



Ombudsman's Commentary

MARCH 2009 REPORTS

I laid eight investigation reports before the Scottish Parliament today. Four relate to the health sector, three to the local government sector, and one to the Scottish Government/devolved administration.

Overview

At the end of this month I will stand down as Ombudsman, the post I have occupied since September 2002. In this Overview I offer some reflections on the past six and half years. Since the office opened its doors, over 11,000 people have turned to the Ombudsman. Each person who brought a complaint was expressing a concern about a public service, and was looking for an independent organisation to take action on their behalf to find out what had gone wrong, and to put it right.

Providing justice for the individual is the essence of the service we offer and will always be central to what Ombudsmen are for. This month's investigation reports (which bring to 953 the total I have laid before the Parliament, with some 55% of the complaints fully or partly upheld) cover a typically diverse range of important issues. They include a mother's concerns about the care and treatment of her daughter who has mental health problems; another mother with questions about the death of her daughter from Sudden Unexpected Death in Epilepsy (SUDEP); and a woman whose mother died in hospital who wanted to know why a scan was not performed or results not communicated properly between health professionals. There is a complaint from a man about collection agents pursuing him for alleged substantial council tax

arrears and concerns about a different council's response to dampness in a property. Another local government complaint relates to a council's failure to undertake adequate assessments or to properly apply policy in providing necessary housing adaptations for a man who was permanently disabled in a traffic accident. In my investigation into a complaint about the Crofters Commission I made a number of recommendations to improve systems and guidance about the role of the Commission in relation to the types of disputes described in the report.

As is frequently the case, a number of the investigations laid today have a resonance beyond the circumstances of the individual case. One of my recommendations in the report about the death from SUDEP is that the Government consider the need for more research into patient views on information giving and into the possible risk factors for SUDEP and the use of this research to inform guidance. In a separate investigation I found that a complainant was initially wrongly charged by a GP practice for the advice she received about vaccines available through the NHS. Clearly, this finding has important implications for GP practices throughout Scotland that provide advice about travel abroad.

Ombudsman's Commentary

MARCH 2009 REPORTS

overview

Sharing the learning about what has gone wrong is an important way in which we contribute to improving public services. Since my appointment I have had the privilege of working not only with members of the public, but also with public service providers and in partnership with the many individuals and organisations who share our common goal of ensuring that the learning from complaints is fed back into service improvements. We have also worked together to make complaints procedures simple, efficient and more accessible.

As I state in my farewell letter to public service Chief Executives:

'Over the past six and a half years, I have been heartened to witness a change in the way complaints are viewed by many organisations. Although there is always room for improvement, I do believe that a positive culture of valuing complaints is emerging in the public sector,

with a strong emphasis being placed on the service user's experience. There is also a greater willingness by organisations to see complaints as important feedback and to make improvements in administration and service delivery.

This is a sound basis for my successor to build on in leading the future work of the SPSO. As you are aware, the Scottish Parliament and Government are currently considering the framework for complaint handling in Scotland. I am confident that the SPSO is in a strong position to support the recommendations they will be making later this year. The SPSO will continue to work in partnership with you to ensure that complaint handling across the country is user-focussed, proportionate and effective.'

I would like to thank all the readers of this Commentary for the support you have given me and my staff during my period in my office.

A handwritten signature in black ink, reading "Aileen Brown". The signature is written in a cursive, flowing style.

Ombudsman's Commentary

MARCH 2009 REPORTS

case determinations

Investigation reports are public documents which we lay before the Parliament. These reports form only part of our overall work. My staff resolve on average 240 complaints each month. Investigators examine complaints with a view to reaching a decision on the issues concerned at the earliest opportunity and report those conclusions in what we call a Determination Letter. In February 2009, we determined 42 complaints after detailed examination. That brings the total for the business year to date to 522 (this is over and above the complaints on which Investigation Reports have been published).

investigation reports

Health

Mental health: clinical treatment; communication

Forth Valley NHS Board
(200602930)

Mrs C raised a number of concerns about the care and treatment provided to her daughter, Ms A, who had mental health problems. Ms A's treatment was initially provided by Clinical Psychologists and was then transferred to a Community Psychiatric Nurse. Mrs C complained that her daughter's treatment by the Clinical Psychologists was inappropriately withdrawn, and that inadequate explanations for this were provided to her and Ms A. I did not uphold the complaint about the transfer of Ms A's care but, as the reasons for it were inadequately documented, I recommended that the Board remind staff that clinical decisions should be documented and of the importance of doing this. I upheld the complaint about the failure to provide explanations as I found that conflicting explanations were given. I recommended that the Board remind staff that adequate explanations of clinical decisions need to be provided to patients, and that the Board apologise for the failures identified in my report.

Policy and administration

A Medical Practice, Lothian NHS Board (200800093)

Mrs C's daughter, Ms A, was planning to travel abroad and sought travel advice from her GP Practice. Mrs C complained that the Practice failed to provide these services in accordance with the relevant regulations. I upheld the complaint as Ms A was initially wrongly charged for the advice she received about vaccines available through the NHS. By way of redress, I recommended that the Practice cease immediately its policy for charging for all travel advice; as far as possible, refund patients it has charged wrongly; and amend its policy in light of the regulations.

Information sharing

Fife NHS Board (200700075)

Mrs C raised a number of concerns about the quality and quantity of information provided to her late daughter, Miss C, following her diagnosis of epilepsy in April 2006. Mrs C was particularly concerned that her daughter was not told about the risk of SUDEP (Sudden Unexpected Death in Epilepsy). She considered that this meant Miss C was denied an opportunity to fully understand the consequences of not taking her prescribed medication on a regular

basis and that this may have contributed to Miss C's premature death from SUDEP. Although medical opinion is clearly divided on whether this risk should be conveyed to patients with epilepsy, I upheld the complaint that the Board failed to provide Miss C with adequate information. I recommended that they provide written information to patients following diagnosis, on a proactive basis and in line with that recommended in Scottish Intercollegiate Guidance Network (SIGN) guidelines. I also recommended that the Board employ an epilepsy nurse-specialist and advise me when this person is in post. Finally, I recommended that the Board apologise to Mrs C that written information about her daughter's condition and changes in her drug regime were not made available to Miss C, and that there was no evidence of an individualised decision being made not to tell Miss C about SUDEP.

This is a complaint in which evidence about whether a patient should normally be told of all the risks attached to their condition, irrespective of the potential consequences, is central, and is disputed. I have, therefore, asked SIGN to consider the findings of this report as part of any future review of guidelines on epilepsy.

Ombudsman's Commentary

MARCH 2009 REPORTS

investigation reports

Further, in light of the difference in views between this Office and the Board about the information that should have been provided to Miss C, I will ask the Directorates of Health and Wellbeing to consider the need for more research into patient views on information giving and into the possible risk factors for SUDEP and the use of this research to inform ethical guidance.

Clinical treatment, communication

Greater Glasgow and Clyde NHS Board (200501303)

Ms C raised a number of concerns about the care and treatment provided to her mother, Mrs A, in hospital. Mrs A was referred to hospital by her GP, and was admitted. She was treated for a urinary tract infection and anaemia and was discharged less than two weeks later. When her health deteriorated she was admitted to a second hospital where, sadly, she died of renal failure and septicaemia. Ms C complained that a renal ultrasound scan was not performed on admission to the first hospital. She also complained that when Mrs A had a pre-arranged scan carried out at the second hospital (while still an in-patient in the first hospital), the results were not acted on by the first hospital, and communication with a consultant at the second hospital was inadequate. She also complained that her mother was inappropriately noted as having 'no medical issues' when allowed home on weekend pass and that she was discharged from the first hospital without appropriate action and with an inadequate discharge letter.

I upheld all Ms C's complaints. I recommended that Mrs A's case be discussed urgently with the relevant consultant in the first hospital and formally recorded at that consultant's next annual appraisal, and that the clinical team responsible for Mrs A's care in the first hospital consider and act on the lessons to be learned as a result of the failings identified in my report. I also recommended that the Board remind staff of the need for accurate records to be kept; share with me a copy of the regular audit of communications presented to their Clinical Governance Committee; and apologise fully and formally to Ms C for the failings identified in my report.

Local Government

Finance: Council tax

The City of Edinburgh Council (200800100)

When the Council and their collection agents pursued him for alleged substantial council tax arrears, Mr C raised concerns at the amount of the arrears and at differences between the Council and their collection agents as to how much he allegedly owed. He complained to me that the Council failed to provide him with an accurate and comprehensive statement of council tax owed and failed to act on his assertions that they had overstated his indebtedness. As there were certainly differences in the statements of indebtedness provided to Mr C I upheld the complaint, but made no recommendation as the Council had already engaged with him to provide an accurate statement. I did not uphold the complaint that the Council failed to act on his concerns.

Disability adaptations; policy/administration

Dumfries and Galloway Council (200602104)

Mr C was permanently disabled in a traffic accident in September 2004. He complained that the Council failed to undertake assessments needed to identify his and his family's needs or to provide necessary housing adaptations in a timely manner. Although there was clearly considerable effort by Council staff working with Mr C and his family, I upheld the complaint, as the evidence showed that there were failures to undertake adequate assessments in time, to properly apply policy or to take action that might resolve matters. I made three broad recommendations in this case, including the introduction of a detailed assessment framework with input from all relevant professionals, a review and clarification of Council policy with respect to Private Sector Housing Improvement Grants and the introduction of a procedure for dealing with adaptation cases where agreement cannot be reached. I also recommended that the Council produce a statement of needs and necessary adaptations for Mr C and his family along with a plan as to how these adaptations might be achieved (which they have now done), and that they make a significant payment to Mr C in recognition of the avoidable delays and distress caused in meeting his long term needs.

Ombudsman's Commentary

MARCH 2009 REPORTS

investigation reports

Statutory Nuisance Abatement Notice; communication

Glasgow City Council
(200603518)

Mr C approached the Council about dampness in his property which he believed was coming from his neighbour's flat. The Council served an Abatement Notice on his neighbour, who undertook some work, but the dampness continued. Mr C complained to me that the Council did not use the powers at their disposal to ensure that his neighbour took action to solve the problem. It was clear that the Council went to some lengths to try to assist, and that in the circumstances of this case there was no requirement for them to undertake a repair themselves. I did, however, uphold the complaint that they failed to effectively enforce an Abatement Notice on the basis that there was a lack of consistency in the Council's approach that raised Mr C's expectations that the Council would take action to remedy the problem. I recommended that they apologise to Mr C for a lack of clarity and consistency in their approach to addressing the statutory nuisance, and reflect on what can be done to address the gap between their statutory responsibilities and customer expectations in situations like this. I could reach no finding on a further complaint that they failed to keep Mr C adequately informed about progress.

Scottish Government and devolved administration

Apportionment, policy/administration, complaint handling

Crofters Commission
(TH0024_04)

Mrs C made 43 complaints to me about the Crofters Commission (the Commission). I decided to investigate 28 of these complaints, which I grouped together and investigated under seven main heads of complaint. The complaints investigated include delay and inaction relating to Mrs C's apportionment application, failure to take action on the conduct of a Grazings Clerk, delay in providing minutes and accounts, mishandling and falsely reporting an Annual General Meeting (AGM), failure to deal with complaints about the financial accounts of a Grazings Committee, failure to give adequate notice of a meeting, wrongly calling this meeting and recording inappropriate and false statements in the minutes; and failure in the handling of a second application for apportionment. I upheld two of Mrs C's complaints and partially upheld four others. I did not uphold Mrs C's complaints about the handling of an AGM and the reporting of it.

In respect of the upheld or partially upheld complaints, I made several recommendations to the Commission, including improvements to systems, and guidance about the role of the Commission in relation to the types of disputes described in my report. I also recommended that they consider introducing a mechanism to assist in the resolution of disputes, and a process to allow an individual shareholder to request investigation of an alleged breach of the Grazings Regulations. I also recommended that the Commission send Mrs C a meaningful apology for the shortcomings I have identified.

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 25 March 2009**

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

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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.spsso.org.uk**

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