



# Ombudsman's Commentary

## MARCH 2008 REPORTS

I laid 27 investigation reports before the Scottish Parliament today. Sixteen relate to the health sector, nine to the local government sector, one to further and higher education, and one to the Scottish Government and devolved administration. This business year (April 2007 – March 2008) I have laid a total of 370 reports, an increase of 21% over the previous year in which I laid 305.

### Ombudsman's Overview

I am highlighting two issues that emerge from this month's compendium of cases – making an apology as a means of redress (especially with regard to health cases) and lack of guidance in aspects of planning complaints.

I have upheld complaints this month about issues ranging from poor professional attitude by a GP to failings in clinical or nursing care in hospital. By way of redress, I often recommend an apology be made to the complainant. To those looking on from outside this may appear to be less significant than other recommendations I make, for example for training, changes in practice, or reviews of policy or guidelines to ensure there is no recurrence of the clinical, nursing or complaint handling issue that led to the complaint.

However, for the patients or families concerned, an apology is often the key action that they are looking for – a full explanation of what went wrong, a heart-felt 'I am sorry' from the individuals who were at fault or from those at the highest levels in an organisation who bear responsibility for what went wrong. Apologising is also a means by which bodies learn, through the process of looking at the part they played in what went wrong and speaking through a letter of apology to the person who was affected. In short, a meaningful apology can be a very powerful tool in rebuilding trust between health professionals and the public. My Office has produced Guidance on the subject, which can be obtained from our website.

I am increasingly concerned about the number of complaints we receive about privacy and private residential amenity (see, for example, case ref: 200603583 about overlooking and the intervisibility of windows). Privacy is not generally a 'material consideration' in planning law unless the planning authority has adopted formal policies for such matters as, for example, the distance between windows of facing habitable rooms or angles of shadows. Third parties have a higher expectation of the protection that planning affords than is actually the case but the Scottish Government has no formal guidance on the issue of privacy. I shall continue to monitor the number of complaints brought to my Office about the issue and, if appropriate, consider what action to recommend to address the problems raised by the lack of formal guidance.

**Professor Alice Brown, Ombudsman** 19.03.2008

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### case summaries

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

##### **Removal from practice list, staff attitude, complaint handling**

A GP Practice in Greater Glasgow and Clyde NHS Board (200503615)

Mr C complained that his GP behaved unprofessionally towards him during a consultation, unfairly removed him from the practice patient list and that his response to a complaint from Mr C's daughter was unsatisfactory.

I upheld Mr C's complaint and made a number of recommendations including apologies for the failures identified and the distress caused to Mr C and his family in pursuing the matter. I recommended that the GP consult with the Director of General Practice Postgraduate Education (or his deputy) to discuss, identify and participate in training and developmental initiatives designed to improve his consultation and communication skills.

I also recommended that the Practice reflect on this case and reconsider their policy for removing patients. This revised policy should be open to the patient population and advertised in a revised 'Practice Information' leaflet.

In relation to complaint handling, I recommended that the Practice revise their Complaints Procedure to ensure that patients are made aware that they can ask that their complaint, and the response, be handled by someone other than the person complained about. Finally I recommended that the Practice communicate the revised complaints procedure in a revised 'Practice Information' leaflet.

##### **Staff attitude, complaint handling**

A GP Practice in Greater Glasgow and Clyde NHS Board (200600808)

The complainant, Mrs C, visited the Practice with her three year old grandson, Child A, who was unwell, and was seen by a GP. After examining Child A, the GP diagnosed that he had tonsillitis. The GP then asked Mrs C to have Child A's parents contact him as he wished to address the issue of 'targeted kicks' from the child towards the GP during the consultation. Mrs C was unhappy with the GP's attitude and complained to the Practice Manager. She remained unhappy with the response to her complaint and asked my Office to investigate.

I upheld the complaint that it was unreasonable for the GP to complain about being kicked by Child A and I found that the handling of, and response to, Mrs C's complaint was unreasonable. I recommended that the GP make a full, formal written apology to Mrs C for the distress caused to her following the consultation and that he take action to improve his consultation and communication skills. I also made several recommendations to redress the failings that were identified in the Practice's complaints procedure.

##### **Delay in treatment, clinical treatment**

Greater Glasgow and Clyde NHS Board (200701522)

Mr C was concerned that he had to wait two years for an operation to remove a benign acoustic neuroma (a tumour which develops on the eighth cranial/hearing nerve), which he felt was an unacceptable amount of time. He was also concerned that no follow-up or review had been conducted within those two years. I upheld Mr C's complaints and recommended that the Board apologise to him for the failings identified.

##### **Care of the elderly: clinical treatment, hospital transfer, communication**

Ayrshire and Arran NHS Board (200602508)

Mrs C raised a number of concerns about her late father, Mr A's, treatment in hospital. I upheld the complaints that Mr A was catheterised without his consent and that a consultant decided not to artificially hydrate him. I also upheld the complaints that the Board inappropriately transferred Mr A to a second hospital and that there was ineffective communication with Mr A's family. I made several recommendations, including that the Board apologise to Mrs C for the failings identified; review the guidelines for catheterisation; take steps to ensure that staff adhere to the General Medical Council's guidance when they consider withholding or withdrawing life-prolonging treatments, by involving the patient (or those close to the patient where the patient's wishes cannot be determined) in the decision making. I also recommended that the Board review this case in order to establish if there are any lessons that can be learnt regarding the transfer of patients to other hospitals.

##### **Clinical treatment**

Grampian NHS Board (200602887)

I upheld the complaint that Mrs C's son, Mr A, received inadequate treatment from staff in relation to his heart problems prior to his death. Mr A had a complex medical history and my clinical adviser indicated that the omission of a left sided catheterisation of his heart was unlikely to have altered the sad outcome. However, given that the adviser did identify the omission as a failing in care and taking into account that the Board were unable to provide an explanation for the omission, I decided, on balance, to uphold the complaint. I recommended that the Board apologise to Mrs C for the failure identified.

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#### Health

##### **Complaint handling, communication**

Lothian NHS Board (200700444)

Mr C did not consider that the Board had taken seriously, or learnt from, the death of his son, Mr A. I upheld his complaint that the Board's response to Mr A's death was inadequate. I made several recommendations, including that the Board apologise to Mr C for the failure to provide convincing evidence of a thorough investigation, with lessons learnt, the impression at various times that no action would be taken in response to his son's death and the poor quality of some of the complaint responses.

##### **Complaint handling**

Lothian NHS Board (200701919)

Mrs C raised a number of concerns about the manner in which the Board had responded to complaints raised originally by her mother, Mrs A, and continued by Mrs C after Mrs A's death. I upheld the complaint and recommended that the Board apologise to Mrs C for this failure.

##### **Local care provision, diagnosis**

Forth Valley NHS Board (200601724)

Mrs C complained about a lack of local care provision for her son, Mr A. Mr A is severely autistic, has learning difficulties and also suffers from epilepsy. I upheld the complaint that there was a lack of care provision for Mr A over a nearly 3 year period. I did not uphold the complaint that the medication prescribed by her son's consultant was inappropriate in that, if fully implemented, it would have placed Mr A at risk.

I recommended that the Board offer Mrs C a full and sincere apology for the shortcomings identified in the report.

##### **Cleanliness and hygiene, nursing care**

Lothian NHS Board (200603703)

Mrs C was concerned that her mother, Mrs A, received inadequate care and treatment after being admitted to hospital and also raised concerns about the cleanliness of the hospital. I partially upheld the complaint that the Board failed to appropriately monitor and audit the cleanliness of the hospital; made no finding on the complaint that nursing staff failed to take action when they were advised of concerns by Mrs A's family and were often unavailable.

I upheld the complaint that a nurse acted inappropriately by trying to remove Mrs A's ring without a local anaesthetic; and did not uphold the complaint that as a result of the poor care Mrs A received, her health and general condition deteriorated during her stay in hospital.

I made several recommendations to the Board to improve monitoring and auditing of cleaning. I also recommended that they apologise to Mrs A and her family for attempting to remove her ring without local anaesthetic and for the distress this caused, and put measures in place to ensure that, where appropriate, removal of a ring is carried out with the use of a local anaesthetic.

##### **Diagnosis, communication, complaint handling**

Greater Glasgow and Clyde NHS Board (200700770)

Miss C was concerned that the cause of her abdominal pain was not diagnosed despite several admissions to hospital and that not all necessary investigations had been carried out. Miss C also raised issues regarding the Board's communication with her and her mother and regarding the accuracy of the Board's response to her complaint. I did not uphold the clinical or complaint handling aspects, but I partially upheld the complaint about poor communication.

##### **Referrals, clinical treatment**

A GP in Lothian NHS Board (200701321)

Mrs C was concerned that her GP waited too long before making a hospital referral and that she prescribed a cream for too long. I did not uphold the referral aspect of the complaint, but I did find that the GP prescribed Proctosedyl for too long. I recommended that the GP acquaint herself with the use of topical steroids, and apologise to Mrs C for prescribing Proctosedyl for too long.

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

##### **Diagnosis**

Lothian NHS Board (200600899)

##### **Diagnosis**

Greater Glasgow and Clyde NHS Board (200601008)

##### **Referrals, clinical treatment**

Greater Glasgow and Clyde NHS Board (200604047)

##### **Diagnosis, clinical treatment**

A Podiatry Clinic in Greater Glasgow and Clyde NHS Board (200601890)

##### **Clinical treatment**

Tayside NHS Board (200602580)

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### Local Government

#### **Roads and footpaths: equestrian right of way** South Ayrshire Council (200502399)

I upheld Mr C's complaint about the way the Council tried to extinguish equestrian rights of way on a pathway due to health and safety concerns. From the evidence provided by both parties, it was clear that the Council had failed to meet their responsibilities under the Countryside (Scotland) Act 1967. Although I noted in my report that the Council had consulted with local residents, organisations and elected members about concerns over shared use of the path and had found this a difficult issue to address, I concluded that they failed to assert the right of access for equestrians by failing to remove barriers placed by the local landowner, despite accepting that the right of way existed. I recommended that they take prompt action to meet their statutory obligations.

I also found that the Council delayed in seeking an Extinguishment Order to formally remove the right of way. They then decided not to pursue the order but to try and regulate the right of access by other means. I noted in my report that their failure to progress an Extinguishment Order meant that a possible right to have the matter determined by the Scottish Ministers was lost. I recommended that the Council introduce robust procedures to ensure they administer their statutory obligations under the Countryside (Scotland) Act 1967 and the Land Reform (Scotland) Act 2003 within acceptable timescales.

#### **Footpaths, complaint handling** Scottish Borders Council (200602421)

I upheld Mrs C's complaint that a footpath built adjacent to her property to offer a safer pedestrian route to school had affected her privacy by directing pedestrians onto her land at the front of her house. The Council have acknowledged that the footpath resulted in an increased number of pedestrians and have also admitted to a degree of responsibility for the impact on Mr and Mrs C's property. I found no evidence that the Council had consulted with Mr and

Mrs C before work began and it is possible that this could have allowed issues to be addressed before problems increased.

The Council have fully apologised to Mr and Mrs C for the encroachment onto their land and I further recommended that they apologise for their lack of consultation, as well as to make sure they consult with residents likely to be affected by future 'Safer Routes to School' projects. As a result of my investigation, I also found clear evidence that the Council did not follow up proposals to address Mr and Mrs C's concerns at an early stage, in part due to conflicting views about the safest way to assist pedestrian traffic. It was my view that if the Council had been more attentive to concerns raised, then the dispute would not have gone on for so long. As the party responsible for the problem, I felt that the Council had responsibility for resolving the matter in a timely and satisfactory way. The Council have apologised to Mr and Mrs C for the time taken to conclude this matter and a practical solution is now being progressed. I have also reminded the Council of their commitment to ensure a timely response to complaints.

#### **Planning advice** The Highland Council (200600763)

I upheld one aspect of Mr C's complaint about planning advice given to him about a plot of land that he wanted to buy. Although in my report I recognised Mr C's disappointment at not being able to realise his plans for the plot, I was satisfied that the planning officer involved gave him the advice that was available at the time. I also agreed that it is the role of planning officers to give general pre-application planning advice, not site specific solutions, which are better for the applicant to achieve with the help of specialist advisers. I did, however, find that there had been some administrative errors made with Mr C's objections to a planning application later made for the same plot. There was also a failure to tell Mr C that planning permission had been granted, which meant that he continued to correspond with the Council on the matter. The Council have apologised to Mr C for this and have put procedures in place to stop a similar situation happening again. I recommended a further apology

and asked the Council to emphasise to staff that they should take care when responding to correspondence and make sure that responses are timely and address the concerns raised.

#### **Handling of planning application, complaint handling** East Dunbartonshire Council (200603583)

Mr C complained about the Council's handling of an application by his neighbour to build an extension at the gable of his house, in particular that they failed to comply with their Local Plan guidance on privacy and intervisibility of windows in granting planning permission, and that they failed to take enforcement action to ensure obscure glazing in the window of an upstairs en-suite bathroom. The planning process cannot guarantee that people will not be overlooked, but it does try to ensure an acceptable level of privacy. Planning guidance, including that concerned with privacy / overlooking issues, is not binding but it does reflect the standards, which if complied with, would normally result in the Council granting planning permission. Therefore, in cases where such guidelines are not met, I would expect there to be a supporting argument. In this case, I did not consider that the assessment by the planning officer demonstrated appropriate grounds for departing from the Guidance Note. In the event, after construction, Mr C's property was significantly overlooked and his privacy compromised.

I recommended that the Council apologise to Mr C and review the privacy issue. The Council have offered to discuss with Mr C and his neighbour whether an acceptable form of screening might resolve matters. If this outcome can be achieved, I would expect the Council to bear any reasonable costs. With regard to the enforcement issue, I found that incorrect information was given to Mr C's local Councillor and so I partially upheld this aspect of the complaint. Opaque glazing has now been installed in the upstairs window. Finally, I found that there was an undue delay in dealing with Mr C's concerns. The Council have apologised to Mr C for this and have stated that they will take care to address complaints within a reasonable timescale.

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### Local Government

#### Estate management, communication

Falkirk Council (200604017)

I upheld one aspect and partially upheld another aspect of Mr C's complaint that users of a garage lock-up site (on Council land) were obstructed and inconvenienced by construction work to a neighbouring house, owned by Mr and Mrs D. In particular he raised concerns about the siting of a skip, the delivery of building materials and the parking of trade vehicles. Mr and Mrs D had applied for permission to site the skip. I considered that the Council could have acted more firmly to clarify and communicate both to Mr and Mrs D and to Mr C whether, in addition to permission for the skip, conditional consent was also being granted for parking and deliveries related to the building works. Also, I felt that an opportunity should have been taken to remind Mr and Mrs D of the consequences if these activities caused problems for users of the site. I made a recommendation to prevent a similar situation happening in future. I also found that the Council gave misleading information to residents, through the local Councillor, about the ownership of a wall dismantled by Mr and Mrs D. They have apologised for this error and have taken appropriate action to make sure it does not happen again.

#### Education: secondary school pupil support, complaint handling

Perth and Kinross Council (200701625)

Mr C complained that the Council did not provide adequate support for his daughter during her transition from primary to secondary school. Although I was satisfied that the School and the Council dedicated appropriate time and resources to Mr C's daughter, I found that there was a delay in dealing with Mr C's complaint at the final stage of the Council's complaints process. I therefore upheld this aspect of the complaint. The time taken to respond to Mr C's complaint was well outwith the Council's anticipated timescales and this

failure was also reflected in other complaints dealt with by the Council at that time, which had a serious impact on service delivery. The Council have apologised to Mr C for the delay and are also looking to refine their complaints procedure.

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

**Social work: complaint handling**  
Inverclyde Council (200600702)

**Housing: capital works**  
North Ayrshire Council (200600900)

**Handling of planning application**  
West Dunbartonshire Council (200500311, 200501522)

### Further and Higher Education

#### Academic appeals

University of St Andrews (200502104)

I upheld one aspect of this complaint by Miss C who raised concerns that her personal circumstances were not considered by the University in determining her degree classification and that her subsequent appeal was not dealt with in line with the University's procedure. I was satisfied that the University did take into account Miss C's specific circumstances, as notified to them, when deciding her degree classification. However, I raised concerns in my report that an explanation of the decision not to adjust Miss C's grades was not recorded in the minutes of the examination board meeting. I would consider recording such an explanation in the minutes to be best practice. I asked that staff involved in minute-taking are reminded of this point. My investigation highlighted a number of failures in the handling of Miss C's appeal that I believe not only amounted to maladministration but also showed that the appeals procedure was not properly followed in all respects. I therefore upheld this aspect of the complaint and recommended that the University apologise for the failings identified

in my report and reconsider Miss C's appeal, taking into account wider points made about her specific circumstances.

### Scottish Government and Devolved Administration

I did not uphold the following complaint in the Scottish Government and devolved administration sector:

#### Policy / administration, complaint handling

The Scottish Commission for the Regulation of Care (200600108)

### 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](http://www.spsso.org.uk)

For further information contact:  
**SPSO**, 4 Melville Street,  
Edinburgh EH3 7NS

Communications Manager:  
**Emma Gray**  
Tel: **0131 240 2974**  
Email: [egrayspsso.org.uk](mailto:egrayspsso.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 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](http://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](mailto:ask@spsso.org.uk)**