of her son's care plan on request and that in one letter they inappropriately referred to allegations about her behaviour, a matter that they should have handled separately. I also found that although the Board made a reasonable attempt to resolve the complaint, their responses were unclear and appeared contradictory. I recommended that they review how complaints are dealt with by the relevant Community Health & Social Care Partnership, to ensure that procedures are followed in future.

Removal from Practice list; policy/ administration; communication

A Dentist, Highland NHS Board (201005321)

Mrs C complained when a dentist de-registered her family from their list of patients. She said that the dentist's receptionist had phoned her daughter to cancel and rearrange an appointment for that day, as the dentist was unwell. Mrs C took over the call as she was unhappy about this. As a result, her daughter saw another dentist at the practice the same day. A few days later, the Board wrote and told Mrs C that the dentist wanted to stop providing the family with NHS treatment and that this would take effect in three months time. Mrs C telephoned the Practice to ask why her family were being de-registered, and was told that the dentist did not have to give an explanation. Mrs C was unhappy about this and complained that the dentist unreasonably de-registered the family without explanation and had also unjustifiably cancelled her son's existing dental appointments.

My investigation found that the Practice has a policy which explains that they operate zero tolerance for anyone who is rude or abusive to dentists or staff. The Practice felt that, during the call about her daughter's appointment, Mrs C was rude, forceful and unpleasant to the receptionist, who was distressed after the call. The Practice considered that Mrs C had done this on behalf of her family, and so the dentist felt that it was appropriate for the whole family to register elsewhere to avoid this happening again. Mrs C said that although she was unhappy about the cancelled appointment, she was not abusive.

On looking at this complaint, I considered the regulations that govern de-registration. The National Health Service (General Dental Services) (Scotland) Regulations 2010 say that a dentist who wants to terminate an arrangement shall give the patient no less than 3 months notice of this in writing. Where a dentist does this, they must complete any care and treatment that it was agreed the patient was to receive before the termination date and any further treatment necessary to secure and maintain the patient's oral health.

I found that in circumstances such as those in this complaint, the regulations do not require a dentist to give an explanation when removing a patient from their list. I did, however, consider whether the actions of the dentist in removing the family were reasonable. The Practice policy says that they do not tolerate abuse of staff, but it does not define abusive behaviour or say what will happen when behaviour is considered abusive. It does not say if the person will be told that their behaviour has given cause for concern and that should it continue then the patient's registration would be at risk. Nor does it say that other members of the patient's family would also be at risk of being de-registered. I therefore upheld Mrs C's complaint about de-registration as I felt that the dentist's actions were unreasonable. I also upheld her complaint about her son's cancelled appointments and recommended that the dentist apologise to him for cancelling at least one of these without establishing whether or not it was for agreed treatment.

I am concerned that Mrs C's complaint highlights an existing unfairness that enables dentists to de-register patients in this way. There is no right of appeal once a decision to de-register has been taken, and the patient has no alternative but to register with another dentist. I have recommended that the Scottish Government Health and Social Care Directorate consider providing a relevant national policy to address this.

Mental health assessment; clinical treatment; hospital transfer; staff attitude

Ayrshire and Arran NHS Board (201005047)

Mr A attended a hospital Accident and Emergency (A&E) Department after making a suicide attempt at his mother's home. He was admitted to a medical ward where he further self-harmed the next day, cutting himself badly with a razor. Mr A was transferred to the Medical High Dependency Unit, where his wounds were treated and he was detained under the Mental Health (Care and Treatment) (Scotland) Act 2003. Later that day, he was transferred to a psychiatric ward where he was initially nursed under constant observation. As the hospital was situated in his mother's health area, he was subsequently transferred to a hospital nearer to his home.

His mother (Mrs C) raised a number of concerns about the treatment that her son received in the first hospital. She said that although he had mental health problems for a number of years, he had not attempted suicide before. She made a number of complaints, including that Mr A was inadequately supervised in the ward where he was able to self-harm, that some staff were hostile after she contacted the Mental Welfare Commission (MWC) about her son, and that his wounds were not properly managed. Mrs C also said that, although she asked for Mr A to stay in the first hospital where she could give him support, he was transferred to his own area.

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Mrs C felt that her son did not receive an acceptable level of care in hospital. I agreed that the care he received on admission was clearly inadequate and I upheld this complaint. My mental health adviser noted that when Mr A was in both A&E and the medical ward he had taken an overdose only a few hours before, and was acutely paranoid. My adviser pointed out that staff in these areas did not seek an immediate psychiatric opinion on Mr A's mental health nor is there any record that they tried to obtain relevant medical history information from his mother. I am particularly concerned about the lack of psychiatric assessment at this point. Assessment would have created a management plan to address the risks to Mr A, and ensured that he was cared for in the most appropriate setting. While there is no guarantee that Mr A would not have tried to self-harm again, he would have been subject to an increased and more appropriate level of observation by suitably experienced staff. I also upheld the complaint about wound care, as there was inadequate documentation in Mr A's wound care plan. I found the Board's view that Mr A was reluctant to allow staff to manage his wounds to be unfair.

I upheld Mrs C's complaint about her son's transfer. Although it is normal practice to return a patient to their home area, there was no evidence to show that staff gave Mrs C's concerns due consideration and they did not tell her that she had the right to appeal to a tribunal against the decision. Finally, I also upheld the complaint about the actions of some staff after they learned that Mrs C had contacted the MWC. It is normally difficult to prove complaints about staff attitude and behaviour but in this case, as the Board had already recognised and accepted problems with staff attitude and had taken steps to address this, I was able to uphold the complaint. I did not uphold a complaint that conditions on the psychiatric ward were unsatisfactory as I could find no evidence of this.

The Board have taken steps to address areas of concern that they found in their investigation of Mrs C's complaint, including reviewing their practice in a number of areas, but I made several recommendations to address further issues that I identified. These can be read in full in my investigation report, and include auditing wound care practice and the safe management of non-clinical sharp items, and sharing my report with the group reviewing clinical processes, to ensure that my adviser's concerns about mental health assessment staff training and inadequate record keeping are taken into account in their review. I also recommended that the Board apologise to both Mrs C and Mr A for the failings I identified.

Mental health assessment; clinical treatment; policy/administration; communication

Tayside NHS Board (201003783)

Mr C raised a number of concerns about the care and treatment that the Board's Mental Health Service provided to his 20 year old son, Mr A, in the 13 months before Mr A's death by suicide. Mr C also raised concerns about the communication between health staff and Mr A's family during this period.

Mr A was first seen in hospital after taking an intentional overdose. He told staff that he was suicidal and suffering stress because of work and home pressures. He also said that he had significantly increased his use of alcohol. A Clinical Nurse Specialist in Liaison Psychiatry reviewed him, arranged an out-patient appointment and contacted Mr A's GP to arrange a prescription for an anti-depressant. Over the next year, the same nurse saw Mr A twelve times, mainly at out-patient appointments. Eventually, after Mr A missed two appointments, the nurse discharged Mr A from his caseload. Shortly after that, Mr A took a further overdose. A consultant liaison psychiatrist saw him about four weeks later, concluded that Mr A did not have a psychiatric illness and referred him to an alcohol counselling service. Some two months after that, Mr A was readmitted to hospital after a third overdose. He was reviewed by the same nurse, who noted that there was no evidence of psychiatric abnormalities and that Mr A said he had no current suicidal thoughts. The nurse suggested that Mr A make contact with a provider of independent mental health care and support in the voluntary sector. They gave Mr A a note with details of two such organisations and he was discharged from hospital later that day. Mr A took his own life just over two weeks later.

Mr C complained to the Board about Mr A's care and treatment, and about the lack of involving his family in his care. Mr C said that, despite numerous appointments with the nurse and review by a psychiatrist, Mr A had made a number of attempts on his own life and each time was sent home to his family, with no information or support. Mr C believed that Mr A's life could have been saved, had the Board not missed opportunities to help him. He met the Board and the Associate Medical Director, but was not satisfied with their explanations. The Board said that the staff involved considered that Mr A was suffering mild to moderate depression as a result of various stressful factors in his life. They said that there was no indication that Mr A required further review, assessment or in-patient treatment.

I took advice from two of my medical advisers on this. They were satisfied with Mr A's initial care and treatment; but felt that more thorough assessments would have assisted in identifying changes in his later behaviour pattern. Crucially, no-one assessed the risk to Mr A, either in terms of the potential for future self harm or suicidality and there was no written plan for his care and treatment, despite relevant guidelines stressing the importance of this.

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Mr C was also concerned that his family had found it difficult to get information about Mr A's progress or treatment because Mr A was an adult. He felt that they should have been involved in his treatment plan, as Mr A was sent home with no immediate support other than his family, who did not have the information they needed to help him. Mr C said they felt excluded from discussions and appointments and that their perspective was not really listened to. My advisers said that although the principle of confidentiality must be observed, there was no evidence that Mr A was asked whether or not he consented to his family being involved. It is clear that his family were extremely concerned about him and did their best to be involved in his care. Both my advisers and the relevant guidance indicate that involvement of family and carers is good practice in assessing and managing patients. In Mr A's case, Mr and Mrs C should in particular have been involved in providing background information about aspects of Mr A's life. According to good practice and the advice I have received, Mr and Mrs C should have been more involved in their son's assessment, treatment and care. They should also have been involved in the preparation of the Board's reviews relevant to Mr A's death (see below), but were not.

I also noted that it was only after I sent the Board a copy of my draft report into Mr C's complaint that they sent me copies of a Significant Incident Review (made not long after Mr A's death) and root cause analysis (made over a year after his death). I am seriously concerned that these were not provided during the investigation and about the quality of these reviews. As a result, I refer to them in my conclusions and recommendations on the complaints.

I upheld both of Mr C's complaints and made a number of recommendations, which can be read in full in my report. These included that the Board apologise to Mr and Mrs C for the failings I identified, and that they make a number of significant reviews of their processes and procedures.

Higher Education

Admissions; policy/administration; communication

The Robert Gordon University (201003198)

Ms C raised a number of concerns about how the University dealt with her admission, examinations, assessment for a learning difficulty, and graduation. She was also concerned about the University's complaints handling. I cannot investigate any matter relating to the quality of a student's work or the academic input of staff and so my investigation was into the administrative processes that the University used. I upheld Ms C's complaint that the University failed to consider her for an advanced entry place in second year, as there was no relevant formal process, and a member of staff did not respond to her statement that she wanted to be considered for this. They also failed to tell her before the relevant deadline that she had to register for graduation and delayed in providing the documents that she needed to validate her qualification in her home country. Finally, I found that they failed to assess her for a possible learning difficulty that one of her lecturers had asked them to consider. I did not uphold Ms C's complaints about the rescheduling of her final exams or about the University's complaints handling, as I did not find any evidence of administrative error on the part of the University.

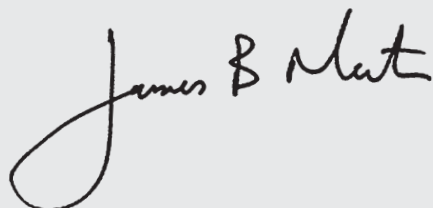
I made a number of recommendations to address the issues identified in the complaints that I upheld, and these can be read in full in my report. They include apologising to Ms C for the failings my investigation found, and introducing systems both for dealing with the administration of advanced entry applications, and for the practices relating to students who are to be screened by the University's Disability and Dyslexia office.

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Compliance and follow-up

In line with SPSO practice, my office will follow up with the organisations to ensure that they implement the actions to which they have agreed.



Jim Martin, Ombudsman, 21 December 2011

The compendium of reports can be found on our website **www.spsso.org.uk**

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The Scottish Public Services Ombudsman (SPSO) provides a 'one-stop-shop' for individuals making complaints about organisations providing public services in Scotland. Our service is **independent, impartial** and **free**.

We are the final stage for handling complaints about councils, housing associations, the National Health Service, prisons, the Scottish Government and its agencies and departments, the Scottish Parliamentary Corporate Body, water and sewerage providers, colleges and universities and most Scottish public authorities.

We normally consider complaints only after they have been through the formal complaints process of the organisation concerned. Members of the public can then bring a complaint to us by visiting our office, calling or texting us, writing to us, or filling out our online complaint form.

The Scottish Public Services Ombudsman was set up in 2002, replacing three previous offices – the Scottish Parliamentary and Health Service Ombudsman, the Local Government Ombudsman for Scotland and the Housing Association Ombudsman for Scotland. Our role was also extended to include other bodies delivering public services.

We aim not only to provide justice for the individual, but also to share the learning from our work in order to improve the delivery of public services in Scotland. We have a programme of outreach activities that raise awareness of our service among the general public and promote good complaint handling in bodies under our jurisdiction.

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