



Ombudsman's Commentary

JANUARY 2008 REPORTS

I laid 20 investigation reports before the Scottish Parliament today. Eleven relate to the health sector, eight relate to local government and one to further and higher education. As ever, there are important lessons to be drawn for the individual bodies and sectors concerned, and there are also messages about complaint handling more generally that have resonance across the public sector.

Ombudsman's Overview

In my Overview this month I am highlighting the value that we add in dealing with enquiries and complaints at the pre-investigative stage. These activities are less visible to the outside world but they form the vast bulk of our work. In the business year to date (April 1 – Dec 31 2007) our office resolved 1,400 enquiries and determined 2,330 complaints. We define an enquiry as an approach to us seeking information, for example about whether we can deal with a complaint about a particular issue or about how to pursue a complaint about a particular organisation. A complaint is an approach to us requesting action in relation to a grievance about a public body.

Naturally, the complaints that result in published reports that are laid before the Parliament, and therefore put in the public domain, attract the most attention. There have been 299 of these so far this business year – almost as many as in the whole of 2006 – 2007. Through sharing the learning from these reports, the SPSO should be seen as a vital resource for those engaged in improving the delivery of public services. However, I believe that the SPSO is also providing a raft of other valuable services, for example when we signpost people to other organisations better placed to deal with their enquiries and complaints. Whether or not a case is taken to the published investigation stage, we often find that highlighting the concerns or issues raised by complainants with public service deliverers gives rise to early positive outcomes and service improvements.

Of the 2,330 determined complaints, 943 were found to be premature (these are complaints that have not yet been through the full complaints procedure of the body complained about). 423 were discontinued because the complainant did not provide us with information or lost touch with our office, or for reasons such as lack of sufficient evidence or the complainant choosing to take legal action instead. A further 268 were out of jurisdiction (these are complaints about matters or organisations that we cannot investigate because the law prevents us from doing so).

Of the remaining 696 complaints that we could investigate, we decided in 397 cases that it would not be proportionate to publish a report. These decisions were made based on a rigorous process – we request additional information where necessary and sift the evidence to determine what has happened. Once the evidence is examined, the complaint is reviewed taking account of its nature, whether we can achieve what the complainant wants, whether the organisation has done all that it could to resolve the matter and whether there might be a broader public interest in putting the facts of the case into the public domain with a published report. Where we see no benefit in publishing a report of our work into the complaint, we write to the complainant and body, detailing our reasons.

These many aspects of complaint handling were addressed in Professor Crerar's *Independent Review of regulation, audit, inspection and complaints handling of public services in Scotland*. Our response to the Crerar Report, detailing our qualified welcome to his proposals is available at: www.spsso.org.uk/news/article.php?id=252.

I have accepted an invitation from the Government to participate in a "fixed-term action group", chaired by Douglas Sinclair (Chair of the Scottish Consumer Council) which held its inaugural meeting earlier this month. We look forward to continuing to provide input to the Scottish Government and the Scottish Parliament's consideration of the way ahead. Improving the system so that the public are better served is an objective we all share.

Professor Alice Brown, Ombudsman
23.01.2008

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Details of the reports are summarised below and the full reports are available on the SPSO website at <http://www.spsso.org.uk/reports/index.php>

Health

Diagnosis

A GP Practice in the Grampian NHS Board area (200603606)

I fully upheld Ms C's complaint that a GP Practice had failed to diagnose her 34-year old brother, Mr A, with pulmonary embolism following a deep vein thrombosis (DVT).

I recommended that the Practice make an apology to Mr A's family for their poor management of his pulmonary embolism and review the circumstances of the case and consider whether any lessons could be learned for the future management of young adults with chest symptoms. My investigation also found that the clinical notes were not very detailed and could be considered insufficient. To address this, I made a further recommendation that the Practice review their clinical record-keeping.

Clinical treatment, record-keeping

A Dentist in the Lothian NHS Board area (200602971)

I upheld the complaint that the dentist failed to provide Ms C with an appropriate level of dental treatment and failed to keep accurate and contemporaneous records. By way of redress, I recommended that the dentist apologise to Ms C for the failings which have been identified in the report; arrange postgraduate training on root canal treatment and periodontal monitoring and screening; carry out a clinical audit on the justification, quality and use of radiographs in providing adequate information to make effective treatment planning decisions; and conduct a review of his record-keeping and treatment planning procedures.

Complaint handling

The State Hospitals Board for Scotland (200501601)

Mr C's advocacy worker raised a complaint about the way the Board had investigated Mr C's complaint about the conduct of a student nurse. Mr C was concerned that the student nurse had reported him for

bullying a fellow patient, an allegation he denied. My investigation found that the Board had managed the alleged bullying incident very well, but that they had not addressed a central aspect of his complaint in their formal response. I, therefore, upheld the complaint and recommended that the Board remind staff that they should ensure that all aspects of a complaint are addressed when providing a response.

Removal from Practice list

A GP Practice in the Grampian NHS Board area (200701715)

I upheld the complaint that a couple were inappropriately removed from the Practice's list and recommended that the Practice apologise to the couple and ensure that the relevant regulations and guidance are adhered to before they ask for a patient to be removed from the Practice list.

Clinical treatment, hospital discharge, complaint handling

Greater Glasgow and Clyde NHS Board (200500816)

Mrs C raised a number of concerns regarding the care and treatment of her husband during admissions to hospital. Mr C is a 79-year old man who suffers from Alzheimer's disease. I upheld the complaint that the Board failed to store medication appropriately and supervise drug-taking and partially upheld two other complaints about aspects of clinical and nursing care. I did not uphold the complaint that Mr C was discharged from hospital too soon, and made no finding on the complaint that the Board had failed to provide any home help to Mrs C after her husband's discharge. I partially upheld her complaint about complaint handling.

As the investigation progressed, I identified issues concerning Mr C's clinical records and his post-operative management. My investigation, therefore, additionally considered two more points, both of which were upheld. My recommendations included that the Board make an apology to Mr and Mrs C for their failure in nursing

care, write to Mrs C repeating the apologies they have provided to me regarding their failure to handle her complaint properly; put measures in place to ensure that meaningful medical records are made on a daily basis; and put measures in place to ensure investigations are carried out more effectively.

I also recommended that the Board consider comments in the report about the management of anaemia and review their practice with advice from, for example, a physician in charge of elderly patients. This review should lead to an agreed policy being formulated, which should particularly be directed towards post-operative care. Finally, I recommended that they regularly review patients' medications so that inappropriate treatments are noted and, if necessary, stopped.

Hospital admission, patient dignity, complaint handling

Grampian NHS Board (200602507)

Mr C raised a number of concerns about the nursing care which he received during his admission to hospital, the advice given to him about MRSA and the way his complaint was handled by the Board. I upheld the complaint that Mr C did not receive adequate emotional support during his admission and that nursing staff advised Mr C's wife to leave the ward at a busy time. I did not uphold his complaint that he was not given clear information in relation to the Board's visitor policy and the risks of MRSA, nor that Mr C's chemotherapy was carried out in a ward setting and he was required to answer personal questions within earshot of other patients. I partially upheld his complaint that his concerns were ignored when he raised them with the specialist nurses and did not uphold his complaint that the Board failed to adhere to the NHS complaints handling procedure when investigating his complaint. I made several recommendations to the Board to address the failings identified in the investigation.

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Health

I did not uphold seven other complaints in the health sector about the following issues and bodies:

Clinical treatment, communication

Western Isles NHS Board (200501744)

Diagnosis, staff attitude

Lothian NHS Board (200700452)

Delay in diagnosis

A GP Practice in the Lothian NHS Board area (200604027)

While I did not uphold the complaint, I did recommend that the Practice review their procedures for recording and tracking the dispatch and receipt of blood tests.

Clinical treatment

Dumfries & Galloway NHS Board (200603869)

Clinical treatment, complaint handling

Forth Valley NHS Board (200502691)

While I did not uphold the complaint, I did make two recommendations. The first related to the recording of ultrasound scans, and the second to complaint handling. I found that the Board's actions in responding to the complaints were commendable but recommended that they make an apology for insensitive comments made during a meeting.

Local Government

Housing benefit

Falkirk Council (200604065)

I upheld two aspects of Ms C's complaint about the Council's handling of her housing benefit application and the serving of a subsequent notice referring to possible repossession. My investigation found that there had been mishandling of Ms C's application for housing benefit. The Council have apologised to Ms C and I commended them for openly admitting to the problem throughout and for the action taken to avoid a recurrence of the situation, which included measures to improve response times and increase individual officer awareness of correct procedures. I therefore made no recommendation on this aspect.

In relation to the notice, I found that, although the Council had correctly placed a manual hold on Ms C's account, this was not extended upon expiry, which resulted in the notice being automatically sent. The Council have accepted that the notice was sent in error and the matter was easily rectified. However, as the issue of such a notice in error is likely to cause distress for members of the public and additional work for the Council, I recommended that the Council review their Rents System to consider whether they could introduce a process of monitoring manual holds on accounts. A third aspect of the complaint was not upheld.

I did not uphold seven other complaints in the local government sector about the following issues and bodies:

Sale of land

Renfrewshire Council (200500865)

Sheltered housing: support charges

Fife Council (200501640)

Traffic regulation and management

Glasgow City Council (200501013)

Handling of planning application

Orkney Islands Council (200700996)

Handling of Planning Application

East Renfrewshire Council (200500226)

Employment of contractors

East Lothian Council (200500394)

I did not uphold this complaint, but it became apparent during the course of my investigation that more could be done to ensure the safety of vulnerable individuals when work is being carried out on their homes by Council staff or their contractors. As such, I recommended that the Council work with its Adult Protection Committee to establish good practice guidelines for Council and contractor employees working in the homes of vulnerable people and also consider including in their revised Corporate Procurement Procedures manual guidance on the protection of vulnerable people when work is being carried out on their homes.

Outdoor leisure facilities

East Lothian Council (200603033)

Although I did not uphold the complaint about how the Council prepared proposals for the development of a play area, the Council did accept that at times noise from users of the play area could be intrusive. I, therefore, recommended that, following a period of proposed monitoring with affected property owners, relevant officers of the Council report to the appropriate Committee on options for the play area including the residents' request that it be closed and relocated elsewhere. The Council informed me that they would report the results, together with any residents' views, to the Council's Cabinet. The report would include a recommendation as to what further action, if any, should be taken with respect to the location and operation of the play area.

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Further and Higher Education

Student discipline

Queen Margaret University
(previously Queen Margaret
University College) (200503073)

Mr C raised a number of concerns about the conduct of disciplinary proceedings against him by Queen Margaret University College. I fully upheld three aspects of the complaint and partially upheld another.

Overall, I found that the allegations against Mr C were upheld, and he was expelled from the University College, on the basis of flawed proceedings. I made a number of recommendations to improve procedural fairness in disciplinary hearings and recommended that relevant staff are reminded of the importance of following processes as laid down in their regulations. I also recommended that the University apologise to Mr C for the failings identified in my investigation report.

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.

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

For further information contact:

SPSO, 4 Melville Street,
Edinburgh EH3 7NS

Communications Manager:

Emma Gray

Tel: **0131 240 2974**

Email: egray@spsso.org.uk



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 'last resort' in handling complaints about councils, housing associations, the National Health Service, the Scottish Government and its agencies and departments, the Scottish Parliamentary Corporate Body, 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.

Further details on our website at: www.spsso.org.uk

Contact us at:

SPSO
4 Melville Street
Edinburgh EH3 7NS

Tel: **0800 377 7330**

Fax: **0800 377 7331**

Text: **0790 049 4372**

E-mail us at: ask@spsso.org.uk