Ombudsman's **Commentary**

SEPTEMBER 2010 REPORTS

The SPSO laid four investigation reports before the Scottish Parliament today. Two relate to the health sector and two to the local government sector.

Ombudsman's Overview

As we detailed in our August Commentary, to use our resources as efficiently as possible and to maximise our impact, we have developed new criteria for deciding which cases should end with a report being laid before the Scottish Parliament. We only lay a report before the Parliament if we consider that the matter is in the public interest. This can include: significant personal injustice complaints; systemic failure cases; precedent and test cases; and cases where there has been significant failure in the local complaints procedure.

Our laid investigation reports become public documents, and can be published in full. Each investigation may contain several complaints, and overall the four reports laid today:

- **Upheld 5 complaints**
- **Did not uphold 2 complaints**
- **Made 16 recommendations**

Our laid investigation reports form only one part of our work. A large proportion of the complaints we receive are handled at the detailed consideration stage of our process. This usually ends with us sending our findings and conclusions to the complainant and the organisation complained about in what we call a **decision letter**. As with investigation reports, we may make recommendations in decision letters.

In August, in addition to the investigation reports laid before the Parliament, we determined 335 complaints. Of these, 84 were suitable for the SPSO to look at. We were able to resolve 62 of them quickly and 22 required detailed consideration. In August we made a total of 14 recommendations in decision letters, and some of these are listed below at the end of this Commentary.

Ombudsman's comment

In one of the investigations laid today, I take the unusual step of making a comment within the report itself. I quote it in full here in order to draw attention to my findings and to underline their significance for all Health Boards. In report 200902396, I say:

'It is important that this case and my conclusions on it are correctly understood. There is no dispute about the facts of the case. In a nutshell, a distressed woman was injected with antipsychotic drugs by hospital staff against her will. There is no documentation to show that this action was properly assessed in advance, or properly recorded after the event.

In upholding the complaint, however, I wish to make clear that the complaint was not about restraint, but about consent. I accept that there are times when restraint is justified. What is unacceptable is for health practitioners not to show proper understanding of the legislation and policies that exist to ensure that patients' human rights are not breached. I believe that in this case they were. Staff must also be made aware of the vital importance of recording the reasons for taking action to restrain or inject despite a patient's clear protestations.

As well as patients' rights, I am concerned about the rights of health practitioners. The legislation and policies should act as a safeguard for them. Health Boards have a duty to provide staff with the right information and training that will enable staff, when difficult situations arise, to make the right split second decisions. Health professionals working in stressful situations need to be well equipped and supported. My recommendations are intended to ensure that in future staff will have the right information and training. For the sake of patients and health practitioners, lessons from this disturbing incident must be learned not only across the Board concerned but across the NHS in Scotland.'

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Consultation Update

Our Consultation on a Statement of Complaints Handling Principles and Guidance on a Model Complaints Handling Procedure (CHP) closed on 8 September. In total we received 91 responses to the consultation with a wide spread across the various sectors as well as from a number of individuals and bodies representing service users. We are pleased with this healthy number and range of responses.

Responses

The responses varied in the level of their detail and support but the majority of respondents backed both the Principles and the Guidance on model CHPs. On the Principles, we received a number of useful suggestions for amendments or additions but on the whole respondents recognised our Principles as a good basis for complaints handling. On the model CHP Guidance the majority of comments (not unexpectedly) related to our proposal to move towards a two-stage internal procedure for all sectors. Several sectors had concerns or questions about removing stages of review or appeal with some outlining what they felt were specific circumstances in their sector's handling of complaints which could make this difficult. Others felt that further clarity was required before implementation on the detail of what we are proposing at frontline and investigation stages and concerns were raised around training, systems and other aspects of implementation.

The majority of responses were from local authorities, which reflects the fact that we have identified that sector as a priority for the work of the Complaints Standards Authority. These responses, along with the feedback from our engagement at our June council liaison conference, will form a good basis for our discussions with key representatives of the local authority sector over the next few months.

Next steps

We are analysing the comments received with the aim of preparing a summary and an SPSO response. All responses will be published on our Valuing Complaints website (assuming we have the respondents' permission). We will also prepare a revised set of Principles to be submitted to the Parliament for approval in October. Following discussion by the Parliament (through committees and in the chamber) we hope to have parliamentary approval by December.

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case reports

Health

Care of the elderly; record-keeping; consent

Grampian NHS Board (200902396)

Mrs C was admitted to hospital after collapsing. The next day, she was very agitated and confused. Nurses were unable to give intravenous antibiotics because Mrs C refused them, and she was given two doses of haloperidol (an antipsychotic drug) by intramuscular injection. Mrs C's representative complained on her behalf that this was done against her will, pointing out that Mrs C has a needle phobia and so found this treatment particularly disturbing. I found that, given her confused state, it seemed that there was concern on the part of medical staff about Mrs C's ability to make such decisions about her treatment. However, there was no documentary evidence to show how they decided what to do, or that they actually reached a decision that she was not competent to refuse treatment, as documentation required by the Adults with Incapacity legislation was not completed. Nor was there evidence that the team considered trying to obtain consent for the treatment, or that they took recent guidance from the Board into account. The Board also failed to provide Mrs C with a satisfactory explanation when she complained. I upheld her complaint and made a number of significant recommendations, including peer review of the hospital's practices in managing assessment, treatment and care of people with confusion; the use of Adults with Incapacity legislation and of restraint; how they train staff about such matters; and that they tell me the outcome of the review. I also recommended that they remind staff of the need to properly and accurately complete written records, and that they tell the staff involved in treating Mrs C about my findings. Finally I recommended that the Board apologise to Mrs C for the failings identified in my report.

Diagnosis; policy/administration; clinical treatment

Lothian NHS Board (200901459)

Ms C injured her knee in a fall and attended the Accident and Emergency (A&E) unit at one of the Board's hospitals. She was initially diagnosed with a soft tissue injury, but after further investigation was later found to have suffered a fracture. She complained that the diagnosis of her injury was not reasonable, and that the care provided was inadequate. Although it was clearly a difficult injury to diagnose, I upheld both complaints. I found that the clinician failed to fully assess the injury as they did not follow accepted guidance (the 'Ottowa knee decision rules'); that no pain scoring assessment was made and that adequate pain relief was not provided. I recommended that the Board give consideration to implementing the relevant rules when assessing A&E patients, and apologise for the shortcomings in the care provided. I also recommended that they review or create pain management guidelines and ensure that all A&E staff are aware of these.

Local Government

Recreation/leisure: complaints handling; policy/administration

Dumfries and Galloway Council (200901153)

Mr C was banned from using a Council leisure facility after becoming involved in an incident with another user, their child and Mr C's child. Mr C believed that the ban was unfair, saying that he intervened only to protect his child. He asked the Council to investigate the decision, but then complained to me that they failed to do so properly and that their child protection measures were inadequate. I upheld the complaint about the Council's investigation as I found that they failed to follow their own procedures, including failing to keep notes at important points, and telling council staff about the findings before the investigation was completed. They also took eight months to reach their findings, by which time the ban Mr C had complained about was almost over. I recommended that the Council act to ensure that future investigations are properly and efficiently conducted, with due regard to confidentiality, and that they remind staff that non-adherence to good practice guidance is unacceptable. I further recommended that they apologise to Mr C for the lengths to which he had to go to pursue his complaint. I did not uphold Mr C's other complaint in which he alleged that the Council failed to satisfy themselves that they had adequate child protection measures in place.

Housing: statutory repairs notices

The City of Edinburgh Council (200903096)

Mr C is the owner of a tenement flat in a building that had roof defects. Eventually the Council became involved and served statutory notices on owners to have remedial work carried out. Mr C raised concerns about the Council and their agents in respect of both the statutory notices and the financial advice and assistance he received. I upheld his complaint that they acted inconsistently with regard to apportioning costs for the work, as I found that the agents made an error by issuing invoices based on an incorrect list of owners. This had financial consequences for Mr C. I also found that the Council had acted inconsistently in respect of their own position (as potential owners of properties that might be similarly affected in other cases). I recommended that the Council address the issue of the invoices issued by the agents, and that they reimburse Mr C for any additional costs incurred as a result of the error. I also recommended that the Council consider whether it is appropriate for them to seek recovery of the costs of works on the basis of title and, if they do, that they tell Mr C about this so that he may seek legal advice on his own options. I did not uphold the complaint about the advice provided.

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Recommendations made in decision letters in August 2010

Recommendations to Councils

- As a planning authority, in conjunction with the Assessor, consider their approach to uses in former agricultural buildings formerly exempt from non domestic rates
- Explore further the allegations of unauthorised activity in respect of the use of buildings and their immediate environs for vehicle repair and reconstruction and another building for the storage, servicing and repair of domestic appliances and, contingent on their findings, report to the appropriate committee
- Apologise to a complainant for the shortcomings identified in a council tax dispute
- Make a monetary payment to a complainant of an amount equivalent to that charged by his solicitors for the initial consultation on his council tax dispute
- Review their performance with regard to a council tax dispute and their procedures for responding to correspondence to ensure that responses are sent in accordance with their response targets
- Remind relevant staff that they should follow the relevant procedures for handling complaints
- Apologise for the failings identified in complaints handling.

Recommendations to Health Boards

- Ensure all staff are aware of their professional responsibilities when completing or amending clinical records and that all changes are signed and dated; after three months, an audit of this to be completed
- Take steps to ensure that the NHS Scotland deadline for treatment of cancers of 62 days from GP referral is adhered to
- Write directly to a complainant to apologise for the circumstances on the day of his mother's death
- Take steps to ensure that the SIGN guidelines are correctly followed when investigating post menopausal bleeding
- Acknowledge and apologise in writing to a complainant that there was no evidence of reasonable consideration or investigation of the cause of the diarrhoea her mother was suffering
- Produce and implement a guide for investigating diarrhoea in patients that includes checking the medication list
- Apologise for failing to respond to a complaint in writing within the timescales detailed in the complaints procedure.

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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.

Jim Martin, Ombudsman
22 September 2010

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

For further information please contact:

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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.spso.org.uk**

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