

Ombudsman's Commentary

OCTOBER 2009 REPORTS

The SPSO laid nine investigation reports before the Parliament today. Five are about the health sector, two relate to local government and two are about higher education. Our investigation reports form only one part of our work. In September, we determined 314 complaints, including 60 resolved after detailed consideration.

Each investigation may contain several complaints, and overall the nine reports laid today:

- **Upheld 13 complaints**
- **Partially upheld 4 complaints**
- **Made no finding on 2 complaints**
- **Did not uphold 10 complaints**
- **Made 38 recommendations**

Overview

Our **health** cases this month include three complaints made by relatives of patients who died in hospital. A woman complained that there had been a failure to properly care for and treat her husband who died of a brain haemorrhage (Cases 200700438 & 200800535). I upheld her complaints about delay in transferring the necessary clinical details to the correct out-of-hours service, and delay in picking up on the clinical symptoms described by the man's wife and family. I made recommendations including apology, improvements in call handlers' training and a review of clinical practice.

A separate complaint involved a woman with severe Multiple Sclerosis who died of a chest infection (Case 200701693). I partially upheld one aspect of the complaint and made six recommendations including apology and measures to improve training, record-keeping and other aspects of care. The third complaint was about the care and treatment of an elderly lady who died in hospital (Case 200703108). I upheld some aspects of the complaint and did not uphold or made no finding on others. My two recommendations were that the Board apologise for the failings identified, and audit and update an Action Plan that they have

already put in place to address the issues raised by the complaint.

There were two investigation reports involving complaints about surgery. In one, Case 200801237, I upheld complaints from the patient that she should have been operated on earlier, that there was inadequate communication with her about the nature and outcome of her condition and that her discharge home did not include adequate follow-up support. I also found that there was no evidence that proper, informed consent to the treatment plan of conservative management was sought and that there was inadequate record-keeping about discussions with the complainant. I made four recommendations to address the failings identified and to try to ensure that the problems would not arise again. Consent was also an issue in Case 200802430, where I upheld a complaint that proper informed consent was not obtained prior to surgery. My recommendations included that the Board review their consent process to ensure that patients have enough time to digest the information provided by staff and in leaflets and that sufficient space is available on the consent forms to list what has been discussed.

Ombudsman's Commentary

OCTOBER 2009 REPORTS

overview

One of the reports about **local government** this month concerned a complaint (Case 200701741) from a parent on behalf of his son, who was being home-educated. I upheld the father's complaints that the Council failed to honour a commitment to admit the child to a class at a school, acted unreasonably in refusing to consider enrolling the child in individual classes and handled a complaint about these matters inadequately. I made six recommendations to the Council to address these issues, prevent their reoccurrence and improve their complaint handling. In another complaint (Cases 200800888 & 200800890), two sets of parents raised a number of concerns about a school trip that their daughters had attended. Their concerns were subsequently investigated by the secondary school, and by the Council. I upheld the complaint that the planning/management of the trip was inadequate and partially upheld another aspect which concerned the investigation into an incident on the trip, and I made no finding on another

aspect. I made five recommendations to the Council including that they urgently finalise their revised draft procedures on excursions and outdoor activities and ensure that the new procedures contain adequate guidance on agreeing expected standards of student behaviour with parents.

One **higher education** report (Case 200801939) was into a complaint by a student who complained that his Director of Studies had wrongly claimed that the student was aware of his supervisors' doubts as to the quality of his PhD work. I upheld this complaint but did not uphold two others, and I made four recommendations to the University relating to research degree supervision and complaint handling. In another report (Case 200602310), I partially upheld a complaint about complaint handling and made a recommendation relating to this aspect.

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

Health

Delay in medical assessment; diagnosis

NHS 24 (200700438) and Greater Glasgow and Clyde NHS Board Acute Services Division (200800535)

Mrs C complained about both NHS 24 and Greater Glasgow and Clyde NHS Board, who together provide out-of-hours emergency medical services. She was concerned that her late husband, Mr C, did not receive appropriate treatment after telephoning the out-of-hours services. He was complaining of a headache,

and was initially advised to take medication available in the house, rest and let NHS 24 know if there was no improvement. Mr C was admitted to hospital the following morning but, sadly, died eight days later of subarachnoid haemorrhage. Mrs C complained that there was a delay of 12 hours without treatment for her husband. I upheld Mrs C's complaint that both Boards failed to provide Mr C with proper care and treatment and recommended that both apologise to Mrs C for the delays involved. I also recommended that NHS 24 evaluate the

improvements that they introduced as a result of this complaint and ensure that call handlers' training, the computer algorithms used and the mechanisms for passing on information are reviewed. I recommended that Greater Glasgow and Clyde NHS Board further review the clinical practice of the triage doctor who handled the telephone call with Mr C and that the doctor reflect on and share the details of this case at his next appraisal, with particular emphasis on the diagnosis of subarachnoid haemorrhage.

Ombudsman's Commentary

OCTOBER 2009 REPORTS

case summaries

Health

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

Greater Glasgow and Clyde NHS Board (200701693)

Mr C raised concerns about the care and treatment that his late wife, Mrs C, received during her time in hospital for treatment of a painful hip. Mrs C had severe Multiple Sclerosis and had to be fed through a tube inserted directly into her stomach. Mr C complained that she was not fed in a sufficiently upright position, causing food to pass into her lungs. I did not, however, uphold this complaint as there was insufficient evidence that this was the case. Mr C also said that the Board then failed to notice early enough that Mrs C had developed a chest infection. He was of the view that they did not, therefore, provide necessary treatment for the infection and that this resulted in his wife's death. I partially upheld this complaint as there was an initial failure to identify Mrs C's symptoms, which were only recognised after a further two days. I could not, however, say that this failure resulted in Mrs C's death as my medical advisers did not find sufficient evidence to suggest this.

I made a number of recommendations. These included passing my adviser's views on this case to the staff involved in the care of patients in similar circumstances, and

providing relevant information and training on care pathways to staff. I also recommended that the Board provide specific feedback to the staff involved in Mrs C's care about my adviser's view on that care, the need for accurate recording of mobility information, and the importance of seeking guidance from senior or technical staff when appropriate. Finally, I recommended that the Board apologise to Mr C for failing to notice and treat Mrs C's chest infection earlier and for failing to provide a revised care pathway.

Delay in clinical treatment; consent; communication; support/information

Greater Glasgow and Clyde NHS Board Acute Services Division (200801237)

Ms C suffers from cauda equina syndrome (CES), a compression of nerves in the spinal area that control the function of the lower limbs, bowel and bladder. When her symptoms appeared Ms C's GP referred her to hospital and she was admitted. She complained that a decision not to operate early in that admission seriously compromised her condition and that, despite ongoing symptoms and inability to manage her daily life, her discharge home did not include adequate follow-up support.

My medical adviser found that the decision not to operate at an early stage was unreasonable given the symptoms with which Ms C presented. He also said

that there was no evidence of adequate communication with Ms C about the nature and outcome of her condition, especially as CES had been identified as a possible diagnosis from the outset. The hospital consultant told her that it might be possible to manage the pain with conservative treatment rather than surgery, and my adviser's view is that the evidence suggests that Ms C was thus unable to make an informed choice about her treatment, nor was she provided with appropriate support. On a second admission she was correctly recognised as requiring surgery, and an after-care package was provided.

I upheld Ms C's complaint, and recommended that the Board apologise for the failure to operate earlier, and satisfy themselves that the consultant has an appropriate understanding of CES. I also recommended that the Board reflect and act on the conclusions in my report, and that they update me on the main findings and plans of the audit they are carrying out into after-discharge support, which I very much welcome.

Ombudsman's Commentary

OCTOBER 2009 REPORTS

case summaries

Health

Consent; clinical treatment

Greater Glasgow and Clyde
NHS Board (200802430)

Ms A had surgery at a hospital's Department of Urogynaecology. She complained, through an advice caseworker, that she subsequently suffered incontinence, urinary infections, loss of lower body sensation, vaginal discharge and severe pain. The Board were of the view that similar problems existed before surgery. When my medical advisers reviewed the case, they had some concerns about the way in which Ms A's case was handled and the information provided to her, including the information she was given before she gave consent for surgery. I upheld Ms A's complaints that proper informed consent was not obtained prior to surgery and that afterwards staff failed to take prompt action to establish the cause of the ongoing symptoms she was experiencing. I recommended that the Board review their consent process to ensure that patients have time to absorb the relevant information and that the consent forms list the main issues discussed. I also recommended that they apologise to Ms A for the failings identified in the report. I did not uphold her complaint that the clinical treatment provided was inadequate, but I did recommend that the Board share this report with the staff involved and ask them to reflect on my medical advisers' comments about

considering alternative procedures in similar cases before surgery.

Care of the elderly; staff attitude; complaint handling

Lothian NHS Board (200703108)

Mr C raised several concerns about the care and treatment that his late mother, Mrs A, received in hospital. While on the ward, Mrs A was moved from the main ward to a smaller room which Mr C did not feel was suitable. He and his family were also unhappy with the way in which the Board dealt with their complaint. In dealing with the complaints, the Board introduced an Action Plan setting out all the actions to be taken to address the issues that Mr C raised, which aims to avoid the recurrence of similar incidents and to improve record-keeping and communication with patients, relatives and their carers. During the investigation of the complaint, we also facilitated a meeting between Mr C and his sister and members of the Board. Ultimately, I upheld Mr C's complaints that the family were given conflicting reasons for the move, that the room was too hot and that staff used inappropriate language to describe Mrs A in their notes. I did not uphold complaints about the attitude of nursing staff or that conditions in the room contributed to Mrs A's decline. I partially upheld Mr C's concerns about complaint handling, while noting that the Board had already taken steps to address this. I recommended that the Board apologise in writing to Mr C and his family for the failings identified and that they

audit and update their Action Plan and share the findings with me.

Local Government

Education: Supervision; policy/administration

North Lanarkshire Council
(200800888 and 200800890)

Mr and Mrs C and Mr and Mrs D (the complainants) raised a number of concerns about events on a trip to France that their daughters, Miss C and Miss D, attended, arranged by their secondary school. These were investigated by the school and the Council, but the complainants remained dissatisfied. I upheld their complaint that planning and management of the trip was inadequate, as some relevant matters (including setting ground rules for expected conduct) were not discussed with parents beforehand and not all parents were made aware in advance of changes to accommodation. I also found that the staffing ratio appeared to lead to some pupils feeling inadequately supervised. I did, however, note that the Council clearly learned lessons from this and have revised their in-house guidance on such visits. The draft guidance addresses most of the issues of concern, and so I recommended that the Council ensure that this is finalised urgently, that it contains guidance on agreeing and setting ground rules with parents in advance of a trip and that they consider how they can improve procedures for notifying parents of arrangement changes.

Ombudsman's Commentary

OCTOBER 2009 REPORTS

case summaries

Local Government

I partially upheld the complainants' concerns about the investigation into their complaints, firstly because female pupils were interviewed by a male teacher as part of the investigation into events on the trip, when it would have been appropriate for this to be done by a female teacher. The Council also failed to keep the parents informed of the progress of the investigation. I recommended that the Council apologise to them for this and ensure that they take steps to ensure that complainants are in future kept informed. I could make no finding on the complaint that the students were not offered counselling, as there was insufficient evidence about this.

Education: Policy/administration; complaint handling

Comhairle nan Eilean Siar
(200701741)

Mr C's son, Child A, was being home-educated, and Mr C asked the Council if they could arrange access to formal exams. After discussion, it was agreed Child A could attend specific classes at the nearest school so that he could sit exams in those subjects at the end of the school year. Child A attended school but teaching staff objected and he was sent home. Mr C complained to the Council and was unhappy with the delay in their response and the response itself. When investigating the complaint, I found that the

information the Council provided was incomplete, lacked evidential backing and was contradictory. I upheld Mr C's complaints in their entirety. I found that the Council failed to honour a commitment to admit Child A to a class, acted unreasonably in refusing to consider enrolling him in individual classes and handled Mr C's complaint inadequately. In saying this I noted my concerns about complaint handling within this Council, which has already been the subject of several reports in which we have made significant criticisms of their complaint handling. I recommended that the Council apologise to Mr C and Child A separately and in full for the failings; put in place policy and guidance to handle future requests for support for home educated children, after consulting appropriately, and that over the coming year they undertake a significant audit of their complaints handling processes and procedures, reporting the results to me at quarterly intervals. I further recommended that they remind staff of the need to ensure that statements about Council decisions, and likewise that the Council's investigation of complaints and responses to me, are evidence based. Finally, in view of these findings, I am requesting an urgent meeting with the Chief Executive and Leader of the Council to discuss my concerns and seek reassurance about the implementation of my recommendations.

Further and Higher Education

Supervision; policy/administration; complaint handling

Glasgow Caledonian University
(200602310)

Mr C raised a number of concerns about how his daughter, Ms C, was treated by her Practice Teacher while on placement for her University course, and how the University acted when considering his complaint about this. I did not uphold the majority of Mr C's complaints as I found that generally the Practice Teacher and University had acted reasonably in the circumstances. I did partially uphold Mr C's complaint that the University failed to handle his complaint in line with their procedures, to the extent that as an allegation of bullying had been made the University should have considered Mr C's complaint under their specific policy for such matters. They should have offered advice about this and about the support available to a student who alleged they had been bullied. I therefore recommended that the University consider reviewing their complaints procedure to take into account complaints involving such allegations, to ensure they are considered under the correct policy in future.

Ombudsman's Commentary

OCTOBER 2009 REPORTS

case summaries

Further and Higher Education

Supervision; communication; complaint handling

Queen Margaret University
(200801939)

Mr C, a PhD student at the University, raised concerns that his Director of Studies had claimed that Mr C had been made aware that his supervisory team had doubts about the quality of his work following a meeting he had with them in May 2005. Mr C had a different recollection of the meeting and said that he was not made aware of any concerns. He was also unhappy that the Director of Studies had made allegations of research misconduct. Mr C said that he only became aware of these issues later, when he saw a letter written by the Director of Studies to a third party. He also had concerns about the way the University handled the subsequent investigation into his complaint.

I upheld the complaint about the claim that Mr C had been made aware of his supervisory team's concerns as there was no evidence that the University took action under their existing procedures to ensure that Mr C was adequately made aware of these concerns. I recommended that the University apologise to Mr C for this failure; reinforce with supervisory staff the importance of properly handling such concerns under their current procedures, and ensure that supervisory staff are fully aware of the University's new Code of

Practice when it is published. I did not uphold Mr C's complaints about the allegation of research misconduct or about complaints handling. I did, however, make a general recommendation that the University reinforce to all staff involved in responding to student complaints the importance of providing a full response and, in particular, that the response includes details of any evidence considered during their investigation.

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
21 October 2009

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

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

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

Contact us at:

SPSO	Tel: 0800 377 7330
4 Melville Street	Fax: 0800 377 7331
Edinburgh EH3 7NS	Text: 0790 049 4372

E-mail us at: **ask@spsso.org.uk**