

## Monthly news from the Scottish Public Services Ombudsman

The SPSO laid five investigation reports before the Scottish Parliament today. Two are about health boards, two about local authorities and one about the Scottish Prison Service. We also laid a report on 66 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](http://www.spsso.org.uk/our-findings).

### Case numbers

Last month (in October) in addition to the three investigation reports we laid before Parliament, we determined 402 complaints and handled 58 enquiries. Taking complaints alone, we:

- gave advice on 262 complaints
- resolved 90 in our early resolution team
- resolved 50 by detailed consideration
- made a total of 68 recommendations in decision letters.

## Ombudsman's Overview



### Reports

#### Health

This month, two reports are about different NHS boards, each involving extremely distressing events which had devastating effects. One was brought by a couple who lost their son following his premature birth (201102612). They complained about the standard of care and treatment provided by two hospitals during and after the pregnancy. I upheld four of their six complaints and made eight recommendations including ensuring compliance with guidelines about amniocentesis, and reviewing consent forms and patient information sheets relating to amniocentesis and post-mortems. I also asked the board to apologise for failing to tell the parents that their baby had an abdominal wall defect. Another complaint that I upheld, and for which the board has already apologised, was that staff did not tell the parents that their baby was born with a beating heart and they were not given the opportunity to hold him. The board recognised the trauma this had caused and have undertaken a review of their policies on miscarriages and stillbirths.

The other health report (201102830) also concerns a failure in communication by hospital staff in relation to a death. The family of an elderly woman were in the hospital when she was being treated but were not told that her condition had deteriorated. When she then died, her daughter complained that the family had lost the opportunity of being with their loved one at the end of her life. I upheld the complaint, and made recommendations including that the board ensure that communication with relatives and carers is addressed within the relevant department.

### **Local government**

One of the local government reports is about planning enforcement (201101316). The complainant raised a number of concerns about the council's failure to take effective enforcement action against the developer of a number of houses, including the house she owns. I upheld her complaint that the council failed to take reasonable and timely action against the developer to address breaches in planning conditions. In investigating the complaint I received independent advice from my planning adviser. His view was that the scale of the delay experienced by the complainant was unacceptable and that she and her co-residents were now required to either live with very substandard access to their properties, or face substantial costs to upgrade the access road themselves. Although I upheld the complaint, I would stress that I fully recognise that a council cannot be considered by the public to be a developer of last resort in cases where a developer fails to comply with planning conditions. However, in view of the circumstances detailed in this particular case, I made two recommendations. One was for an apology, and in the other I asked the council to meet the reasonable costs associated with the works in the event that the owners of the properties concerned do take forward a scheme to carry out the works required to upgrade the road.

The other local government complaint is about the standards of prelim exams in a school (201100845). A pupil who could not sit an exam due to a family bereavement was awarded a lower grade than his school had assured him he would receive. I agreed with the complainant that this was because the school had not used a paper of the required standard when they set the exam. I made a number of recommendations to the council, several of which related to ensuring that the school improve their procedures for ensuring that prelim exam papers comply with Scottish Qualifications Authority (SQA) standards. I also asked the council to issue a formal written apology to the pupil concerned for the issues highlighted in my report.

### **Scottish Government and devolved administration**

The complaint (201104614) about the Scottish Prisons Service (SPS) is a troubling one. It is from a prisoner (Ms C) who believes that she is being restricted from progressing to less secure conditions. In her original complaint to the prison, Ms C said she felt that she was being discriminated against because she maintained her innocence, and that she was being withheld from progressing due to a lack of resources. I upheld Ms C's complaint and made two recommendations to the SPS.

As part of our investigation, my staff reviewed relevant documentation and interviewed Ms C and key staff in the prison. I found that there did indeed appear to be little progress twenty months after Ms C had been informed she would start preparations for progression. I also found that the SPS itself in the establishment where Ms C is held were unclear as to what was actually expected of Ms C in terms of her progression and working towards less secure conditions.

I say in the report that Ms C's case is clearly a complex and difficult one for the prison to manage. However, the report concludes:

*'Failure to complete Ms C's psychological risk assessment within a reasonable timescale due to lack of appropriate resources, the absence of a clear and structured progression plan and poor communication have all contributed to the position Ms C is in. Furthermore, there are clear differences in the views of staff and management as to what is required of Ms C in order for her to progress. I find the lack of clarity about these issues to be unreasonable and for those reasons, I have upheld Ms C's complaint.'*

## **Complaints Standards Authority Update**

### **Further and higher education – model complaints handling procedures (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. The CHPs and information on compliance checking will be provided shortly.

We held a discussion with further education stakeholders at an event hosted by Scotland's Colleges on 14 November. A consultation event for the higher education sector is planned for early in the new year. Further details will follow soon. We have also had positive discussions with the Scottish Funding Council on compliance monitoring for both sectors on which we will provide further detail in due course.

### **Local authority complaints handling network**

The next meeting of the local authority network of complaints handlers will take place on 23 November in Paisley. This meeting will focus on challenges in implementing the model CHP and will host a presentation from Queens Cross HA on their successful implementation of the registered social landlord (RSL) CHP and the challenges they faced. The meeting will also discuss the development of guidance on learning from complaints. 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 at [CSA@spsa.org.uk](mailto:CSA@spsa.org.uk) who will provide your details to the network chair.

### **Registered social landlord model CHP – deadline for responses now closed**

The deadline for registered social landlords (RSLs) to return the SPSO pro-formas was 12 October. The vast majority of RSLs have confirmed implementation, or their plans to do so. However, a small number remain outstanding. We will shortly provide a summary of compliance pro-forma returns to the Scottish Housing Regulator. In advance of this we would like to remind RSLs who have not provided a response to return the compliance pro-forma as soon as possible to [CSA@spsa.org.uk](mailto:CSA@spsa.org.uk). We will shortly contact all RSLs who have not responded to request a response.

### ***RSL performance indicators***

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 in assessing 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 requirements in relation to reporting on the Charter. We aim to publish the performance indicators shortly.

### ***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](http://www.valuingcomplaints.org.uk/forum) or contact the CSA for details.

## **E-learning training and Valuing Complaints forum**

Our e-learning training modules on frontline resolution are available through our training centre [www.spsotraining.org.uk](http://www.spsotraining.org.uk).

As always, the CSA team will be happy to provide further information on any aspect of this work and can be contacted at [CSA@spsa.org.uk](mailto:CSA@spsa.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](http://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](http://www.valuingcomplaints.org.uk)

# Investigation Reports



Investigation report ref: 201102612

## **Clinical treatment, communication, policy/administration**

Highland NHS Board

### **Summary**

Mr and Mrs C lost their son following his premature birth. They complained about the standard of care and treatment provided at two hospitals during and after Mrs C's pregnancy. I upheld their complaints that the board failed to follow guidelines when carrying out Mrs C's amniocentesis procedure (a test carried out during pregnancy to assess whether the unborn baby could develop an abnormality or serious health condition) and that they failed to tell Mr and Mrs C that their baby had an abdominal wall defect which was detected at the time of the procedure. I also upheld their complaint that the board failed to tell them that their son was born with a beating heart and they were not given the opportunity to hold him, and that the board failed to arrange a consultant review to determine what went wrong and what implications this could have for a future pregnancy. I did not uphold their complaints that the board inappropriately carried out the amniocentesis procedure in one hospital, despite an earlier audit report suggesting this should not happen, nor that the board inappropriately placed the baby in what looked like a cardboard box.

I made eight recommendations for redress and improvement. These included: ensuring compliance with guidelines on amniocentesis; reviewing the amniocentesis consent form and patient information; issuing a full and sincere apology to Mr and Mrs C; reviewing local guidance concerning suspected fetal abnormalities discovered on any obstetric ultrasound scan; reflecting on comments about examination options after a stillbirth/late miscarriage where the baby has some abnormalities, and reviewing the post mortem patient information sheet and consent form to include examination options. The recommendations can be read in full in my report.

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Investigation report ref: 201102830

## **Communication**

Greater Glasgow and Clyde NHS Board – Acute Services Division

### **Summary**

Ms C complained about the lack of communication with her family after her 84 year old mother (Mrs A) was admitted to a hospital emergency department. The family were not told that Mrs A's condition had deteriorated. Mrs A subsequently died and her daughter said that the family had lost the opportunity of being with Mrs A at the end of her life. I upheld the complaint about the board's lack of communication with the family just before Mrs A's death and made two recommendations for redress and improvement.

**Summary** (continued)

In my investigation, my nursing adviser said that evidence of communication with Mrs A's family was minimal. She commented that there were various places in Mrs A's notes where staff could have noted that information had been given and yet there was no record anywhere in the notes of that being done. She stated that whilst she could understand that staff would have been occupied with Mrs A's clinical care and treatment, this did not justify the lack of communication (and indeed compassion) in providing the family with a few moments with their mother. She commented that even with the most critically ill patient, time must be afforded to relatives to see them.

My adviser also said that it would appear that there was a breakdown in communication between staff within the emergency department. She said that the staff nurse had indicated in her notes that the family had not been spoken to, but this was not acted on. The most senior doctor is responsible for ensuring that relatives are fully informed of the patient's condition, particularly when the situation is critical. The adviser stated that she would have expected a member of staff, usually a senior doctor or delegated to a senior nurse, to have given Mrs A's family an update; explained that a CT scan was needed; and also prepared them for the strong possibility that Mrs A was dying. She said that they should also have offered to accompany the family to Mrs A's bed. There is no evidence in the contemporaneous records that this happened.

The adviser said that the absence of a senior member of the emergency department team talking to Mrs A's family prior to her going for the CT scan was a significant failing in communication and compassion. She agreed with Ms C that the family were not afforded the opportunity to say goodbye to Mrs A and that this has probably impacted on the distress of their bereavement.

Another source of distress for Ms C was the conflicting information given to the family about Mrs A's time of death. The board have apologised to Ms C about the human errors that led to different times being given and they have told my office that staff have been spoken to about the consequences of providing inaccurate information on the time of death.

I made two recommendations to the board - that they issue a written apology to Ms C for the failure to inform her of the deterioration in her mother's condition; and that they provide my office with an action plan and / or steps in place to ensure communication with relatives and carers is addressed within the emergency department.

## Investigation report ref: 201101316

### **Planning: enforcement** North Lanarkshire Council

#### **Summary**

Mrs C raised a number of concerns about the council's failure to take effective enforcement action against the developer of a number of houses, including the house she owns. I upheld her complaint that the council failed to take reasonable and timely action against the developer responsible for building her home, to address breaches in planning conditions.

In late 2002, planning permission was granted to build four houses with parking and an access road. In considering the application, the council had decided that upgrading of a private road was necessary to ensure satisfactory access for vehicles and pedestrians. Accordingly, they attached conditions to the planning consent. Mrs C bought one of the houses from a previous owner in 2007. At the time of buying the property she was aware that the road and communal driveway had to be completed, however, a Breach of Condition Notice (BCN) had been served on the developer in 2006. Mrs C explained that the previous owner of her property had been in contact with the council and chased up the developer, who had indicated that the outstanding work would be carried out. Although the BCN had been served in 2006 it was not until September 2008 that the matter was referred to the Procurator Fiscal. Mrs C complained about inefficiency by the council in handling of the matter which caused delays. She said that this resulted in the residents being told that if they wished to bring the road up to a reasonable standard they would now have to pay for any work to be carried out.

Mrs C complained formally to the council in early 2011. In their response the council explained that they had attempted to have the works completed and had held a protracted dialogue with the developer over a number of years. When those attempts were exhausted, they referred the case to the Procurator Fiscal. However, the developer died and the case against them was dropped in 2010.

In investigating this complaint I received independent advice from my planning adviser. His view was that the council had waited an 'inordinately long time' from the time of establishing the first breach to its first, unsuccessful, referral to the Procurator Fiscal. He said that after their initial positive approach to what was a clear-cut and relatively straightforward matter, the council's response 'faltered and then became bogged down in a mire of inactivity and repetition'. He said that the scale of the delay experienced by Mrs C was unacceptable and that she and her co-residents were now required to live with a very substandard access to their properties, or face substantial costs to make up the road themselves. In the conclusion of my report, I also voice concern that the council gave the developer so many opportunities to resolve the matter.

Although I upheld the complaint, I would stress that I recognise that, in general, a council cannot be seen as a developer of last resort where a developer fails to comply with planning conditions. However, in view of the circumstances in this particular case, I made a number of recommendations. I asked the council, in the event of the owners of the properties concerned themselves taking forward a scheme to carry out the works required to upgrade the road under the relevant planning conditions, to meet the reasonable costs associated with the works. I also recommended that they apologise to Mrs C for the failings identified in their handling of the enforcement action, including their failure to clarify the position with regard to the communal driveway.

Investigation report ref: 201100845

**Education: policy/administration**

The Highland Council

**Summary**

Mr C's son (Mr A) was a pupil at a school in the council's area. Mr A was unable to sit his Higher Physics exam due to a family bereavement. Assurances were given by his school that he would be awarded a grade based on his preliminary exam results. However, the evidence provided by the school in support of Mr A's performance did not comply with the requirements of the Scottish Qualifications Authority (SQA) and he was awarded a lower grade. Mr C complained that the school did not use a prelim paper of the required standard and that they did not provide adequate evidence to the SQA in support of the subsequent appeal of Mr A's result. Mr C also complained about the council's handling of enquiries and complaints from him and his wife. I upheld his complaints and made a number of recommendations to the council, including that they ensure that the school develops a procedure for checking all prelim examination papers for compliance with SQA standards; work with the SQA to increase their understanding of the SQA's standards and how SQA staff assess the suitability of prelim papers; conduct a review of the types of evidence that will be accepted by the SQA in support of appeals and absentee assessments; ensure that the SQA's comments on the marking of Mr A's prelim examination have been fed back to the principal teacher concerned, and issue a formal written apology to Mr A for the issues highlighted in my report.

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Investigation report ref: 201104614

**Policy/administration**

Scottish Prison Service

**Summary**

Ms C, who is a prisoner, complained that the prison were unreasonably restricting her progression to less secure conditions. She said that when her appeal against her conviction concluded, she was told she would begin preparations for progression to less secure conditions but she felt that those preparations were not happening appropriately. In her original complaint to the prison, Ms C said she felt that she was being discriminated against because she maintained her innocence and that she was being withheld from progressing due to a lack of resources.

Ms C was sentenced to life in prison. She lodged an appeal against her conviction and because of this, she was given appellant status by the Scottish Prison Service (SPS) until that process concluded. Our investigation found that even after her appeal concluded, and despite various discussions taking place in which action points had been agreed, there appears to be little progress over twenty months later, in terms of preparing Ms C for less secure conditions. I also found that the SPS itself in the establishment where Ms C is held were unclear as to what was actually expected of Ms C in terms of her progression and working towards less secure conditions.

**Summary** (continued)

My view is that Ms C's case has presented as a complex and difficult one for the prison to manage. It is the role of the courts to determine whether an individual is guilty of their offence. The SPS' role is to manage and help rehabilitate convicted prisoners and it is the Parole Board for Scotland who are responsible for determining whether the risk an individual presents to the community is acceptable. Whilst the SPS must manage those prisoners who have been convicted, it is not for prison staff to influence the position of an individual prisoner who may maintain their innocence. Through my office's enquiries, there appears to be sufficient evidence to suggest that the approach taken by some staff at the prison in relation to Ms C's progression, and in particular to her maintaining her innocence, has lacked clarity.

Failure to complete Ms C's psychological risk assessment within a reasonable timescale due to lack of appropriate resources, the absence of a clear and structured progression plan and poor communication all contributed to the position Ms C is in. Furthermore, there are clear differences in the views of staff and management as to what is required of Ms C in order for her to progress. I found the lack of clarity about these issues to be unreasonable and for those reasons, I upheld Ms C's complaint. I recommended that the SPS review Ms C's case as a matter of urgency to ensure that appropriate and reasonable steps are being taken to progress her in line with relevant policy. I also recommended that they undertake a review of practice being applied at the prison in relation to the progression of those prisoners who do not admit guilt, to ensure that staff are managing those cases appropriately and in line with relevant policy.

## 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, 21 November 2012**

SPSO findings can be found on our website: <http://www.spsso.org.uk/our-findings>

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## 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.



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