

## Monthly news from the Scottish Public Services Ombudsman

The SPSO laid three investigation reports before the Scottish Parliament today. Two are about health boards and one is about a higher education institution. 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.spsso.org.uk/our-findings](http://www.spsso.org.uk/our-findings).

### Case numbers

Last month (in November) in addition to the five investigation reports we laid before Parliament, we determined 467 complaints and handled 46 enquiries. Taking complaints alone, we:

- gave advice on 295 complaints
- resolved 116 in our early resolution team
- resolved 51 by detailed consideration
- made a total of 93 recommendations in decision letters.

## Ombudsman's Overview



### Understanding our remit

It is very important that our remit is understood. If it's not, there is frustration all round – for the person bringing us the complaint who thinks we can investigate it and achieve the change they want, and for us, because with the best will in the world we can only work within our remit. The kinds of things that may prevent us from looking at a complaint are:

- the complaint is not about a body or subject in our jurisdiction
- the complaint has not completed the public body's complaints process
- time limits for making a complaint to us (normally a year from when the person knew they had something to complain about)
- rights of appeal to tribunals and the courts
- the complaint is about employment or personnel matters
- the complaint is about commercial or contractual matters (most aspects of these are out of jurisdiction).

It's also important that people appreciate that we can normally only look at whether the way a decision was arrived at was faulty, not at the decision itself. An important exception to this are complaints about the NHS, where we can look at clinical decisions.

As far as non-NHS complaints are concerned, this is worth explaining further. Public authorities are entitled to make decisions about areas for which they are responsible. The SPSO Act says that we can't question a decision simply because someone is unhappy with it. We can, however, look at the procedures that led up to a decision. When we do this we often find that service providers have correctly followed the procedure. In such cases, the complainant is likely to remain unhappy with the organisation's decision, but if there is no evidence of anything having gone wrong in the way a decision is reached, we cannot question its merits.

We know that it is frustrating for someone to bring us a complaint and find that we cannot look at it. This happens in about a third of the complaints that we receive. If in any doubt about whether a complaint is something we're likely to be able to look at, our advice team may be able to help – they can be reached on 0800 377 7330. There is also information about our remit on our website and in leaflets for the public, service providers and MSPs. We can only accept a complaint from a representative (such as an MSP, councillor or advice worker) on someone's behalf if they provide the signed consent of the person who has been affected by the issues complained about.

## Reports

### Health

This month's reports contain distressing examples of the consequences of things going wrong in the NHS. In one complaint (201103604) I found that a community psychiatric nurse failed to take appropriate action to safeguard a woman when it was reported that she was suffering from mental health problems. I would urge all boards to read my report and satisfy themselves that they have sufficiently thought through how risk is assessed and recorded in telephone assessments to try to ensure as far as possible that patients assessed over the telephone receive the same quality of assessment as those spoken to face-to-face. I would also ask boards to clarify for themselves and relevant staff the criteria or threshold for when concerns should be raised with a mental health officer.

Another investigation published today (201102521) is about all too familiar themes – poor hospital nursing care resulting in detriment to the dignity of an elderly man with dementia. I agreed with his daughter's complaint that nursing staff failed to maintain a reasonable level of hygiene for her father. I considered that one scheduled weekly bath was inadequate, given her father's personal needs, and upheld complaints that staff failed to pay adequate attention to her father's dignity by ensuring that his clothing was appropriately attended to.

I also found that there were inadequate transfer systems and documentation in place for her father. He was known to staff as vulnerable, but not only were procedures not followed but his safety and the safety of others was compromised. My investigation also identified failings in the board's complaints handling.

Next month, I will be giving evidence to Parliament's Health Committee about the regulation of care of older people in acute hospitals. Today's investigation report is yet another example of the kinds of issues that still arise and I therefore invite boards to read my report and do what they can to ensure that, as far as possible, measures are in place that will prevent these kinds of failings in their hospital wards and clinics.

### Higher Education

The third case, unusually, is an investigation about a university (201002095). We do not receive a high volume of complaints about the higher education sector (in the last financial year we had 93, most of which were resolved at earlier stages in our process). I am reporting this complaint because it constituted a significant injustice to the individual and because it highlights the importance of institutions adhering to due process.

My investigation found that the university had unreasonably and unfairly conducted an inquiry into a student's alleged plagiarism as part of a viva (oral) examination, and noted that this had been recognised by the appeal panel. I also found that, having accepted that the alleged plagiarism was not investigated reasonably and fairly, the university then unreasonably added an addendum to the minute of an exam board meeting that implied, without explanation or evidence, that there had been academic failing. The explanations the university gave me about this were not satisfactory either and, further, were not borne out in the evidence I reviewed. I further found that the university failed to tell the student about the addendum until he requested a meeting to discuss the alleged plagiarism, and that the university's subsequent complaint investigation was poor. I also found that the university's policy on subsequent potential progression of a complaint to a complaints panel was not clear. I made several recommendations for redress and improvement, and would encourage other universities to read the report and learn from my findings.

## **Complaints Standards Authority Update**

### **Further and higher education – model complaints handling procedures (CHPs) to be published in December**

The model CHPs and associated student/customer leaflets for the FE and HE sectors have been finalised and will be published in December. They will be accompanied by an implementation guide outlining requirements for adoption and compliance, including timescales for returning self-assessment compliance forms to SPSO. The documents will also include an outline of how the requirement to adopt the CHPs will be incorporated into the Scottish Funding Council's financial memorandum for FE and HE institutions and an outline of performance indicators.

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

The local authority complaints handling network met most recently in late November at Renfrewshire Council. The main focus of the meeting was implementing the model CHP. The network enjoyed an excellent presentation from Queens Cross Housing Association about the benefits and challenges in implementing the CHP. The network also shared respective experiences of implementing the CHP across council services, including potential challenges with the implementation and actions to successfully resolve these issues.

The network agreed the requirement to work towards producing a 'Learning from complaints' guide. A number of attendees volunteered to form a sub group to take this work forward, and will update the next meeting of the network with their proposals about this.

The network will meet again in January, when it will discuss performance indicators in regards to complaints handling, standardised complaint categories, self-assessment of performance and the monitoring role of Audit Scotland.

### **Registered social landlord model CHP**

We have written to the majority of RSLs outlining our assessment of their compliance. We have also written to other RSLs who have not yet been in touch with us to remind them of the requirement to update us of their progress towards implementation as soon as possible by sending their *pro forma* to [CSA@spsa.org.uk](mailto:CSA@spsa.org.uk). We have provided the Scottish Housing Regulator (SHR) with a summary of our assessment and will keep them updated on progress.

Overall we are pleased with the positive response from the sector to adopting the model CHP.

### **SPSO self-assessment indicators for the housing sector**

We have finalised the production of the 'SPSO self-assessment indicators for the housing sector' guide which has been designed to complement the SHR's monitoring of the Scottish Social Housing Charter. This will be published in December. The guide provides a list of high level indicators for monitoring complaints handling under the SPSO's model CHP for RSLs and the local authority model CHP for housing complaints. The indicators provide the basis for self-assessment and benchmarking activities around the CHP.

### **Housing complaints handlers network**

Information will be provided shortly on the dates and agenda for the next meeting of the RSL complaints handling network.

If you would like more information about the network, or are interested in joining, please visit the forum on our Valuing Complaints website [www.valuingcomplaints.org.uk/forum](http://www.valuingcomplaints.org.uk/forum) or contact the CSA for details.

### **Training and Valuing Complaints forum**

Our e-learning training modules on frontline resolution are available through our training centre at [www.spsotraining.org.uk](http://www.spsotraining.org.uk). These courses have been developed to help with the introduction of the model CHPs for each sector. This training is available to all public sector bodies and is currently free.

We are also running complaints handling training courses for all sectors in January. These include frontline complaint handling (stage 1 of the model CHP) and complaint investigation skills (stage 2 of the model CHP).

As always, the CSA team will be happy to provide further information on any aspect of this work and can be contacted at [CSA@spsso.org.uk](mailto:CSA@spsso.org.uk). We would also 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's Valuing Complaints website for more information: [www.valuingcomplaints.org.uk](http://www.valuingcomplaints.org.uk)

### **Fair and Equal: How does the Equality Act 2010 affect complaints handling in Scotland?**

The Equality Act 2010 contains duties for the private, public and voluntary sectors across a range of activities. The simple message of the Equality Act is that everyone has the right to be treated fairly.

Earlier this month, we published an article on our Valuing Complaints website which explains that for people working in the public sector, including in complaints handling, there are many implications of the Equality Act.

We would encourage you to read this article which can be found [here](#). We would ask

anyone working in complaints handling within the public sector in Scotland who has already begun to work on equality and complaints handling, developed good practice policies and procedures or indeed is struggling with a particular area of the Equality Act, to provide comments on the article or ask questions through the Valuing Complaints forum or by contacting the CSA team.

# Investigation Reports



Investigation report ref: 201103604

## **Mental Health Services**

Greater Glasgow and Clyde NHS Board

### **Summary**

Miss A suffered from mental health problems. Although she had been living in the area for five years, she was not known to the board's mental health services team and had not had any contact with them. Her family, who lived in England, were increasingly concerned about Miss A's mental state. Her grandmother called the board and spoke initially to a non-clinical call handler and then to a nursing adviser. It was recorded that Miss A's psychotic symptoms were worsening and that she was experiencing auditory, tactile and visual hallucinations. The call was referred to the out-of-hours community psychiatric nursing team.

A community psychiatric nurse (CPN) contacted Miss A by telephone. Over the following days, there were more calls between Miss A's family and the board and the community practice nurse team, and between the CPN and Miss A. The CPN attempted to visit Miss A at home. She was unable to gain access and left a message on Miss A's mobile telephone, which was switched off. Miss A's family themselves made the journey to visit her. Miss A's mother arrived at her daughter's flat to be met by police who told her that Miss A had jumped from a window in her fourth-floor flat and had suffered serious injuries to her lower body.

My mental health adviser examined recordings of the calls between the CPN and Miss A. He said that there was sufficient information about Miss A's mental health from both the telephone conversations and from Miss A's relatives to form an opinion that she was experiencing either an acute organic confusional state or an acute episode of psychosis. He said that both carry considerable risk and the individual cannot be expected to be able to exercise responsibility for their safety. Their ability to think rationally and critically would obviously be impaired. The adviser said that the level of telephone assessment fell below what he considered to be reasonable. He also commented that concerns about Miss A could have been raised with a local mental health officer. They could have exercised their powers under sections 33 and 35 of the Mental Health (Care and Treatment) (Scotland) Act 2003 to gain entry to Miss A's flat.

My investigation therefore upheld Miss A's mother's complaint that the CPN failed to take appropriate action to safeguard Miss A when it was reported that she was suffering from mental health problems. I found a number of failings and areas for improvement and made several recommendations including an apology from the board. I also recommended that they review how risk is assessed and recorded in relation to telephone assessments in such circumstances to try to ensure as far as possible that patients assessed over the telephone receive the same quality of assessment as those spoken to face-to-face. I also recommended that the board clarify to relevant staff the criteria or threshold regarding when concerns should be raised with a mental health officer.

Investigation report ref: 201102521

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

Greater Glasgow and Clyde NHS Board

**Summary**

Mrs C complained that her late father (Mr A) had been inappropriately cared for by nursing staff in hospital. Mr A had dementia and was in his early 80s. After a fall at home, he was admitted to one hospital, transferred to a unit and from there moved to another hospital. Mrs C complained to us that her father was badly let down by the hospital systems and that a poor standard of nursing care was delivered in the second hospital.

I upheld Mrs C's complaints that nursing staff in the second hospital failed to maintain a reasonable level of hygiene for her father. I considered that one scheduled weekly bath was inadequate, given Mr A's personal needs. I was also critical that there was scant information recorded in the notes about the frequency and type of personal care given to Mr A. I also found that there were inadequate transfer systems and documentation in place. While the investigation showed that the transfer plan for Mr A contained relevant information, it was clear that Mr A should have been accompanied by a member of staff on his transfer. Not only were procedures not followed but, Mr A, who was known to staff as vulnerable, had his safety and the safety of others compromised.

I also upheld the complaints that inadequate attention was paid to Mr A's dignity by ensuring that his clothing was appropriately attended to, and I found that the investigation of Mrs C's complaint to the board was inadequate. I found that the board's reply to Mrs C's complaint did not adequately convey the details and outcome of their investigations. I criticised the board for this, saying that it represents a failure of the investigative complaints process if, as a result of that process, Mrs C was not provided with the results of the investigation that addressed all the specific issues she had raised.

I did not uphold the complaints that nursing staff unreasonably failed to monitor and maintain Mr A's fluid levels nor that they unreasonably failed to deal with incontinence issues. Although I did not uphold the complaint that there was poor communication from staff, I am critical that little communication was recorded and I made a recommendation for improvement. I also did not uphold the complaint that nursing staff unreasonably failed to pass on information to the relevant social work team when Mr A was transferred.

I made five recommendations to the board including that they ensure that measures are taken to feed back the learning from this complaint to nursing staff and complaints investigation staff to avoid similar situations recurring; ensure that communication between family members and staff are appropriately recorded and apologise to Mrs C for the failures identified in my report.

Investigation report ref: 201002095

**Policy/administration; communication; complaints handling**

University of Stirling

**Summary**

Mr C complained about the manner in which the university investigated an allegation of plagiarism in relation to his son (Mr A)'s dissertation. The university's appeal panel found there were errors in the way the allegation had been raised with Mr A and offered him the opportunity to attend a further meeting about it. However, Mr C then complained about the way in which the university had subsequently added an addendum to the minutes of the exam board relating to Mr A's dissertation, which stated that it had failed on academic grounds in any event. Mr C also complained about the way in which the university handled Mr A's complaint about the addendum.

My investigation found that the university had unreasonably and unfairly conducted an inquiry into Mr A's alleged plagiarism as part of a viva (oral) examination, and noted that this had been recognised by the appeal panel. I also found that, having accepted that the alleged plagiarism was not investigated reasonably and fairly, the university then unreasonably placed an addendum on the minute of the exam board meeting to imply academic failing without explanation or evidence. The explanations the university provided with regards to this were not satisfactory and further were not borne out in the evidence I reviewed. I further found that the university failed to inform Mr A about the addendum until he requested a meeting to discuss the alleged plagiarism, and that the university's subsequent complaint investigation was poor, in that there were lengthy delays and the investigation did not appear to consider the substantive issues of Mr A's complaint. I also found that the university's policy regarding subsequent potential progression of a complaint to a complaints panel was not clear. I did not uphold the complaint that the university failed to grant the outcome sought by Mr A when his appeal was upheld.

I made five recommendations to the university, including that they make provisions for an independent re-assessment of the dissertation. I also recommended that, if required following that re-assessment, they re-consider referral of Mr A's complaint to a complaints panel. I asked them to provide evidence to my office of the steps they have taken to implement specified improvements and to review specific aspects of their academic complaints policy, and I recommended that they issue a full apology to Mr A for the failings identified in my report.

## 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, 19 December 2012**

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



**CONTACT US**  
T **0800 377 7330**  
W [www.spsso.org.uk/contact-us](http://www.spsso.org.uk/contact-us)

**VALUING COMPLAINTS WEBSITE**  
W [www.valuingcomplaints.org.uk](http://www.valuingcomplaints.org.uk)