SPSO NEWS

OCTOBER 2012

Monthly news from the Scottish Public Services Ombudsman

The SPSO laid three investigation reports before the Scottish Parliament today about different health boards. We also laid a report on 73 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.spso.org.uk/our-findings**.

Case numbers

Last month (in September) in addition to the five investigation reports we laid before Parliament, we determined 358 complaints and handled 34 enquiries. Taking complaints alone, we:

- gave advice on 239 complaints
- resolved 73 in our early resolution team
- resolved 41 by detailed consideration
- made a total of 47 recommendations in decision letters.

Ombudsman’s Overview

Annual report

We have laid our annual report before the Scottish Parliament.
It is available on our website at **www.spso.org.uk/media-centre/annual-reports**

Twitter

To enhance our range of communications tools we have launched Twitter accounts for SPSO and the Complaints Standards Authority (CSA). We will use these to communicate news and information about our work, including the annual report, investigation report and decision findings, events, conferences and other matters of interest to the public and others.

SPSO on Twitter: **@SPSO_Ombudsman**
CSA on Twitter: **@valuecomplaints**

Reports

This month I am laying three complaints about different NHS boards. At the heart of one of the complaints (201100758) is the issue of consent. The complainant was in labour when she was advised to take antibiotics, which she had made clear she did not want to take in the absence of infection. She had discussed this with a paediatric registrar and had agreed that she would not take antibiotics, but a second registrar told her that under their duty of care to the child there were avenues open to them, such as a child protection order obtained through the courts, if the mother continued to refuse treatment. The complainant felt that she had no option but to take the antibiotics.

Reports (continued)

In my investigation I emphasise that one of the principles central to getting consent from the patient is freedom of choice. This means that the patient's agreement to proceed must be given voluntarily without pressure, deceit or undue influence being used. As the report makes clear, undue pressure was put on this patient.

The two other investigations reported this month concerned complaints about poor clinical treatment and missed diagnosis. In one case (201200068), I criticise a GP practice for failing to make timely and appropriate investigations to establish the cause of symptoms reported by a patient who was subsequently found to have bone cancer. The other complaint (201100366) concerns a man who became tetraplegic following a fall on a bus. I established several failings in this case, including that staff did not follow guidance about patients with possible head/neck injury. There was not enough imaging of his injuries, the quality of the x-ray imaging film was poor and no correct diagnosis was made in the accident and emergency department. The man's diagnosis was delayed due to a lack of MRI scanning at the hospital and when he was scanned, the radiologist misinterpreted the findings. Although I accept that all these failures either individually or collectively did not have a material effect on the outcome, I am critical of the lack of reasonable care and treatment identified.

In each investigation I made several recommendations for redress and improvement, which aim to ensure that the circumstances that gave rise to the complaints are not repeated.

Complaints Standards Authority Update

Local authority model complaints handling procedure (CHP) – compliance assessment

We are pleased to report that the vast majority of local authorities have confirmed their plans to implement the CHP over the coming months. Over a quarter of local authorities are already operating the CHP across all council services.

We have assessed all submitted CHPs and implementation plans and will inform councils soon of their assessment of compliance with the model CHP. We will at the same time provide Audit Scotland with this assessment to allow them to report through the Shared Risk Assessment and annual audit process.

Local authority complaints handling network

The next meeting of the local authority network of complaints handlers will take place on 23 November in Paisley. The network is being chaired by North Lanarkshire council. A number of meetings are planned before the end of the financial year all focusing on various aspects of implementation of the model CHP. If you are interested in further information, or joining, please get in touch with the CSA who will provide your details to the network chair.

Registered social landlords model CHP – deadline for responses now closed

The deadline for registered social landlords to return the SPSO pro-formas closed on 12 October. The vast majority of RSLs have submitted their pro-formas confirming implementation or their plans to do so. We would like to remind RSLs who have not provided a response to do so as soon as possible and return it to **CSA@spso.org.uk**. We will contact all RSLs who have not responded shortly to request a response.

For all RSLs we will shortly provide a summary of compliance pro-forma returns to the Scottish Housing Regulator.

RSL performance indicators

As previously reported, the CSA has been working with the Chartered Institute of Housing, HouseMark and the Scottish Housing Best Value Network to develop performance indicators to assist RSLs with their assessment of their complaints handling in line with the Scottish Social Housing Charter (the Charter). These indicators will be in line with the Scottish Housing Regulator's (SHR) requirements in relation to reporting on the Charter. We aim to publish the performance indicators soon following the publication of the SHR's updated Charter indicators in early October.

Housing complaints handlers network

The newly formed housing complaints handlers network, which is being co-ordinated by representatives from Castle Rock Edinvar HA and Queens Cross HA, is currently surveying members on the future work of the network. If you would like more information about the network, or are interested in joining, please visit the forum on the Valuing Complaints website **www.valuingcomplaints.org.uk/forum** or contact the CSA for details.

Further and higher education – model CHPs developed

We are in the process of finalising draft model CHPs for further and higher education following work with stakeholders from those sectors to develop these. We have also had positive discussions with the Scottish Funding Council about compliance monitoring on which we will provide further detail in due course.

E-learning training and Valuing Complaints forum

Our e-learning training for housing has now been launched and is available through our training centre **www.spsotraining.org.uk**.

As always, the CSA team is happy to provide further information on any aspect of this work and can be contacted at **CSA@spso.org.uk**. However, we would encourage all complaints handlers to log on and join the discussions on the online complaints handling forum at **www.valuingcomplaints.org.uk/forum**. If you have any questions on implementation, put them up on the forum and you will get a response from the CSA team or from other complaints handlers.

See the CSA website for more information: **www.valuingcomplaints.org.uk**

Investigation Reports

Investigation report ref: 201200068

Delay in diagnosis; clinical treatment; referral

A medical practice in the Forth Valley NHS Board area

Summary

Mrs C raised a number of concerns about her sister's (Ms A) treatment from a GP practice. Mrs C said her sister's symptoms of increasing chest, neck and back pain were not properly investigated. Between August and December 2011, Ms A was prescribed strong analgesia (pain killers) but these had little or no effect and the GPs did not physically assess Ms A sufficiently regularly nor record detailed reviews. In December 2011, Ms A was referred to hospital by a GP from NHS 24 where bone cancer was diagnosed. Shortly after the diagnosis, one of Ms A's vertebra in her neck collapsed and she is now paralysed from the neck down. Her cancer is terminal and she was recently told that she only has months to live.

I upheld all the aspects of the complaint. I found that the practice unreasonably failed to make timely and appropriate investigations to establish the cause of Ms A's symptoms; unreasonably failed to make any referrals for specialist opinions in view of her symptoms; and inappropriately issued prescriptions for morphine without physically assessing Ms A. I made a number of recommendations, including that the practice issue a written apology for the failings identified; carry out a significant event audit on the case; carry out a review of a case note sample to assess the quality of examinations conducted and the information recorded; and complete its review of how acute prescriptions are issued and put a robust monitoring system in place.

Investigation report ref: 201100366

Clinical treatment; delay in diagnosis; record-keeping

Ayrshire and Arran NHS Board

Summary

Mrs C said that her husband (Mr A) suffered a fall on a bus. She said he hit his face when he fell and lost consciousness. The bus driver took him to a hospital accident and emergency department (A&E), where he arrived about 15:20. Mrs C said that when she arrived there at about 17:45, Mr A was sitting on a trolley without a neck collar. She said that her husband's face was bruised and bloodied, and he was complaining of a variety of symptoms. These included loss of power in his right arm and leg, a sore neck and pins and needles. Mrs C later left the hospital, and when she phoned at 23:00 the receiving doctor had still not seen Mr A, although he was seen a short time later, when his head was immobilised for the first time. Mr A had an MRI (magnetic resonance imaging) scan (a scan used to diagnose conditions that affect organs, tissue and bone) some four days later. He was subsequently diagnosed with complete tetraplegia (paralysis) and is now severely disabled. Mrs C complained that after her husband's admission to hospital there were unacceptable delays in his diagnosis and treatment.

Investigation report ref: 201100366

Clinical treatment; delay in diagnosis; record-keeping

Ayrshire and Arran NHS Board

Summary (continued)

The board said that delayed diagnosis was not a factor in the final outcome. They also said that early immobilisation would not have influenced the clinical outcome in this case. I took independent advice from four of my medical advisers, including experts in spinal surgery and spinal trauma. As a result of this advice and my consideration of the evidence, I decided to uphold Mrs C's complaint. The original possible diagnosis in the hospital was that Mr A may have had a fit or a stroke, which my advisers said was reasonable in the circumstances of his collapse as described by an eye-witness. However, in fact, he had suffered a spinal cord injury as a result of the collapse. My adviser who is a consultant spinal surgeon agreed that once Mr A had collapsed, the damage he suffered meant that the outcome was probably inevitable and that delay in diagnosis would not be likely to have led to a significantly different outcome. However, I found a number of areas where there was failure on the part of the board. The record-keeping was poor which contributed little to the board's investigation. Guidelines about record-keeping and about patients with possible head/neck injury were not followed. Insufficient imaging was undertaken; the quality of x-ray imaging film was poor; and no correct diagnosis was made when Mr A was in A&E. Mr A's diagnosis was delayed due to a lack of 'weekend' MRI scanning at the Hospital and a radiologist's report misinterpreted the findings.

Although I accepted the advice of my advisers that this set of circumstances would not have altered the outcome for Mr A, I did criticise this level of failure across the scope of his care and treatment. I was also concerned that there appears to be limited access to MRI scanning. I therefore upheld the complaint and made eight recommendations, which can be read in full in my report. These included that the board take steps to feedback the learning from this event to all A&E staff; conduct a significant event review with an emphasis on the misinterpretation the radiologist gave to the findings of the scan; ensure that all A&E staff are familiar with and adhere to the relevant guidelines on suspected head/neck injury; and review the procedure for obtaining urgently required MRI scanning outwith normal hours.

Investigation report ref: 201100758

Maternity care; consent; communication

Greater Glasgow and Clyde NHS Board

Summary

Ms C complained that undue pressure was put on her by hospital staff to take prophylactic antibiotics (treatment given as a preventative measure) during her labour. I upheld her complaint and made a number of recommendations.

Investigation report ref: 201100758

Maternity care; consent; communication

Greater Glasgow and Clyde NHS Board

Summary (continued)

Ms C was advised by medical staff to take the antibiotics because she had a prolonged ruptured membrane. The board's guidelines indicated that in such circumstances intrapartum (during childbirth) antibiotics that can reduce the incidence of death from early group B streptococcal infection should be administered. Ms C was against the use of such antibiotics in the absence of any sign of infection. She agreed with one paediatric registrar that she would not take the antibiotics and that her baby would be monitored for signs of infection after birth. However, a second paediatric registrar told Ms C that she had spoken to the neonatal consultant and that they were concerned about her decision not to take antibiotics. The second registrar told Ms C that the consultant had made it clear that if she continued to refuse treatment, then there were options available to them through the courts to ensure that her baby would receive the treatment required. Ms C said the registrar went on to say that they would obtain a child protection order from the courts (which would apply when the baby was born). Ms C felt that she had no choice at all in the matter and took the antibiotics so that staff would not take her newborn baby away from her to directly administer antibiotics to the child.

My report concludes that Ms C did not properly consent to the treatment administered and was wrongly put under extraordinary pressure during labour when she was in a very vulnerable situation. I made several recommendations including that the board bring this report to the attention of relevant staff, including the second registrar, to ensure lessons are learned and highlight the relevant guidelines and guidance on group B streptococcus and consent; review the guidance on group B streptococcus to clarify the limited circumstances where a child protection order should be considered; consider a multidisciplinary approach involving obstetricians and paediatricians when a patient refuses treatment in similar situations; and apologise to Ms C.

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, 24 October 2012

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

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

Emma Gray, Head of Policy and External Communications
Tel: **0131 240 2974** Email: **egray@spso.org.uk**

The 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 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.

COMMUNICATIONS TEAM
T **0131 240 8849**

SPSO WEBSITE
W **www.spso.org.uk**

VALUING COMPLAINTS WEBSITE
W **www.valuingcomplaints.org.uk**

CONTACT US
T **0800 377 7330**
W **www.spso.org.uk/contact-us**