Ombudsman's Commentary

FEBRUARY 2009 REPORTS

Summaries of Investigation Reports

I laid eight investigation reports before the Scottish Parliament today. One relates to further education, four to the health sector, two to the local government sector and one covers both local government and the Scottish Government.

Case determinations

Investigation reports are public documents which we lay before the Parliament. As I have stated in previous Commentaries, these reports form only part of our overall work. My staff resolve on average 240 complaints each month. Many of these are complaints that are not ready for our office. Where appropriate, we will give advice to members of the public about how to complete the complaints process of the organisation they are unhappy with. If their complaint is not about an organisation or a subject that we can look into, we will try to help them find an organisation that may be able to help.

In some cases, the problem brought to us can be easily fixed, for example by a phone call to a public body requesting that they look into why a repair was not carried out. More complex complaints require detailed research, evidence gathering and analysis. Complaints Investigators may do this by:

- speaking to the complainant and the organisation they are complaining about
- seeking written answers to questions
- getting copies of documents (such as medical records)
- taking expert advice where necessary
- interviews
- site visits.

The Investigators carefully examine all valid complaints with a view to reaching a sound decision at the earliest opportunity. Usually, the process of examining a complaint allows them to reach firm conclusions. They report those conclusions in what we call a Determination Letter. In January 2009, we determined 37 complaints after detailed examination. That brings the total for the business year to date to 486 (this is over and above the 172 complaints this year on which Investigation Reports have been published).

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Overview

In my Overview this month, I am drawing attention to an investigation report which highlights issues around supported decision-making in helping disabled people manage direct payments. Direct payments are made so that people who have been assessed as requiring community care services can organise and pay for their own services. They are intended to provide an individual with flexibility, choice and control over how their services are provided. Supported decision-making plays a major role in helping people with learning difficulties and mental health problems to both consent to and manage direct payments.

My investigation (Case ref: 200701108) was prompted by a complaint from Ms C, who is registered disabled. Ms C was assisted in the process of applying for direct payments by a support organisation which acts on behalf of the Council to provide support, information and advice to clients accessing direct payments. We were able to look at Ms C's complaint because the SPSO Act 2002 states that we can investigate actions taken 'by or on behalf of' a public body over which we have jurisdiction in exercise of their administrative functions.

Ms C was concerned that the support the organisation provided was inadequate and that there was delay in processing her application. I upheld most aspects of the complaint, and made a number of recommendations to the Council to improve their procedures. These included that they give appropriate assistance and advice to Ms C to help her decide what help she needs to receive in her home and to maintain this after implementation of any service offered by the Council. I also recommended that they make an appropriate payment in recognition of their service failure and of the time and trouble to which Ms C had to go in order to pursue her complaint.

Ms C also complained about the Council's investigation of her concerns. I upheld this complaint as there was no clear process nor written evidence of their investigation. I recommended that as a matter of priority the Council take steps to introduce an open and appropriate complaint process for service users.

Further and Higher Education

Further Education: supervision; communication; complaint handling

Edinburgh's Telford College (200702229)

Ms C was concerned that the College did not provide her with appropriate support during her Performing Arts course. She was unhappy with the process around her audition for a higher level course, and the way in which the outcome of this was conveyed to her. Ms C was also unhappy with the way the College dealt with her subsequent complaint. I partially upheld her complaint about support (as inaccurate information was provided to students) and about the audition (as there was inconsistency in the way in which the outcome of auditions was conveyed). I recommended that the College ensure information provided to students about tutorials and the role of the Course Tutor is in line with current practice. I also recommended they review their policy about the methods used to inform applicants of the results of auditions, and review support and guidance for staff investigating complaints. Finally I recommended that they apologise to Ms C for the failings identified in their handling of her complaint, for failing to ensure that the course handbook explained clearly the role of the Course Tutor and for the inconsistency in the way students were notified of results.

Health

Diagnosis; transfer arrangements

Highland NHS Board (200602779)

Mrs C raised concerns about her husband, Mr C's, care and treatment in hospital. She complained that when his condition deteriorated medical staff did not consider a diagnosis of acute meningitis, and a delay arose in transferring him to a second hospital. Following the decision to transfer Mr C, he became very unwell and died that day in the first hospital. I did not uphold the complaints but I did make recommendations for improvements based on information obtained during my investigation. I recommended that the Board ensure that the local redesign process being undertaken by them and the Scottish Ambulance Service covers the need for medical staff to have access to the most up-to-date details of inter-hospital transfer times, with all relevant transportation matters clearly established at the time of arranging the transfer; and that they review their acute unit transfers policy to take account of changing patterns of acute stroke management.

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Health

Mental Health; care and treatment; complaint handling
Greater Glasgow and Clyde NHS Board (200500267)

Mr C raised a number of concerns about the response he received from the Board following an investigation by the Mental Welfare Commission for Scotland into the care and treatment of his late son. He complained to me that there had been an inadequate level of supervision for a member of staff making decisions about his son's care; that the Board had responded incorrectly in saying a care plan was agreed by all staff; that a second member of staff failed to act on an instruction that Mr A was not allowed to leave the ward unaccompanied; and that the Board had not accepted responsibility for failing in its duty of care, or offered an appropriate apology. I upheld all four complaints, and recommended that the Board give consideration to amending their risk assessment tool to include issues such as impulsivity or when the patient's state of mind is unknown, and that they offer Mr and Mrs C a full apology for the failings in care identified in my report. I also drew the Board's attention to the SPSO guidance note on 'apology' (which sets out what is meant and what is required for a meaningful apology).

Care and treatment; consent; complaint handling
Greater Glasgow and Clyde NHS Board (200603139)

After Ms C attended hospital for surgery for recurring breast cancer, she complained to the Board as she felt that the care and treatment she received was inadequate. I partially upheld her complaint about care and treatment to the extent that there were failings in obtaining consent and in communicating with her about administering a local anaesthetic (rather than the general anaesthetic that was originally discussed with her and that she expected to receive on the day of her operation). I recommended that the Board apologise to Ms C for the way in which this decision was communicated to her; and remind staff of the correct procedures to be followed when obtaining consent prior to surgery. Ms C was also unhappy with the time taken to respond to her complaints and said that she found the Board's final reply unsatisfactory. I upheld these complaints and recommended that the Board also apologise to Ms C for these failings.

Diagnosis; care and treatment; complaint handling
Greater Glasgow and Clyde NHS Board (200700891)

Mrs C was referred to a dermatologist as she was concerned about a lump on her leg in a place where a mole had previously been excised. The dermatologist considered the lump to be benign, as did another clinician at a review three months later. About 18 months after the referral, Mrs C became unwell and was eventually diagnosed with secondary cancers, as a result of which she died. Her husband, Mr C, complained to the Board who, with his agreement, considered his concerns through a case review outwith the standard NHS Complaints Procedure. On completion of that review Mr C's complaint was not, however, returned to the NHS Complaints Procedure, nor was he advised of his right to contact SPSO about his concerns. He was eventually advised of this right by his MSP. Mr C then complained to the SPSO that the treatment that his late wife received was inadequate and that staff had failed to diagnose that she was suffering from melanoma.

Although on reviewing the clinical records of Mrs C's case I found that the diagnosis process was reasonable in the circumstances of the case, I found cause to uphold significant aspects of the complaint. This was because I had concerns about Mrs C's care and treatment after the diagnosis of cancer, especially as she and Mr C continued to raise their concerns about the lump on her leg. Although biopsy of the lump would have been appropriate in the circumstances, this was not done. I was also concerned about the actions of the Board in their complaints handling after the case review. I recommended that the Board review their procedures for carrying out biopsies on cancer patients with a similar history to Mrs C, and that they consider the findings of this report in relation to complaints handling. Finally, I recommended that the Board write to Mr C to apologise for the distress caused by the failings that I have identified.

Local Government

Social Work: Complaint handling; policy/administration
Scottish Borders Council (200703245)

Mr and Mrs C were unhappy with the level of support provided to their late son by the Council's Social Work Department. They pursued this through the Council's complaint procedure and then to a Complaints Review Committee. Mr and Mrs C then complained to me that the Committee had said on the day of the hearing that they did not have enough information but had proceeded to make a decision. It was clear from my investigation that although Committee members were critical of the information provided by the Department before the meeting, they obtained adequate further information before reaching their decision. I did not, therefore, uphold the complaint, but because of the nature of the matter under consideration I recommended that the Council apologise to Mr and Mrs C for the distress caused.

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Local Government

Social Work: charges for services; direct payments

The Moray Council (200701108)

Ms C, who is registered disabled, raised concerns about the Council's handling of her request for direct payments to enable her to purchase help with domestic tasks in her home, and about their subsequent investigation of her complaint. Ms C was assisted by a support organisation which acts on behalf of the Council to provide support, information and advice to clients accessing direct payments. She was, however, concerned that the support they provided was inadequate and that there was delay in processing her application. I partially upheld her complaint about the actions of the support organisation, to the extent that they failed to refer Ms C back to the Council for advice about issues that were not within the organisation's remit.

I upheld her complaint about delay as, although some of the delay related to information required from Ms C, she was not properly supported by the Council during the application process, and I consider that this prolonged the process. I recommended to the Council that they take account of the failings identified in this report when they review their direct payments procedure. I also recommended that they now give appropriate assistance and advice to Ms C to help her decide what help she needs to receive in her home and to maintain this after implementation of any service offered by the Council. I also recommended that they make an appropriate payment in recognition of their service failure and of the time and trouble to which Ms C had to go in order to pursue her complaint. Finally, I also upheld Ms C's complaint about the Council's investigation of her concerns, as there is no clear process nor written evidence of their investigation. I recommended that as a matter of priority the Council take steps to introduce an open and appropriate complaint process for service users.

Local Government & Scottish Government

Planning enforcement, policy/administration

Fife Council (200502409)

Conflict of interest, policy/administration

Directorate for Planning and Environment (200503071)

Mr and Mrs C relocated their sports tour package business to their new home in February 2004. Shortly after, neighbours complained about some activities associated with the business, and the Council issued a Planning Contravention Notice (PCN) and later a Planning Enforcement Notice (PEN). Mr C appealed against the PEN to the then Scottish Executive Inquiry Reporters Unit (SEIRU) and his appeal was heard before a Reporter at a Public Local Inquiry. The Reporter confirmed the PEN subject to a number of amendments and refused an application on Mr C's behalf for expenses. Mr C then complained to me about both the Council and SEIRU and I have reported on both complaints in a single report.

I did not uphold complaints that Council officers gave poor and/or incorrect advice to Mr C, or that the Council handled matters poorly and inconsistently and failed to follow appropriate procedures. I partially upheld the complaint that the Council issued the PCN and subsequently the PEN based on insufficient evidence, to the extent that there were inadequacies in the report presented to the Committee. I recommended that the Council review the scope of information to be presented to the Committee on planning contravention when seeking authorisation to consider the expediency of taking enforcement action.

I upheld Mr C's complaint that SEIRU's initial appointment of a Reporter did not follow guidance on conflict of interest, and recommended that DPEA remind their staff and reporters of the need to consider whether particular appointments may be perceived as involving a conflict of interest, and that DPEA take account of ethical standards in public life in relation to such appointments. I partially upheld the complaint that activity related to the Public Local Inquiry was poorly handled, but only to the extent that some correspondence was not shared with all parties. I did not uphold a complaint that the Reporter who determined the appeal did not adequately justify his decisions.

Compliance & 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.

Professor Alice Brown, Ombudsman 18 February 2009

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

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

Communications Manager:
Emma Gray
Tel: **0131 240 2974**
Email: **egray@spso.org.uk**

SPSO Scottish Public Services Ombudsman

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.spso.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@spso.org.uk**