

May 2012

The SPSO laid three investigation reports before the Scottish Parliament today, two about health boards, and one about local government. We also laid a report on 87 decisions about all the sectors under our remit. All of the reports can be read on the 'Our findings' section of our website at www.spsso.org.uk/our-findings.

Case numbers

Last month (in April) in addition to the six full reports we laid before Parliament, we determined 338 complaints and handled 47 enquiries. Taking complaints alone, we

- gave advice on 232 complaints
- resolved 70 in our early resolution team
- resolved 36 by detailed consideration
- made a total of 40 recommendations in decision letters.

This month we published 23 decisions about local government cases that we held over from last month. This was because the Scottish local government elections were held on 3 May 2012 and we published the Ombudsman's April Commentary just a week before. (We follow Scottish Government guidelines on publishing before elections.)

Ombudsman's Overview

Reports

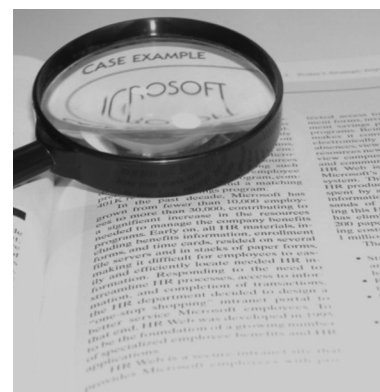
This month I report in detail on three investigations, two about health boards and one about local government.

Yet again, the health cases make distressing reading. In both, a bereaved family member complained to me about the care and treatment of a relative, and in both I found that the care provided to the patient in their last hours was inadequate. In one case, an elderly woman died in hospital without any of her family at her bedside, although she had a large and loving family who would have wanted to be there. The evidence I found also showed that she did not receive the end of life care that both she and her family were entitled to expect. My medical adviser was particularly concerned about the failings that my report identified, and made significant comments about these. I recommended that the board carry out a significant events review of what happened, as well as taking on board my adviser's comments and taking action to address the failings.

The second health case was about a man who died in hospital after suffering seizures for which he was normally prescribed medication. Although his wife had taken his anti-seizure medication to the hospital when he was admitted, staff did not give it to him due to an oversight. In this case I found that there were several systemic failures in administering the prescribed medication, and also that there were significant delays in getting medical attention for him the night before he died. This I attributed directly to poor management of staffing by the board, as there were clearly not enough doctors available to deal with demand. The patient suffered unnecessarily during his last hours, causing additional distress to him and his family. Again, I made a number of recommendations to the board about this, including feeding back the learning from the complaint to all the staff concerned and reviewing and improving procedures.

In the local government case, a council committee decided to change the status of an area that was originally considered unsuitable for limited housing development. In doing so, they went against the advice of their planning officers, who had given the elected members on the committee clear information about the process they should go through in these circumstances. The committee were, of course, entitled to make their own decision on the merits of the situation, but there were failings in the way they went about it. I, therefore, upheld complaints about the way in which the committee assessed the criteria relating to that decision, and that they did not, as required, justify their decision at the outset. I recommended that the council review the way in which the case was handled, to ensure confidence in public administration and the planning system in future.

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This month's findings

**Care of the elderly;
communication;
nursing care;
record-keeping**

Greater Glasgow and Clyde
NHS Board – Acute Services
Division (201100402)

**Nursing care; clinical
treatment; policy and
administration**

Ayrshire and Arran NHS
Board (201100469)

**Planning; policy and
administration;
complaints handling**

Dumfries and Galloway
Council (201003487)

Ombudsman's Commentary

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Complaints Standards Authority (CSA) Update

Model complaints handling procedures (CHPs) published

Local Authorities and Registered Social Landlords (RSLs)

The CSA unit have attended a range of events to publicise the model CHPs and the requirements on local authorities and RSLs to adopt the CHPs in the coming months. We are pleased to report that a number of local authorities and RSLs are moving towards implementing the model CHPs, with several expected to introduce these in June this year.

As we have previously outlined, local authority compliance will be monitored by Audit Scotland (in conjunction with SPSO) as part of their existing annual audit process in 2012/13. RSL compliance will be monitored by the Scottish Housing Regulator within the developing framework for assessing the Scottish Social Housing Charter, which will be consulted on over the summer. Monitoring of performance will also be developed and built into existing arrangements including self-assessment. As part of this, for housing, we plan to have discussions with the Chartered Institute for Housing, the Scottish Housing Best Value Network and Housemark on the recently re-published toolkit for measuring Charter performance. Development of all these arrangements, including further development of the SPSO's suggested high level performance indicators, will be taken forward through the development of sectoral networks of complaints handlers.

Other sectors

We are continuing to work with representatives from further and higher education to discuss plans for developing a model CHP for each of

these sectors, with drafts now developed and under discussion for both. Further information will be available shortly through our Valuing Complaints website.

Valuing Complaints website

In the coming weeks, we will launch our re-designed website: www.valuingcomplaints.org.uk. As well as information about the model CHPs and CSA guidance and best practice, the site will host a new community forum which aims to generate online discussion amongst complaints handlers from all sectors. This will help us achieve the aims of the Sinclair report to develop a cross-sector network of complaint handlers to help share best practice in complaints handling. Further details on how to register for the forum will be available shortly.

E-learning training

Our e-learning training for local authority frontline staff goes live this week. You can find this at our learning portal www.spsotraining.org.uk. Learning modules can also be accessed through a link on the Valuing Complaints website. We aim to provide this training free of charge, but we will review demand after the initial phase, to assess whether we can maintain that commitment.

Although this training is aimed at supporting local authority staff involved in frontline resolution, much of it is also suitable for staff elsewhere. Specific training programmes for housing and other sectors are scheduled to follow. For further information about SPSO training, contact our training coordinator Kerry Barker at kbarker@spsos.org.uk.

For further information about the work of the CSA, contact the CSA team at CSA@spsos.org.uk.

Councillors' Guide

We will shortly be publishing our *Guide to the SPSO* for councillors. The Guide explains our role and remit, and provides information about our service as well as advice and support in complaints handling. We are keen to engage with elected members to ensure that they are aware of our service and of what we can, and cannot, do for members of the public. We also want to draw attention to the new requirements on councils to put in place the SPSO's model complaints handling procedure, which we have developed in consultation with local authority partners.

You can find the Guide online at <http://www.spsos.org.uk/media-centre/news-releases/spsos-new-guide-for-councillors>. If you want a paper copy please call our freephone number 0800 377 7330.

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Case Summaries

Health

Care of the elderly; communication; nursing care; record-keeping

Greater Glasgow and Clyde NHS Board – Acute Services Division (201100402)

Mrs A, who was 86, had for some years had an aortic aneurysm (a weakened and bulging area in a vein or artery) that could not be operated on. When Mrs A was admitted to hospital suffering from severe pain, staff told her daughter (Mrs C) that they thought the aneurysm was leaking and that they would not be able to do anything about it. Mrs C was advised to contact other family members and for the next few days they took it in turns to visit Mrs A in hospital. Mrs C and her family were under the impression that Mrs A was getting better, but she died suddenly, four days after being admitted, with no members of her family with her. Mrs C raised concerns about the nursing care provided to Mrs A. She said that when Mrs A was moved from a single room to a normal ward, the family took this as a sign that Mrs A was improving. When she was then moved back to a single room, they were told only that this was because staff had learned that some years earlier Mrs A had contracted MRSA (an infection that does not respond to some commonly used antibiotics) and it was the board's policy to nurse such patients separately. Mrs C told us that she lives only ten minutes away from the hospital, yet when staff contacted her to say that Mrs A was really ill, her mother had died by the time she arrived there. She also said that on the day Mrs A died a doctor was rude and insensitive.

Mrs C felt that, generally, staff did not communicate well with the family. She said that this meant that her mother's many relatives were unprepared for Mrs A's death. They were a close and loving family, and found it particularly distressing that Mrs A died without any family members beside her. In responding to Mrs C's complaint, the board took the view that staff had made Mrs A's family aware both of her condition, and that Mrs A was at significant risk of dying. They apologised, however, for a number of identified failures, that included the added upset caused to Mrs C around the time of Mrs A's death. They also said that Mrs A had been moved from the single room at her own request and apologised for a delay in providing MRSA screening information.

In investigating this case, I took advice from my nursing adviser. She said that the nursing documentation, including about Mrs A's assessment, care planning and care given, was poor. She pointed out that, on balance, it appeared that nursing staff did not take the needs of the family into account by allowing them access to Mrs A at the end of her life. She also said there was little evidence that Mrs A was provided with the care that could be expected for someone at the end of life and that her family were, therefore, unprepared and distressed when she died. My adviser noted that Mrs A was given a single room as her condition was very poor and she was not expected to survive. She said Mrs A was appropriately moved back there for infection control reasons. However, my adviser noted that the records contain contradicting information about why Mrs A was moved into the normal ward, and did not show that Mrs A asked for the move. She said that there appeared to be a lack of insight into how ill Mrs A was. An important conversation between the consultant surgeon and members of Mrs A's family was not recorded in the notes as it should have been. My adviser said that had this been done, it would have set a good example for other staff to see and follow to ensure that Mrs A and her family received consistent information.

I took account of this advice, and considered that the evidence shows that Mrs A did not receive the end of life care that Mrs C and her family, quite rightly, expected. I upheld the complaint and made a number of recommendations to address the issues identified in my report. As well as apologising to Mrs C, these included that the board conduct a significant events review of what happened in this case, and that they consider my adviser's comments on the failings in Mrs A's end of life nursing care and draw up and implement an action plan to address these.

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Case Summaries

Health

Nursing care; clinical treatment; policy and administration

Ayrshire and Arran NHS Board (201100469)

Mrs C raised a number of concerns about the care and treatment that her late husband (Mr A) received in hospital. She said that although Mr A had a brain tumour, when he went to the hospital his condition was under control. Mr A was referred as an emergency by his GP, for a chest x-ray and because he had a low level of platelets (blood particles vital for blood clotting). Mrs C expected him to receive a platelet transfusion. While Mr A waited to be admitted, he suffered a seizure and was taken to resuscitation. Mrs C said she was told that Mr A would be taken for a scan and if there was no major change in his condition he would be given the platelets. She handed over Mr A's anti-seizure and steroid medication to staff, but they did not give this to him nor did he receive the transfusion. Mr A died two days after being admitted to hospital. Mrs C felt that had it not been for these failures by the board, Mr A might have survived his final episode of seizures. She also told me that the board failed to recognise and address her husband's pain; did not provide him with adequate care and attention on the night before he died, and did not implement the Liverpool Care Pathway (a framework of care for dying patients) until his last day. She described Mr A's treatment as 'barbaric'.

The board agreed that Mr A did not get his anti-seizure medication, and that this was due to an oversight, not a medical decision. They also confirmed that there was a failure to give him steroid medication. They said that they had made the doctors involved aware of these problems, and were piloting a new form to minimise the risk of such omissions in future. They said that, after reviewing Mr A's condition, a consultant had decided that there was no need for a platelet transfusion when Mr A was admitted.

I took advice from one of my medical advisers, who said that management of the acute seizures was initially reasonable and that in his view the platelet transfusion was not needed. However, given Mr A's diagnosis and the likelihood of further fits, doctors should have given much more consideration to providing him with a preventative regime of anti-seizure drugs. My adviser was also critical of the board's use and discontinuation of some of the drugs involved, and said that staff appeared to lack knowledge about a particular drug. He criticised the record-keeping, and said that members of the medical team were responsible for failing to ensure that the required drugs were properly prescribed and administered to Mr A. Having taken his advice on board, I found that there were several systemic failures in administering Mr A's prescribed anti-seizure and steroid medication, and upheld this complaint.

I did not uphold Mrs C's complaints about pain relief and the Liverpool Care Pathway, as I found that the records showed that adequate and reasonable pain relief was provided to Mr A, and that the pathway is a tool that staff can use, rather than something that they must implement. I did, however, recommend that the board review elements of both these issues and feed back the learning to staff in the unit concerned.

Finally, I upheld Mrs C's complaint about the lack of care and attention given to Mr A the night before he died. Mrs C said that for a number of hours medical staff either did not attend or delayed attending to Mr A. The board confirmed that there were difficulties in getting Mr A reviewed by a doctor for about a seven-hour period that night, although they also said that generally they believed Mr A was reviewed properly and at the right times. They said they were taking action with the doctor concerned, and that they did not think the delay in reviewing Mr A would have substantially altered his care.

My medical adviser, however, disagreed with this view, and pointed out that it was the board's responsibility to ensure that a patient at the end of his life received full palliative care. He said that medical assistance was clearly needed and requested during that night, but for too long that help did not arrive. The on-call doctor was alone, although the board had a duty to provide adequate medical cover at all times. This led to Mr A suffering a variety of unpleasant symptoms for longer than was necessary, and caused additional distress to him and his family. My adviser said that the remedial actions taken by the board did not address this problem. Having considered my adviser's comments, I agreed that the board's organisation of medical staffing that night was inadequate/mismanaged, and should not have occurred. I also took the view that the board's explanations about the situation were unacceptable.

I made a number of recommendations to the board, which can be read in full in my report. They included feeding back the learning from Mrs C's complaint to those involved in Mr A's care to avoid recurrence of these distressing events and taking a number of measures to review and improve their procedures.

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Case Summaries

Local Government

Planning: policy and administration; complaints handling

Dumfries and Galloway Council (201003487)

A firm of solicitors brought a complaint to my office on behalf of a number of clients. They were unhappy with the way in which the council decided to include a particular location (Site A) in the list of Small Building Groups (SBGs) suitable for limited housing development. Site A had formerly been considered 'unsuitable'. The council's Local Plan General Policy 16 (GP 16) says that there will be a presumption in favour of small scale housing developments in SBGs identified in Section 3 of the Local Plan (the plan). The plan lists SBGs identified as 'suitable' and 'unsuitable' for development. It also sets out a number of criteria that SBGs must meet in order to be considered 'suitable' for such development, and says that the council will review the lists to see whether there have been any material changes that mean that lists should be amended.

The council's Planning, Housing and Environmental Services Committee (the PHES committee) had agreed to review SBGs, and carried out a public consultation to get views about the existing lists. An initial report from council officers identified which SBGs were 'suitable' and which 'unsuitable', and recommended changing the status of a number of locations. This report showed that Site A had been considered at a local inquiry and dismissed as 'unsuitable'. The relevant Area Regulatory Committee (the Area Committee) considered the report and decided (against the council officers' recommendation) that Site A should be included as 'suitable'. The report made it clear that the committee had to give clear reasons and justification for doing so, but at this point they did not. Over the next eighteen months or so, council officers and the two committees gave a great deal of further consideration to the issues involved. During this process, council officers prepared a number of further reports, all of which said that Site A should remain 'unsuitable'. They also pointed out to the elected members that failure to identify a material change in circumstances and to state reasons for the decision to move groups from the 'unsuitable' to the 'suitable' list made the committee decision susceptible to challenge by judicial review. Ultimately, however, the PHES committee agreed that revised lists of 'suitable' and 'unsuitable' SBGs should be published as supplementary planning guidance, and would constitute a material consideration in assessing future development proposals. These showed Site A as 'suitable', still contrary to the recommendations of council officers. (By this time, the reasons for showing Site A as 'suitable' had been given. These were stated to be because the Area Committee believed that constraints to development had been removed at the site, and they considered this to be a material change.)

The solicitors complained about a number of issues relating to the decision to include Site A. These included that the council did not act in a consistent and fair manner in assessing the criteria for identifying suitable locations, and failed to produce adequate reasoned justification for moving Site A from the 'unsuitable' to the 'suitable' list (and, in doing so, ignored advice in committee reports). The solicitors said that there was no proper basis for the decision to include Site A in the 'suitable' list in the published supplementary planning guidance. They also said that the council failed to adequately handle their complaint about the matter.

I took advice from one of my professional planning advisers. My adviser said that he felt the information that council officers provided to both committees was sufficient. He also noted that officers took the opportunity to introduce further evidence as the review progressed. He noted that one of the reports from council officers was unusually forthright in setting out factors weighing against the committee's preferred position. He said that there was no evidence to support the solicitors' suggestion that officers had not done enough to make councillors aware what was required of them.

My adviser did, however, express concern about the council's decision to list Site A as now 'suitable' for development. In his opinion, the infrastructure issues that the Area Committee considered to be a material change in circumstances for Site A (overhead power lines, water main and access) did not relate to GP 16(a). He said that the infrastructure issues could not be considered relevant, given that GP 16(a) demands reference to four specific criteria and does not refer to infrastructure.

Having carefully considered all the available evidence, including this advice, I found no evidence of procedural fault in the review that led to the final decision. However, I did find that there were procedural failings in relation to the committee's original decision, and I upheld the solicitors' complaints about how the council assessed the criteria and did not justify that decision. I recommended that the council review the manner in which the case was handled, to ensure confidence in public administration and the planning system. I also upheld the complaint about the council's complaints handling, as I found that they had failed to reply to many of the letters sent to them about this. As, however, they have since formed a corporate complaints unit and have already taken a number of actions to improve their complaints handling, I recommended simply that they apologise fully and clearly to the solicitors for the failings identified in the handling of the complaint.

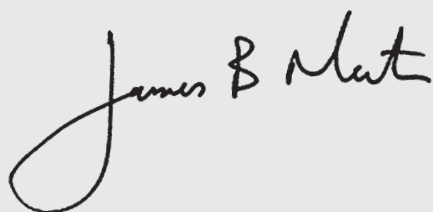
I did not uphold complaints that the council did not adhere to the governance advice provided by council officers, failed to adequately advise the public of the proposed changes or failed to follow the established procedure of considering each location on its merits in favour of a 'block group' consideration. I found no evidence that anything went wrong in these processes.

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Compliance and 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, 23 May 2012

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

For further information please contact:

SPSO, 4 Melville Street, Edinburgh EH3 7NS

Gráinne Byrne, Communications Officer

Tel: **0131 240 8849** Email: **gbyrne@spsso.org.uk**

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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 sewerage 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

Contact us at:

SPSO

4 Melville Street

Edinburgh EH3 7NS

Tel: **0800 377 7330**

Fax: **0800 377 7331**

Text: **0790 049 4372**

