Ombudsman's **Commentary**

JUNE 2009 REPORTS

The SPSO published 15 investigation reports today. Eight are about the health sector, six about local authorities and one is about a Scottish Government body. Our investigation reports form only one part of our work. In May we determined 279 complaints, including 64 that were resolved after detailed consideration.

Overview

Three of the investigations were highlighted by the new Ombudsman, Jim Martin. In his first statement on cases he has laid before Parliament since taking up his post as Scotland's new Public Services Ombudsman, he heavily criticised two Health Boards and a local authority.

Mr Martin said:

In the first Health case, my nursing adviser reports that the patient, while in Glasgow's Southern General Hospital, endured the worst case of pressure sores my adviser had witnessed in her career. Sadly the patient involved in this case did not recover from his operation and later died. The upheld complaints are:

- the decision to operate was not appropriate in that further tests should have been carried out prior to the operation
- the post-operative care provided to the patient was inadequate
- communication with the patient and his family was inadequate

I have recommended that the Board apologise to the patient's family and have made ten other recommendations, all of which the Board accept, about how the Board can implement the lessons learned from this case.

In the second Health case, I have upheld a complaint where Lothian NHS Board failed to get the informed consent of the guardian of a man with a serious learning disability prior to dental work conducted under general anaesthetic. I have made seven recommendations arising from this investigation to the Health Board for future action, including that the Board apologise to the patient's mother for their failure to seek informed consent. These recommendations concern how the Board generally approaches the question of consent for adults with mental incapacity and are not restricted solely to dentistry matters.

In the local authority case I have upheld three complaints from a tenant that Aberdeenshire Council:

- failed to make the house wind and watertight and to repair or modernise the house or garden prior to the tenant taking up tenancy
- rented the property to the tenant when the house's central heating system was not fit for purpose, and installed a replacement central heating system which was ineffective
- failed to connect a mains water supply to the home

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I have made six recommendations, all of which the Council accept, namely that they:

(i) Provide a full formal apology for the delay in connecting the complainant's house to a mains water supply together with the other failings identified in my report

(ii) Agree all outstanding repairs required to the property

(iii) Provide an action plan and timescales to complete the work

(iv) Reconsider a claim for compensation

(v) Take action to insulate and draught proof the property

(vi) Reassess the effectiveness of the replacement central heating system

I have laid a further 12 reports before Parliament dealing with complaints brought to me about health and local authority matters and a Scottish Government body.

In the health sector, the issues include poor care and treatment of the elderly, lack of informed medical consent, communication, record-keeping, inadequate clinical treatment, hospital cleanliness and policy issues relating to assessment of NHS Continuing Care.

In the local authority sector, the issues include housing repairs and maintenance, anti-social behaviour, noise pollution, the handling of a planning application and two reports about social work involving community care assessments.

The Scottish Government report is about the handling of an appeal in respect of a proposed Alteration or Removal of Buildings or Works Order.

Each report may contain several complaints, and in the 15 reports laid today overall, I have:

- **Upheld 18 complaints**
- **Partially upheld 2 complaints**
- **Not upheld 14 complaints**
- **Made no finding on 1 complaint**
- **Made 56 recommendations**

Summaries of all the reports laid today are below, and they can be accessed on the SPSO website at **www.spso.org.uk/reports/index.php**.

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case summaries

Health

Care of the elderly; clinical treatment; nursing care; communication; complaint handling

Greater Glasgow and Clyde NHS Board – Acute Services Division (200702913)

Mr C was concerned because his late father, Mr A, suffered serious pressure sores (clinically known as pressure ulcers) while in hospital after an operation on both his knees. Mr C felt that the decision to operate had not been taken appropriately and that the post-operative care provided was inadequate. Mr C was also unhappy about communication with him and his family. I upheld all of these complaints and made 11 significant and detailed recommendations, full details of which can be read in the report. As well as asking the Board to provide a full apology, my recommendations included analysing the reason for the sores developing in this particular case (which my adviser said were the worst she had seen in her career), providing policy and guidance on the assessment and treatment of pressure sores and providing details of an audit made in response to an earlier report from my office on another case where communication problems were identified. I also recommended that the Board fully audit documentation in the ward concerned, undertake an extensive external peer review of nursing care there and provide me with details of all the audits and action plans resulting from my recommendations. I partially upheld Mr C's complaint about the way the Board responded to him, to the extent that there was a delay in responding with no reasonable explanation provided.

Care of the elderly; referrals; clinical treatment

Greater Glasgow and Clyde NHS Board (200702628)

Mrs A had suffered from stomach pain and constipation over a number of days. She was admitted to hospital, where she died some days later. Concerns were expressed on behalf of her son that Mrs A should have been admitted earlier, and that inadequate treatment by the hospital might have contributed to her death. I did not uphold the complaint that out-of-hours doctors should have referred Mrs A to the hospital earlier, as I found that they acted reasonably on the information available to them at the time. I did, however uphold the complaint that Mrs A's care and treatment in the hospital were inadequate although it was not possible to say whether this had caused her death.
I recommended that the Board ensure that all appropriate healthcare professionals in their hospitals are made aware of the appropriate management of constipation in older people; and that the Board reflect on the lessons learnt from this complaint and take appropriate action to help avoid a recurrence. Additionally when, during the investigation, I asked to see certain records I found that some were missing. I therefore upheld a complaint that the Board lost some of Mrs A's medical records. I did not make any recommendations about this as I found that the Board had since taken significant action on this matter.

Consent; adult with mental incapacity

Lothian NHS Board (200700789)

Mrs C's son, Mr A, had a dental operation, under general anaesthetic, in the Department of Special Care and Sedation at St John's Hospital. During the operation a great deal of work was carried out, including nine extractions. Mr A, who was 19, had a learning disability – this meant he did not have the mental capacity to make decisions about treatment or consent, nor to understand much of what was happening to him at the hospital. His disability also meant that it was difficult to say for sure what work would need to be done in advance of the operation as Mr A found it difficult to sit still for examination or x-rays. After the operation, Mrs C said she had not been told before the operation of the possibility that so much work was needed. She felt that so much work had to be done that it should have been spread across more than one surgical session, and complained that she did not have the chance to withhold her consent to all the work being done at once. She added that the amount of work done caused her son such distress that, amongst other things, he had been chewing his lip, which had become an open, infected, sore.

I found that the relevant staff did not appear to have properly understood the Adults with Incapacity (Scotland) Act 2000, its Code of Practice and other relevant guidance, and that the Board did not, therefore, properly seek Mrs C's informed consent to the operation as they should have done.

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I fully upheld the complaint and made a number of recommendations. These included an apology for the failure to properly seek consent and that the Board share the learning from this complaint across all their hospitals and disciplines, and use it as an example in induction and other training programmes. I also recommended that the Board consider revising their consent form in respect of adults with incapacity, ensure their own Consent Policy is followed in future, and satisfy themselves that relevant staff have an appropriate knowledge and understanding of the Adults with Incapacity (Scotland) Act 2000, its Code of Practice and other relevant guidance.

Clinical treatment

A Dentist, Lothian NHS Board (200800963)

Mrs C raised a number of concerns about root canal treatment she received from her dentist, which led to her attending her local hospital in great pain and with a swollen face. I upheld Mrs C's complaint that the dentist provided her with an inadequate level of treatment and recommended that the dentist apologise for the failings identified. I also recommended that the dentist reflect on the comments of my dental adviser in the report, with regard to the standard of radiographs, working length calculation and record-keeping.

Care of the elderly; clinical treatment; nursing care; communication

Grampian NHS Board (200702838)

Ms C complained about aspects of care and treatment and communication with the family in respect of her elderly mother, Mrs A. Mrs A was admitted to hospital having been badly injured in a road traffic accident and never properly recovered full consciousness. She died in the hospital about a fortnight later. I upheld the complaint that some aspects of Mrs A's care and treatment were inadequate, and I identified several other areas of concern related to record-keeping and complaint handling. I made a number of recommendations in respect of this, including that the Board apologise to Ms C and reflect on the lessons to be learned from this case. The Board had already taken some action on areas of concern, but I further recommended that record-keeping and evidencing of monitoring are improved, including a wider audit of record-keeping if needed. I could make no finding on the complaint about communication with Mrs A's family as no discussions are documented in the records. Although I could make no finding, I have emphasised that my recommendations about record-keeping are also relevant to the recording of such discussions.

Policy/administration; communication

Ayrshire and Arran NHS Board (200800078)

Mrs A was initially resident in an English nursing home, where she was self-funding. Mr C (her stepson and only surviving relative) moved Mrs A to a Scottish nursing home which was closer to him. Mr C later appealed the funding of her care in England, with the outcome that her fees were refunded. Mr C then asked for her eligibility in Scotland to be assessed. The Board carried out an assessment and decided that she was ineligible for NHS continuing care under Scottish guidelines. Mr C complained to me that the Board inadequately assessed her condition and discounted the benefits to her of moving to be closer to him. He further complained about how the Board handled the matter. I did not uphold Mr C's complaints that Mrs A was not properly assessed or that the benefits of the move were discounted, as I found that the consultant who considered this acted appropriately. I did, however, uphold the complaint that the Board failed to properly explain their decision not to award continuing care funding, and as a result I made a number of recommendations. These included an apology to Mr C, a retrospective assessment of Mrs A's eligibility from her arrival in Scotland up to the date of her death, and significant review of the Board's documentation, instruction and procedures for assessment of eligibility for NHS continuing care, particularly in respect of cross-border transfers.

Consent; clinical treatment; communication

Lanarkshire NHS Board (200800695)

Mr C raised concerns about the treatment he received for a finger injury, saying that a consultant orthopaedic surgeon did not amputate enough of the damaged finger, and that this had hampered his ability to continue in employment as an electrician. In addition, Mr C complained that another consultant orthopaedic surgeon had agreed to further amputate the finger if alternative therapy did not work but then subsequently denied that he had promised this.

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I did not uphold Mr C's complaint that the decision not to provide his requested level of amputation was unreasonable, or the complaint that his overall treatment was inadequate. I did, however, find that the clinicians failed to obtain informed consent before surgery, and recommended that the Board apologise to Mr C for this. I also recommended that they consider whether procedures need to be amended so that the surgeon is available at the pre-assessment clinic to discuss the planned amputation and to take consent.

Facilities; cleanliness and hygiene; complaint handling

Grampian NHS Board (200700577)

Mr C raised a number of concerns about his care and treatment while he was in hospital for surgery. At the time, the unit and the ward in which Mr C was treated were housed in temporary accommodation, which Mr C considered to be unsuitable. When he later attended another hospital, he was found to have contracted MRSA (although I did not find evidence that confirmed that this occurred while he was an in-patient). Mr C also complained about how his complaint was handled by the Board. I upheld his complaint about the way in which the Board dealt with his concerns, as there was delay in responding to Mr C, and the Board did not reply at all to one of his letters. I recommended that the Board remind staff of the need to have regard to NHS complaints timescales. I did not uphold complaints about the facilities at the hospital, MRSA testing or lack of cleanliness.

Local Government

Housing: repairs and maintenance

Aberdeenshire Council (200602628)

Mrs C raised a number of concerns about her new tenancy. She said that the Council failed to repair or modernise the house and garden, both before and after she took up her tenancy, and that they had failed to make her home wind and watertight. She also said that the original central heating system was not fit for purpose and that the new central heating system that the Council installed was inadequate. Finally, she complained that the Council failed to connect a mains water supply to her home. I upheld all of the complaints, and recommended that the Council apologise to Ms C for the failings identified and meet with her to identify and agree all the repairs still required to the house. I also recommended that they provide me with an action plan detailing timescales to complete the outstanding works; reconsider Mrs C's claim for compensation for flood damage and reassess the effectiveness of the new heating system.

Anti-social behaviour; record-keeping

Aberdeen City Council (200602882)

Mr and Mrs C complained that the Council failed to respond appropriately to complaints they made about a neighbour's alleged behaviour; mainly to do with noise. I upheld Mr and Mrs C's complaints that their telephone calls to the Neighbour Complaints Unit and meetings with Housing Department officials were either not recorded or not fully recorded, but as the Council have already taken steps to improve practice in these areas, I recommended only that the Council apologise to Mr and Mrs C for this. I did not uphold the complaint that the Council failed to take appropriate action in response to Mr and Mrs C's complaint of anti-social behaviour.

Noise nuisance

East Lothian Council (200703169)

Mr C lives in a conservation area. He considered that the Council's response to his complaints about noise nuisance from an adjacent children's day care nursery was inadequate. I partially upheld the complaint that the Council failed to carry out their duties under the Environmental Protection Act 1990 to detect, investigate and take appropriate action in respect of that noise nuisance. I recommended that the Council's Environment Department agree with Mr and Mrs C an appropriate regime of noise monitoring during summer 2009 to establish whether the noise levels constitute a statutory noise nuisance and, if so, seek instructions from the Council as to further action.

Handling of planning application; communication

North Ayrshire Council (200701748 & 200801358)

Mr and Mrs C and Mr and Mrs D are two sets of neighbours whose properties sit either side of a residential property which was granted planning permission to be extended. They complained about the Council's handling of the planning proposals for the development and the subsequent amendments to the consent.

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I upheld the complaint that the Council mishandled the planning proposals as I found that the report that Council officers submitted to the Council's Planning Committee was flawed. I recommended that the Council review their procedures to ensure these contain clear advice on reporting to the Committee where premature works have been carried out; that the Council apologise to the complainants for the shortcomings identified in my report, and that they make payment to the complainants towards their expenses. Although I did not uphold a complaint that the Council delayed and failed to reply to Mr and Mrs D, I did recommend that in any ongoing service review the Council examine and consider improvements in how they handle correspondence.

I did not uphold complaints about the following local authorities, although I did make a number of recommendations in the reports.

Social work: community care assessments; local care provision

North Lanarkshire Council
(200502695)

Ms A, who has a learning disability, receives a care package from the Council. I did not uphold the complaint made by her sister, Ms C, that the package was inadequate for Ms A's needs. I did, however, recommend that the Council and Ms C enter into constructive dialogue to try to resolve any outstanding issues and to help manage any future changes. This would, of course, take place only with Ms A's consent in the light of the Council's stated responsibility to give primary consideration to her needs and wishes.

Social work: community care assessments; communication

Dundee City Council
(200601045)

Mr A is a young man with autism. I did not uphold the complaint made by his grandmother, Mrs C, that the Council failed to provide a service to meet his assessed needs, as I found their decision to have been reasonable in the circumstances. I did, however, note that, although the Council have since taken steps to improve their service, there were failings in the way in which Mr A's case was handled while his future was being considered. I therefore made recommendations about communication and record-keeping, including a payment in recognition of the time and trouble involved for Mrs C in pursuing her complaint.

Scottish Government and Devolved Administration

Planning: policy\administration; complaint handling

Directorate for Planning and Environmental Appeals
(200702113)

Mr C raised concerns about the handling of his appeal by the then Scottish Executive Inquiry Reporters Unit (SEIRU) in respect of a proposed Alteration or Removal of Buildings or Works Order. He was unhappy with the actions of the reporter and the conduct of a hearing. I did not uphold complaints that the hearing and site visit were not conducted in a proper and fair manner and that documentation relating to the hearing was mismanaged. I did, however, uphold his complaint that his subsequent complaints were not fully considered, and I recommended that the Directorate for Planning and Environmental Appeals (which has replaced SEIRU) apologise to Mr C for the lack of clarity in responses to his complaints. I also reminded them of the importance of clearly explaining to members of the public their role and remit, and any restrictions on these.

Compliance & Follow-up

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

Jim Martin, Ombudsman
17 June 2009

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

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