

Ombudsman's Commentary

AUGUST 2009 REPORTS

The SPSO laid eleven investigation reports before the Parliament today. Six are about the local government sector and five relate to health. Our investigation reports form only one part of our work. In July, we determined 421 complaints, including 124 that were resolved after detailed consideration.

Each investigation may contain several complaints, and overall the 11 reports laid today:

- **Upheld 17 complaints**
- **Partially upheld 3 complaints**
- **Did not uphold 6 complaints**
- **Made 41 recommendations**

Overview

Since taking up post as Ombudsman in May 2009 I have had concerns that the SPSO is carrying a significant number of old and aging cases. We identified at the start of the SPSO business year 1 April 2009 that 82 cases had been with the SPSO for nine months or more. Therefore, in June, I set the organisation the target of clearing all those identified cases by the end of 2009 while in addition meeting new challenging key performance indicators relating to timescales. I am pleased to say that as of today 66% of these cases have been completed and with the exception of two particularly complex cases, we are set to meet our old cases target by the end of 2009.

One report (Case 200502514) that I am laying before the Parliament today, however, has been with the SPSO for around three years. I regard such delay as unacceptable both for the complainant and the local authority involved, and generally as being contrary to the SPSO's aim of arriving at fair and speedy decisions.

I have therefore asked Jerry White, one of the Local Government Ombudsmen in England, to review the handling of this case and to advise me on particular and general lessons to be

learned for the SPSO in the areas of investigative process, stakeholder engagement and reporting. I will publish the findings and recommendations of the review. The decision on the original complaint was made by me as Ombudsman and is, as set out in the report, final.

This month's reports cover a wide range of issues about local government and health service providers. In the **local government** sector, complaints related to school bullying, procedures in education complaints, statutory notices to repair private property, the handling of a planning application and provision of information about an Education Maintenance Allowance. In all the reports I made recommendations to redress the hardships or injustices caused to individual complainants by the councils' failings. Many of the recommendations will be of relevance to other councils and I would draw their attention the following:

- Councils should support schools to ensure that methods of identifying, recording and collating incidents of bullying are clear; processes for managing incidents of reported bullying are appropriate and Complaints Review Committees can be held within set timescales (Case 200700224)

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overview

- Complaints about education should include an independent element in the final stage process for handling such complaints (Case 200502514)
- Councils should ensure that information about how to make a complaint about a school or their staff is made available in their schools (a suggestion made in Case 200502514)

In the **health** sector, we laid reports about complaints the public have brought us about concerns including delayed or missed diagnosis, poor care and treatment (in one

case leading to pressure sores) and a lack of communication with patients' families. I made 26 recommendations for improvement, many relating to issues raised in previous reports. As in the local government sector, I would encourage senior managers, especially those involved in risk management, to learn from the individual cases any lessons that could be applied in their medical practices or hospitals.

Summaries of all the reports laid today are below, and they can be accessed on the SPSO website at www.spsso.org.uk/reports/index.php.

Local Government

Education: complaint handling; policy/administration

North Lanarkshire Council
(200502514)

Mrs C raised several concerns about the way complaints relating to her children's school were dealt with by the Council and the Council's Education Department. I upheld the complaint that the Council failed to properly handle complaints made by Mrs C and her husband as I found that the Council should have done more both to investigate the concerns raised and to properly explain their actions to Mr and Mrs C. I upheld a further complaint that the Education Department's procedures for considering complaints are biased against the complainant, but only to the extent that my

investigation found insufficient independence in the complaints process. I recommended that the Council apologise to Mr and Mrs C for the failings identified in the handling of the complaints; and review their complaints process to include an independent element in the final stage of the process for handling complaints about education. I further suggested that the Council ensure that information about how to make a complaint about a school or their staff is made available in schools.

Education: policy/administration; record keeping

Shetland Islands Council
(200700224)

Mrs C said that her daughter had been the victim of bullying at school. She complained that the school had not recorded incidents of reported bullying

clearly or managed the reports of bullying in line with the Council's procedures. She also complained that the Council failed to convene a Complaints Review Committee (CRC) to consider aspects of a complaint against the Council's social work department. I upheld all Mrs C's complaints and made a number of recommendations to the Council as a result. These included supporting the School in reviewing and clarifying their recording criteria and record-keeping and development of appropriate contingency plans for the future; ensuring local policies are adhered to, and reviewing their own practice to ensure that CRCs can be held within set timescales. I also recommended that they apologise to the mother and child concerned.

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case summaries

Local Government

Policy/administration

Dumfries and Galloway Council
(200800480)

Mr C is a young man with severe learning difficulties and special educational needs. His mother, Mrs C, complained that his school did not bring to her attention that Mr C was entitled to apply for an Education Maintenance Allowance (EMA) for the academic year 2006-2007, causing him to lose the opportunity to do so. I upheld the complaint as the Council were unable to say with certainty that the relevant information had been provided to the family. I recommended that the Council pay Mrs C £1,140 in lieu of the basic allowance payment and £300 in lieu of the bonus payment to which Mr C would have been entitled had he applied for and received an EMA for session 2006-2007. I also recommended that the Council apologise to Mrs C.

Housing:

Statutory repairs notices

The City of Edinburgh Council
(200802060)

Mr C and Ms D purchased a commercial property on the ground floor of a tenement block in Edinburgh. Three and a half years later the Council told them they were due to pay nearly £7,600 for works instructed by the Council under statutory notices. Mr C and Ms D raised a number of concerns about the Council's handling of the matter. I upheld the complaint that the

Council did not update their records on ownership or keep Mr C and Ms D informed of progress on the contract. I did not uphold complaints that the Council failed to serve statutory notices on Mr C and Ms D, or to respond sympathetically to a request for time to pay the unexpected sums. I recommended that in future statutory notices and later correspondence include a statement about alerting the Council about change of ownership; that the Council include a practice of checking the Scottish Assessors Association website when commercial properties are involved, and that they reconsider the administration charge levied on Mr C and Ms D.

Handling of planning application;

policy/administration
East Lothian Council
(200800537)

Mr C, who lives on a main road in a conservation village, raised concerns about the Council's handling of an application for planning consent for a new house opposite his property. I found that the Council's Transportation Division carried out a site visit after they had responded to consultation about the plans. I partially upheld Mr C's complaint that in recommending approval of the application, the Council failed to require compliance with their planning policy. I recommended that the Council review their procedures for the need for site

visits by their Transportation Division officers prior to responding to consultations on planning applications.

I did not uphold the following complaint

Housing:

Statutory repairs notices

City of Edinburgh Council
(200802077)

Health

Delay in diagnosis

Greater Glasgow and Clyde NHS Board – Acute Services Division
(200801842)

Mrs A's husband, Mr A, died of advanced prostate cancer. Mrs A was concerned that this had not been detected some years before, when Mr A attended a number of hospital appointments with lower urinary tract symptoms. My report found that, given Mr A's symptoms, there was insufficient attention paid to the possibility of prostate cancer at the earlier appointments. I upheld the complaint that the Board failed to provide Mr A with all appropriate care and treatment and so missed an opportunity to secure an earlier diagnosis of prostate cancer. I recommended that the Board review the Urology Department protocol for the assessment and management of men with new lower urinary tract symptoms, bearing this case in mind.

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Health

Care of the Elderly; delay medical assessment; referral; communication

Highland NHS Board
(200800761)

Mrs C raised a number of concerns about the care and treatment that her late father, Mr A, received from his GP Practice. She said that the family had contacted the Practice saying that Mr A (who had ongoing health problems) had chest pain and asking that he be seen urgently, but there was delay before he was seen by a GP and referred to hospital. When he was, it turned out he had had a heart attack. I upheld her complaints that the Practice delayed in examining Mr A after his family contacted them, and that later action taken to flag Mr A's notes to show that he had special requirements was inadequate. I recommended that the Practice apologise to Mrs C for the delays in examining Mr A, organise a review of their triage systems and ensure that the revised procedures are communicated effectively to staff. I also recommended that the Practice apologise to Mrs C for the failure to effectively flag Mr A's notes and that they consider how in future they can effectively flag the electronic records of a patient with significant health problems.

Clinical treatment; nursing care; communication

Shetland NHS Board
(200603164)

Mr C was unhappy with the care and treatment provided to his late mother, Mrs A, before and during her final admission to hospital. Mrs A was discharged to her care home the day after admission and, sadly, died there later that evening. Mr C felt that Mrs A should have remained in hospital longer. I partially upheld his complaints that the reasons for prescribing certain medications were unclear, and that staff failed to adequately assess and record treatment and care requirements, in relation to the hospital's involvement in these. I upheld his complaints that Mrs A was not provided with an acceptable level of fluids while in hospital and that she should have remained longer in hospital. I made a number of recommendations which included sharing the report with the hospital staff involved in Mrs A's care and ensuring that staff assess and record treatment and observations, including specific recommendations with regard to fluid intake. I also made recommendations about discharge planning. Finally, I recommended that the Board apologise to Mr C for the failures in care identified in my report.

Delay in diagnosis; clinical treatment; nursing care; complaint handling

Tayside NHS Board (200800508)

Mr C raised a number of concerns about delays by the Board in the diagnosis and treatment of his late father, Mr A's, illness in the weeks and days before Mr A's death from Pneumococcal Pneumonia. Mr C also complained about aspects of the care provided to his father and was unhappy with the handling of his complaint. I upheld his complaints about the delay in diagnosis and the care provided to Mr A, as I found that there were failures to reasonably interpret a CT scan, investigate lung symptoms and in nursing oversight of Mr A's symptoms. I recommended that the Board apologise to Mr C for the failure to make a timely diagnosis and provide adequate care to Mr A, and that they review current arrangements for selecting patients for out-of-hours review, including processes for communication and handover between medical staff. I also recommended that they ask the consultant to apologise for any contribution he may have made to a misunderstanding about visiting Mr A.

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Health

Care of the Elderly; nursing care; delay in treatment; communication

Greater Glasgow and Clyde NHS Board – Acute Services Division (200800634)

Mr A, an elderly man, had been diagnosed with bladder and prostate cancer and his condition was deteriorating when he was admitted to hospital. Over a period of almost two months before his death, he was transferred between hospitals in the Board's area. He was also discharged and readmitted twice. In that time he developed pressure sores (pressure ulcers) and contracted infections. Mrs C, Mr A's daughter, complained about several aspects of the care provided to Mr A. I upheld her complaint that the Board failed to effectively manage Mr A's pressure sores as it was clear that these were not adequately treated and an appropriate mattress was not provided quickly enough. I noted that this issue had been the subject of another recent report about the Board. I also upheld complaints about delay in referring Mr A to the palliative care team towards the end of his life, and a lack of continuity in the nursing care provided to him. I made ten detailed recommendations. These focussed on learning lessons from this case and ensuring that the policies now in place reflect current national best practice, in terms

of the prevention and care of pressure sores, and in end of life planning and care. I recommended that the Board continue to closely monitor nursing care in one particular ward with particular reference to best practice methodology. I reflected in my recommendations that staff failed to communicate properly with Mr A's family, and pointed out that poor staff communication with relatives had featured in a number of earlier reports from my office about this Board. I did not uphold a complaint that Mr A contracted infections because of inadequate infection control measures, as there was no clear evidence of this. Finally, I recommended that the Board make a full and detailed apology to Mrs C for the failings identified in my report.

Compliance & Follow-up

In line with SPSO practice, investigators will follow up with the organisations concerned to ensure that they implement the actions to which they have agreed.

Jim Martin, Ombudsman
19 August 2009

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

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SPSO

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 in handling complaints about councils, housing associations, the National Health Service, the Scottish Government and its agencies and departments, the Scottish Parliamentary Corporate Body, 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**

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