

# Ombudsman's Commentary

## AUGUST 2011 REPORTS

The SPSO laid three investigation reports before the Scottish Parliament today, all about health boards. We also laid a report about 58 decisions covering all the sectors under our jurisdiction. You can read these online in the 'Our findings' section of our website.

### Case numbers

Last month (in July) in addition to the five full reports laid before the Parliament we determined 315 complaints and handled 47 enquiries. Taking complaints alone, we:

- > gave advice on 195 complaints
- > resolved 98 in our early resolution team
- > resolved 22 by detailed consideration
- > made a total of 17 recommendations in decision letters.

### Ombudsman's Overview

#### Complaints processes failing the public

We are posting our statistics for the financial year 2010–11 today. These can be found on the statistics section of our website. My key message from these figures is to service providers about the quality of their service provision and their complaints handling procedures.

I am very concerned about the high number of cases that we are upholding. Of all the complaints that were valid for SPSO in 2010–11, we upheld or partly upheld 34%. To put this another way, in over a third of cases that had already been investigated by the local service provider – through multiple, often lengthy stages of review and appeal – that provider had got something wrong.

**This scale of upheld complaints is unacceptable and demonstrates that public bodies need to have better processes and policies and a better culture of valuing complaints to support staff in making the right decision first time round.**

The public deserve services that are run by bodies that are responsive and that sort out problems at the first opportunity. The hundreds of cases I see where councils, health boards and other bodies have got something wrong or handled a complaint poorly underline the importance of the Complaints Standards Authority (CSA) we are developing. The CSA's role is to streamline and standardise complaints handling procedures and encourage good complaints handling. Evidently, it is a much needed agency for change.

### Water complaints

We took on responsibility for complaints about water and sewage providers from 15 August 2011 when Waterwatch Scotland closed. This change resulted from the Public Services Reform (Scotland) Act 2010 which

transferred the complaints handling function of Waterwatch to the SPSO. The customer representation function of Waterwatch transferred to Consumer Focus Scotland.

We worked closely with the Government, Waterwatch, Consumer Focus Scotland, Scottish Water and the Water Industry Commissioner for Scotland to prepare for this transfer. As well as Scottish Water complaints transferring to SPSO, the legislation gave license providers the option to have SPSO as their final complaints stage and three elected to do so – Business Stream, Aimeria and Wessex Water.

The Government has estimated that the transfer of Waterwatch's combined functions to the SPSO and Consumer Focus Scotland will, following a transitional period, result in annual savings of over £300K on an ongoing basis.

### Complaints Standards Authority update

The work of our CSA team on standardising complaints handling procedures (CHPs) continues to move forward. We are taking a phased approach to developing a model CHP for each sector, with local government and housing our immediate priority. Working with the Society of Local Authority Chief Executives and the Convention of Scottish Local Authorities we have established a working group of local authority representatives to develop a model CHP for that sector in line with the framework of the SPSO's complaints handling principles and guidance.

There was further discussion on this work at our annual Council Liaison Officer conference which took place in early August. Delegates from councils across Scotland heard from a variety of speakers including from a council which has implemented the SPSO two-stage model with resounding success and from the General Manager of Customer Service at Scottish Water. Delegates also participated in workshops designed to identify what councils need and how SPSO can support them and others in three key areas – complaints handling training (especially of frontline staff), guidance materials and supporting the establishment of networks of best practice within each sector. On training, we would like to play a supporting and coordinating role and are looking at providing a range of options and materials. We are grateful to the delegates for their enthusiastic participation and look forward to progressing these areas with them.

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On housing we are meeting key high level stakeholders to discuss a similar approach to developing a model CHP for Registered Social Landlords (RSLs). The stakeholders include the Scottish Housing Regulator, the Scottish Federation of Housing Associations, the Chartered Institute for Housing, the Scottish Housing Best Value Network and tenants groups. Next month, we will issue a survey to tenants, housing associations and management committees on future complaints handling. We have also contributed to the emerging Scottish Government proposals on the Scottish Social Housing Charter, which will be central to the future development and monitoring of complaints handling with RSLs.

Further engagement with other sectors will be taken forward over the coming months. Details will follow in due course. In the meantime you can contact our CSA team at [CSA@spsos.org.uk](mailto:CSA@spsos.org.uk) if you would like more information. SPSO complaints handling principles and guidance can be found at [www.valuingcomplaints.org.uk](http://www.valuingcomplaints.org.uk)

### Investigation report findings

Two of the cases this month concern suicides. While there is some similarity in the devastating impact on the families of the individuals, the circumstances and the causes of the complaints are entirely different and require different responses from the Boards concerned.

The first complaint I will describe here (Ref: 200800448) is from the parents of a child who took his own life. Mr and Mrs C complained about the treatment and management of medical care provided to their son by the Board's Child and Family Mental Health Service (CAMHS) and also about the subsequent failure of the Board to provide adequate services for the treatment of his mental health. The events go back to 2000 and I commend Mr and Mrs C for their perseverance in seeking answers to their questions.

In the report's conclusion I state:

*'The Board commissioned three reviews by an independent clinical consultant in adult and child psychiatry in an attempt to address the complaints and ongoing concerns of Mr and Mrs C. It is evident that the reports produced identified a number of failures relating to the care and management of Master C. These related to record-keeping, communication, a lack of cohesive working, insufficient information communicated to relevant parties relating to Master C's referral and a failure to make a definitive diagnosis of Master C. Fundamentally the report acknowledged that these failures were accepted practice during the time of Master C's involvement with CAMHS and the Board...'*

*'...Whilst these concerns have now been addressed, and the Board's representative has acknowledged the closure of the waiting list was wrong, has been banned, and will never occur again, this admission is much too late in the*

*day for Master C and his family. I anticipate that Mr and Mrs C will continue to seek answers to the failures identified in this report, but given the passage of time it is doubtful these questions will ever be fully answered. I commend Mr and Mrs C for their perseverance.'*

My report makes clear that there were systemic failures, and that it is evident that the service failure was a result of poor policy and practice. I recognise however, that the Board, as a consequence of this complaint, demonstrated by the evidence presented to this office detailing improvements to CAMHS since 2001, have undertaken action to remedy the service failures identified in order to improve current services.

In the second case I describe (Ref: 201001620), Mr C complained that the Board failed to provide appropriate mental health care for a woman, Mrs A, during a period when she was also physically unwell. Mrs A had a history of depressive illness and had been taking anti-depressant medicine for 30 years.

Although I did not find that surgery carried out on Mrs A was inappropriate, I upheld a number of complaints about the way the Board handled Mrs A's health issues. I found that they did not take a holistic view of Mrs A's situation and did not discuss her psychiatric needs before or after her bowel cancer operation. I found that Mrs A was sent home after cancer surgery without reasonable instructions about aftercare and that this led to further problems for her. I found that she was able to self-harm while in two hospitals, one of which was a facility specifically for the treatment of patients with psychiatric problems. I was particularly concerned that Mrs A, who eventually did commit suicide after leaving hospital, was able to self-harm several times while under the Board's care. I made a number of recommendations to the Board including actions they could take where patients have expressed thoughts of suicide, an apology to Mr C, and ways of improving record-keeping and procedures.

The third complaint laid today (Ref: 201002030) is about the care and treatment of a woman who underwent surgery for an inguinal hernia. Miss C raised concerns about delays to Mrs A's operation, which she felt could have been avoided, and raised complaints about the service that Mrs A received when she was in hospital. I upheld the complaints that Mrs A's operation was unnecessarily delayed and that her special medical requirements were not made known to ward staff prior to her admission to the ward. I also found that food service on the ward was poor and that the Board discharged Mrs A without ensuring that she had access to adequate support outwith the hospital. I did not uphold complaints about cleanliness and staff hygiene practices in the ward nor about the Board's complaint handling. I made a number of recommendations to address the failings identified.

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### Health

#### Mental health, care and treatment

Dumfries and Galloway NHS Board  
(201001620)

Mr C complained about the care and treatment provided to his late sister-in-law, Mrs A, while she was in the Board's care. He said that the Board failed to provide appropriate mental health care for Mrs A during a period when she was physically unwell. Mr C told us that Mrs A had a history of depressive illness and had been taking anti-depressant medicine for 30 years.

When Mrs A was diagnosed with bowel cancer and required an operation, she stopped taking the medicine. Mr C thought this was because doctors had told her to, but I found that in fact Mrs A had decided to stop taking it because she knew that she should not do so before receiving anaesthetic. However, I upheld his complaint as I found that the Board did not take a holistic view of Mrs A's situation and did not discuss her psychiatric needs before or after her operation.

Mr C also expressed concern that keyhole surgery carried out on Mrs A was inappropriate, but my medical adviser said that it was reasonable in the circumstances. I did, however, make a number of recommendations, which can be read in full in my report, as my investigation revealed other concerns about the way in which the Board handled Mrs A's health issues. I upheld Mr C's complaint that Mrs A was sent home after cancer surgery without reasonable instructions about aftercare and that this led to further problems for her. I found that Mrs A was able to self-harm while in two hospitals, one of which was a facility specifically for the treatment of patients with psychiatric problems. I was particularly concerned that Mrs A, who eventually did commit suicide after leaving hospital, was able to self-harm several times while under the Board's care. Among other things, I asked the

Board to carry out, fully record and act on risk assessments where patients have expressed thoughts of suicide, to apologise to Mr C for a number of failings identified in my report and to improve record-keeping and procedures.

#### Mental health, care and treatment

Lothian NHS Board (200800448)

Mr and Mrs C complained to the Board about the care and treatment provided to their late son (Master C) by the Board's Child and Family Mental Health Service (CAMHS) whilst he was a patient during 2000 and 2001. Mr and Mrs C also complained about the subsequent failure of the Board to provide adequate services for the treatment of his mental health in 2001.

Mr and Mrs C complained to the Board after the death of their son in January 2006. Mr and Mrs C believed that following Master C's discharge in July 2001 they were left without adequate support services following the closure of the CAMHS patient list to anything other than emergency cases. When Master C's GP re-referred him in November 2001 he was advised the waiting list was closed to all but emergency referrals, despite Mr and Mrs C believing that Master C was not a new referral but remained a patient at that time. Mr and Mrs C claim that they were not previously told that Master C had been formally discharged from the service. They said that during discussions with one of the Board's consultants in July 2001, Master C had been conditionally discharged from the service with the provision that should his behaviours change, he could re-access it.

My office considered the case in 2009 and decided that there was insufficient evidence to establish a causal link between the Board's decision to close the waiting list to CAMHS and Master C's death. Mr and Mrs C, however, continued to correspond with the Board and provided me with new and

material evidence which led me to take the decision to re-open and investigate their complaint.

I was satisfied that there was confusion around the administration of the discharge process, which led Mr and Mrs C to believe that they would have access to treatment for Master C. Mr and Mrs C complained that their son was rejected by the medical services at a crucial time and that there was a link between this rejection and Master A's suicide. The advice I received agreed with that view. I found that there were failures in communication, record-keeping and cohesive working, and a failure to make a definitive diagnosis at that time. I am satisfied that these factors demonstrate systemic failures by the Board, and that these were the result of poor policy and practice. The extent of these failures can be read in my report.

I was, however, satisfied that the Board, as a result of this complaint, have sought to learn lessons from it. They have also provided me with evidence that they have taken action to remedy the service failures and have taken steps to improve current services. I have however, recommended that the Board provide evidence that their patient discharge process for CAMHS is clear and robust and available to patients, parents and carers; and that they ensure that their complaints policy reflects a clear process with a structured, timely approach to gathering information from key personnel involved in the complaint. I also noted and commended the perseverance that Mr and Mrs C have shown in pursuing their complaint.

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case reports

## Health

### Assessment for surgery, communication, hospital discharge

Lothian NHS Board (201002030)

Mrs A, an elderly lady who has difficulty in communicating due to hearing difficulties, had surgery as an in-patient for an inguinal hernia. Her friend, Miss C, raised concerns on Mrs A's behalf. She said that there were delays in carrying out Mrs A's operation, which Miss C felt could have been avoided. She also complained about the service that Mrs A received from the Board when she was in hospital. She said that Mrs A's particular medical requirements were not passed on to staff on the ward, that food service was poor and that Mrs A was discharged without the Board ensuring that she had adequate support at home.

I found that there was delay in carrying out the operation because a holistic view of Mrs A's suitability for surgery was not taken. She was initially put forward for day surgery, when it was clearly appropriate to have considered whether she should have in fact been placed on the list for admission as an in-patient. The consultant and my medical adviser shared the view that her age and other medical conditions meant she was more suitable to be an in-patient and these medical conditions also meant it was important that staff in the receiving ward understood and catered for Mrs A's needs. I upheld all these complaints and made a number of recommendations as a result, including sharing my report with the staff involved, reviewing procedures, improving record-keeping and providing training to staff on nutrition, communication and record keeping.

I did not uphold Miss C's complaints about cleanliness and staff hygiene practices, or about complaint handling, as I found no evidence to suggest that these were unreasonable in the circumstances.

## 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, 24 August 2011**

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

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# Ombudsman's Commentary



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 for handling complaints about councils, housing associations, the National Health Service, prisons, the Scottish Government and its agencies and departments, the Scottish Parliamentary Corporate Body, water and sewage providers, 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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