

# Ombudsman's Commentary

## JULY 2009 REPORTS

The SPSO published 19 investigation reports today. Eight are about the health sector, ten relate to local government, and one to the Scottish Government. Our investigation reports form only one part of our work. In June, we determined 344 complaints, including 71 that were resolved after detailed consideration. Each investigation may contain several complaints, and overall the 19 reports laid today:

- **Upheld 20 complaints**
- **Partially upheld 8 complaints**
- **Did not uphold 24 complaints**
- **Made no finding on 2 complaints**
- **Made 50 recommendations**

### Overview

A theme in this month's **health cases** is complaints about poor standards of care of the elderly. The distress and pain of patients and relatives is, of course, heightened when care, which includes communication and record-keeping, is inadequate. This is especially the case at the end of a person's life. Several health complaints (Refs: 200800181; 200702704; 200800173; 200800720) contain important lessons about how gaps in care and treatment including poor communication and record-keeping can have a profoundly negative impact on patients and relatives.

In one report (Ref: 200800720), the complainant recounts that shortly after being informed that his mother was dying in hospital, she was moved to an open ward. Staff there did not appear to be aware of his mother's condition and no curtains had been drawn to ensure that she had some privacy in her final hours. While the Board's response demonstrated that they are in the process of implementing improvements in how the terminally ill are cared for in hospital, I nonetheless concluded:

*'Mrs A and her family deserved greater care and respect. The issue was not just the layout of the ward but also the fact that there was very little recognition and support from staff at such a difficult time, which left Mrs A's family feeling isolated, and there was a lack of dignity afforded to Mrs A in her final hours...'*

I made nine recommendations resulting from this investigation. They relate to policies and initiatives in record-keeping, infection control and communication as well as examining the clinical failures identified in the patient's care.

Poor record-keeping and a lack of communication between health professionals and with a patient's spouse were highlighted in another report (Ref: 200801921). The complaint centred on information provided to the wife of a man who had suffered a heart attack, was hospitalised and died of a second heart attack in hospital. I fully upheld the complaint that staff failed to communicate adequately with the patient's wife, and in particular that they failed to follow procedure for instituting and implementing a Do Not Resuscitate order. My recommendations in the report aim to ensure as far as possible that her distress is not experienced by any other patient's relative.

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### overview

The investigations about **local government** issues covered a wide range of subjects including:

- the handling of planning applications
- Community Charge debt recovery
- administration of housing benefit
- school transport costs
- housing repairs and maintenance
- complaint handling

I made recommendations including that the Councils concerned:

- pay a complainant an amount equal to the relevant outstanding rent arrears from a tenant
- in a planning case, consider whether it would be appropriate to reinforce an apology by a modest payment in recognition of the effect of shortcomings in handling the application
- explore with a complainant and his neighbour whether steps can be taken at the Council's expense to mitigate the detriment to their privacy as a result of overlooking from a house
- apologise to complainants for failings or shortcomings identified
- make improvements in complaint handling
- revisit the repairs history of a complainant's house compared to similar houses nearby to establish whether there are recurrent problems; review arrangements for carrying

out repairs where there is a risk to the health of a tenant with a known medical condition; and review the adequacy of advice on the Council's reimbursement policy when they supply dehumidifiers to tenants

- report the circumstance of a planning enforcement case, where I found fault, to the appropriate Council committee as a potential enforcement action issue.

In the complaint about the **Scottish Government**, I fully upheld the complaints about the handling of an application for a Rural Home Ownership Grant (RHOG). I recommended that the Scottish Government Housing and Regeneration Directorate (who are now responsible for such grants) formally apologise to the complainant for the confusion and delay caused by the predecessor body, and that they take steps, including producing clear guidelines, to ensure that their agents clearly understand all their responsibilities in respect of RHOG applications. I also recommended that they review the events of this particular application to identify areas where communication with the agents could be improved.

Summaries of all the reports laid today are below, and they can be accessed on the SPSO website at [www.sps.org.uk/reports/index.php](http://www.sps.org.uk/reports/index.php).

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## Health

### Follow up care; record-keeping

Greater Glasgow and Clyde NHS Board (200503048)

Ms C, who fractured a finger in a riding accident, raised a number of concerns about the care and treatment she received from the Board. Two operations were performed on her fractured finger. Ms C believed that the second operation, the levels of pain she suffered and the ultimate restricted use of her finger were avoidable. Although I found that the surgical treatment Ms C received was reasonable, I upheld the complaint that the Board failed to provide reasonable care because record-keeping was poor, there was a question over whether proper consent was obtained before operating and Ms C was not treated by a specialised hand physiotherapist. I did not, however, make any recommendations to the Board as I was satisfied that they had already made changes addressing the concerns identified in my report.

### Diagnosis; clinical treatment Forth Valley NHS Board (200703272)

Mr and Mrs C raised a number of concerns about the care and treatment provided to their baby daughter, Baby C, by the Board. They also complained that the Board's hospital clinicians failed to diagnose meningitis and hydrocephalus when their daughter was initially referred there by her GP. Baby C was subsequently diagnosed with both conditions a

week later. I found that in assessing Baby C's condition, hospital doctors failed to address specific signs and concerns that Mr and Mrs C's GP highlighted when she referred Baby C to hospital. I, therefore, upheld the complaint that the Board failed to provide reasonable care and treatment to Baby C. I recommended that the Board carry out a root cause analysis of the inadequate assessment, exploring why the obvious concerns of the GP were not addressed by the junior paediatricians, and whether the staff grade doctor involved in the decisions was sufficiently trained and experienced to be in this position of responsibility. I recommended that the Board give consideration to further training for these staff in light of the results of their analysis, and note my medical adviser's comments about the need to have performed a cranial ultrasound scan. They should also provide Mr and Mrs C with a full and detailed explanation of their findings and the steps that will be taken to prevent recurrence; and apologise to Mr and Mrs C for the failings identified in my report.

### Care of the elderly; patient dignity; hygiene; communication

Greater Glasgow and Clyde NHS Board – Acute Services Division (200800720)

Mr C complained about the care provided to his late mother, Mrs A, who was admitted to hospital after a fall. Shortly after her admission, the hospital identified an outbreak of the winter vomiting virus in the receiving ward. While there, Mrs A was diagnosed with an infection,

her condition deteriorated and, sadly, she died a few days later, after a move to a second ward. Mr C was concerned that Mrs A's care and treatment were inadequate, and said that he and his family had been distressed by the way Mrs A had been cared for after it became clear she was unlikely to recover. I upheld Mr C's complaints about inadequate care and treatment; insufficient care in handling the infection outbreak; significant communication failures in the receiving ward; and failure to ensure Mrs A's dignity during her final hours. As a result I made a number of recommendations. These are detailed in my report and include providing me with evidence of the effect of the introduction of new policies and initiatives on record-keeping, infection control and communication as well as examining the reasons for the clinical failures identified in Mrs A's care. I made no finding on a complaint about inadequate hygiene in the first ward as the matters were not raised with staff at the time. I did, however, recommend that the Board use details from this complaint to inform their own hygiene and cleanliness improvement programme. Finally, I recommended that the Board apologise in full and in detail to Mr C and his family for the failings identified in my report.

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**Care of the elderly; nursing care; record-keeping; communication; policy/administration**  
Lanarkshire NHS Board  
(200702704)

Miss C was unhappy with the level of nursing care that her late mother, Mrs A, received, particularly in relation to a fall Mrs A suffered within hours of admission to hospital. Miss C also said that a series of decisions to cancel Mrs A's surgery for damage sustained to her femur in the fall were unreasonable. I upheld the complaint that the standard of nursing care was inadequate as I found a number of issues in the areas of both nursing care and record-keeping that caused me concern. These included failure to follow the correct procedure when administering a controlled substance, inadequate assessment for both pain management and risk; failure to make/record vital signs observations; and the number of bed moves that Mrs A experienced. As a result I made a number of recommendations aimed at improving the care of vulnerable and confused patients such as Mrs A. The full recommendations can be read in my report, and include conducting an urgent investigation into the administering of the controlled substance; the implementation of a formal bed move policy; clarification of the policy on nursing confused patients; and reminding staff of the importance of frequent vital observations. I also recommended that action be taken to address the failure to assess Mrs A's pain, and that the Board apologise to Miss C for all the failings identified. I did not

uphold the complaint about repeated cancellation of Mrs A's surgery, as I found that despite a lack of clarity between the different teams responsible for Mrs A's care the decisions to postpone surgery were appropriate. I did, however, recommend that the Board in future ensure a proper and demonstrably effective multi-disciplinary approach to patient care.

**Clinical treatment; communication; record-keeping**  
Ayrshire and Arran Health Board  
(200800173)

Mrs C raised a number of concerns about the care and treatment of her late mother, Mrs A. Mrs A was resident in a care home where two doctors from the Board's out-of-hours GP service visited her in the final hours of her life. I found that some aspects of Mrs A's care and treatment were not reasonable, including record-keeping and decision-making. I recommended that both doctors reflect on this case at their next appraisal in respect of the factors where I found them to be at fault.

**Clinical treatment; nursing care**  
Tayside NHS Board (200800181)

Mrs C raised a number of concerns regarding the treatment that her late father, Mr A, received from hospital staff. She complained that, for a five day period following admission, her father was neglected by nursing staff, his condition left unmonitored and incorrect assumptions made regarding his mental state. Mrs C felt that staff inattention and poor record-keeping contributed to the deterioration in Mr A's condition, and to his death. I did not uphold

the complaint about the assumption that Mr A was suffering from dementia, as there was no evidence in the medical records to support that. I was, however, very concerned to note that staff failed to notice early enough that Mr A's vital signs indicated that intervention was required. Although, before I considered this complaint, the Board took significant steps to learn from and resolve it, I recommended that they update the action plan that resulted from Mr A's case and provide me with both this and with details of the steps they have taken in respect of the Scottish Government's new Food, Fluid and Nutrition programme and related Clinical Quality Indicators. I also recommended that the Board formally apologise to Mrs C and her family for the distress and anxiety caused to them and Mr A during his stay at the hospital.

**Communication; consent; policy/administration**  
Fife NHS Board (200801921)

Mrs C was concerned about the information provided to her about the extent of her late husband's ill health and the operation of a Do Not Resuscitate (DNR) order. She was also concerned about the adequacy of steps taken to protect him in hospital. I fully upheld Mrs C's complaint that the Board failed to communicate adequately with her, and in particular that they failed to follow procedure for instituting and implementing a DNR order. I recommended that the Board review their DNR policy and Unitary Patient Record entries, along with an audit or similar to ensure clarity and understanding of the policy and that they review how such status is communicated at ward level as well as the staff training required on such issues.

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I also recommended that the Board review mechanisms to ensure that such communication is recognised as an important part of the patient experience. I partially upheld the complaint about Mrs C's late husband's safety, to the extent that the method used to monitor his whereabouts was not consented to, and recommended that they develop a specific policy for the use of this method, in particular to ensure that its use complies with the Adults with Incapacity (Scotland) Act 2000.

I did not uphold a complaint about the following NHS Board:

#### **Discharge planning; communication**

Ayrshire and Arran Health Board  
(200600199)

### Local Government

#### **Finance: housing benefit; policy/administration; communication**

The City of Edinburgh Council  
(200800154)

Mr C raised a number of concerns about the Council's administration of housing benefit for one of his tenants. He complained that the Council failed to properly investigate the tenant's personal circumstances, or follow the correct procedures, when paying housing benefit and that this resulted in financial loss for Mr C. I upheld all his complaints and recommended that the Council apologise to Mr C, pay him an amount equal to the relevant outstanding rent arrears from his tenant, and remind staff of the Council's internal procedures for telling interested parties about decisions relating to Local Housing Allowance accounts.

#### **Handling of planning application; communication** Falkirk Council (200502604)

Ms C complained about the handling of a planning application by the Council. I upheld her complaints that the Council failed to deal adequately with the pre-planning application enquiry and that there were delays by the Council in submitting information in connection with Ms C's appeal to the Scottish Executive Inquiry Reporters Unit. I partially upheld the complaint that the Council failed to handle adequately the outline planning application, to the extent that there was an error in the relevant newspaper advertisement and delay in determining the application. I recommended that the Council offer Ms C a full apology for the shortcomings identified, and consider whether it would be appropriate for this to be reinforced by a modest payment in recognition of the effect of those shortcomings on her. I did not uphold a complaint that the Council failed to respond to correspondence and calls.

#### **Handling of planning application; communication** Falkirk Council (200503618)

Mr C raised concerns about the way in which the Council dealt with the development of land to the rear of his home, and in particular the development of the nearest plot. He also complained that the Council failed to respond to his correspondence in a timely manner. I upheld his complaint that in considering the planning application for the plot and in treating requests for variations in the finished floor and ground level as non-material, the Council failed to demonstrate that they had proper regard to the effect on the amenity of Mr C and Mr B (his neighbour). I recommended that the Council

explore further with Mr C and Mr B whether steps can be taken at the Council's expense to mitigate the detriment to their privacy as a result of overlooking from the house constructed on the plot. I partially upheld the complaint about failure to respond, to the extent that the Council delayed unnecessarily in sending Mr C finalised minutes of a meeting. I recommended that the Council take steps to ensure they keep complainants updated if they are unable to respond to complaints within published timescales.

#### **Complaint handling; policy/administration** Glasgow City Council (200800255)

Mr C raised concerns about how the Council's Social Work Service handled complaints made by local residents about problems arising from a nearby children's unit, about the Service's application for planning consent for the extension of the unit, and the consideration of that application by the Council's Development and Regeneration Service. I partially upheld his complaint that the Council's Social Work Service failed to record and respond appropriately to complaints about the behaviour of children in the unit. I recommended that the Council review whether when similar complaints are received, and are not appropriate for being dealt with in terms of the statutory Social Work complaints procedure, these should be considered under their corporate complaints procedure. The Council confirmed that they have already taken steps in this direction. I did not uphold complaints about conditions attached to a previous planning consent or the failure to apply a relevant City Plan policy accurately when considering the planning application.

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### Local Government

#### **Housing: repairs and maintenance; policy/administration**

West Lothian Council  
(200800803)

Mrs C raised concerns about the Council's responses to problems she reported in her home, including water ingress and dampness. The Council had over a period of time carried out many visits and repairs to the property. I partially upheld two complaints; the first being that the Council failed to carry out repairs when the family were absent (upheld to the extent that they did not immediately say that repairs could not be carried out at that time). The second was that although the Council supplied dehumidifiers, they did not reimburse Mrs C for additional electricity costs (upheld to the extent that they did not make clear their position on reimbursement when providing the equipment). I did not uphold complaints that the Council failed to address persistent problems of water ingress and dampness; or that their workmen damaged Mrs C's flooring and misrepresented the extent of that damage to the Council's insurers. I recommended that the Council revisit the repairs history of Mrs C's house compared to similar houses nearby to establish whether there are recurrent problems; review arrangements for carrying out repairs where there is a risk to the health of a tenant with a known medical condition; and review the adequacy of advice on the Council's reimbursement policy when they supply dehumidifiers to tenants.

#### **Planning; enforcement**

Fife Council (200801970)

Mr C raised a number of concerns about the Council's handling of a planning application to upgrade a children's play area in a public park adjoining his home, which he did not consider had been installed according to the approved plans. I upheld his complaint that the Council's planning enforcement team did not properly investigate whether the development as built complies with the approved plans, as I found that the plans were mislaid and unavailable for comparison with the built development. I partially upheld his complaint that the Council did not take appropriate steps to secure for the public record a copy of the approved plans and recommended that, in light of the failure to obtain a copy of these, the circumstances be reported to the appropriate Council committee as a potential enforcement action issue. I did not uphold a complaint that in deciding to grant planning consent the Council failed to have proper regard for the amenity of neighbours.

I did not uphold complaints about the following Local Authorities:

#### **Finance: policy/administration** Midlothian Council (200702527)

Although I did not uphold any aspect of the complaint, I recommended that to avoid misunderstandings in future the Council tell complainants that action in relation to the arrestment of wages for the recovery of debt may continue during the handling of a complaint.

#### **Education; School transport; policy/administration**

Perth and Kinross Council  
(200801931)

I did not uphold two complaints and was unable to reach a finding on a third. The Council, however, took action to provide a remedy which the complainant found satisfactory. I recommended that the Council inform me of the outcome of their review of the home to school policy of the Education and Children's Service.

#### **Handling of planning application**

South Lanarkshire Council  
(200701640)

#### **Handling of planning application**

Dumfries and Galloway Council  
(200703193)

### Scottish Government and Devolved Administration

#### **Handling of application; communication**

Scottish Government Housing and Regeneration Directorate  
(200800277)

Mrs C raised a number of concerns regarding the handling of her application for a Rural Home Ownership Grant (RHOG). She complained that the Grant Provider (the former Communities Scotland) and their local agents failed to follow the correct procedures, or to communicate with her properly, when processing her application. I upheld both complaints as I found that the local agents failed to properly provide information to the Grant Provider on Mrs C's behalf.

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This both impacted adversely on her application in terms of time and misled her about her chances of success. I also found that communication from the agents to both the Grant Provider and Mrs C was unclear and, indeed, caused confusion. I recommended that the Scottish Government, Housing and Regeneration Directorate (who are now responsible for such grants) formally apologise to Mrs C for the confusion and delay and that they take steps, including producing clear guidelines, to ensure that their agents clearly understand all their responsibilities in respect of RHOG applications. I also recommended that they review the events of this particular application to identify areas where communication with the agents could be improved.

## 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**  
**22 July 2009**

The compendium of reports can be found on our website, [www.spsso.org.uk](http://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](http://www.spsso.org.uk)**

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