

Ombudsman's Commentary

JANUARY 2010 REPORTS

The SPSO laid seven investigation reports before the Scottish Parliament today. Six relate to the health sector and one to local government. Our investigation reports form only one part of our work. In December, we determined 271 complaints, including 68 resolved after detailed consideration.

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

- **Upheld 10 complaints**
- **Made 25 recommendations**

Ombudsman's Overview

Unusually, all ten complaints in the seven investigations reported to the Parliament this month were upheld. The cases speak for themselves in the suffering many of them describe. They include a complaint made on behalf of the husband of an elderly woman with dementia whose broken leg was not discovered by hospital staff, another by a man who made life choices for himself and his family based on a wrong diagnosis of Huntingdon's disease and a third from the parents of a child who had severe medical complications as a result of failures and delays in the handling of the mother's pregnancy and the child's birth.

In two other health cases we report today, a young man had the wrong length of nail inserted in his bone during surgery and another complainant suffered permanent nerve damage as a result of poor care and treatment in his operation for carpal tunnel syndrome. In the final health report, a woman with painful symptoms in her jaw was referred to specialists in two NHS Board areas over three years. Neither Board identified the cause of the problem. At a private hospital, however, she was subsequently diagnosed with a rare condition and she paid for private treatment. My recommendations included that one Board reimburse the complainant for the costs of the private treatment required to identify her condition.

Together, these health complaints contain stories of inconvenience, pain, distress and suffering with often serious emotional, physical and practical consequences. Our work in investigating the cases is to try to bring some measure of comfort through an explanation that can provide some kind of

closure. We make recommendations for redress for the individual, which in many health related cases is an apology that contains a full and felt recognition of what has gone wrong. We also make wider recommendations, to bring medical staff and managers' attention to areas where changes to policies and practices aim to prevent the same thing happening to someone else. Our work in publicising these cases has the same goal – we share the learning about what goes wrong and what we expect to change to put things right in order to reduce the likelihood of the same mistakes being made elsewhere.

This aim is equally important in complaints arising from other public services which fall within our remit. Our seventh report this month is about a Council that failed to take effective enforcement action against unauthorised works by the owners of a disused quarry site next to the complainant's home. I found that, although the Council had been actively involved in these issues over many years and despite the serving of an Enforcement Notice, the terms of which had to some extent been complied with, they had in fact failed to take effective enforcement action. I upheld the complaint and recorded serious concerns about this failure. By way of redress, I recommended that the Council take immediate action to obtain and act upon an independent consultant's report, which should recommend steps to ensure final compliance with the Enforcement Notice. I further recommended that they write to those neighbouring the site to apologise for these failures and carry out a full review of their enforcement practice taking into account the relevant planning circulars and advice.

Ombudsman's Commentary

JANUARY 2010 REPORTS

case reports

Health

Care of the elderly; delay in diagnosis; record-keeping

Greater Glasgow and Clyde NHS Board – Acute Services Division (200803152)

Mrs A, an elderly woman suffering from dementia, fell twice while in hospital and suffered a broken femur. Although after the second fall Mrs A's family told staff that they were concerned about her mobility, the fracture was not diagnosed until a complaint was made and Mrs A was x-rayed, some two months later. Mr C, a caseworker at a Citizens Advice Bureau, complained on behalf of Mrs A's husband about Mrs A's care and treatment. Mrs A died in a nursing home before my investigation was completed. The Board accepted that they should have x-rayed Mrs A earlier and have already taken significant improvement measures as a result of learning from this complaint. I did, however, uphold the complaint that, despite the family's concerns, the Board failed to identify that Mrs A had a broken femur as I found no evidence that Mrs A was medically assessed after either fall. I recommended that the Board remind staff of the need to carry out and record medical assessments in line with policy; to provide me with the results of their audit of compliance with the new measures; and to consider implementing my medical adviser's suggestions in the report about taking account of family views and recording information.

Policy/administration; genetic testing

Lothian NHS Board (200800801)

Mr C was tested and diagnosed in his early thirties as a likely sufferer of Huntington's disease (HD), an incurable hereditary neurological condition causing deterioration in later life. The understanding that Mr C would develop HD and that his daughters had a 50 per cent chance of being affected by the condition caused a great deal of anxiety for the family, and led them to make certain life choices. The test in which Mr C tested positive for HD in 1989 carried a four per cent probability of error. A new, more accurate test was introduced in 1993 but Mr C was not re-tested with this until 2007. The result was negative, showing that Mr C did not in fact have the disease at all and that he must have fallen within the four per cent of people for whom the original test provided an inaccurate result. Mr C and his wife complained that, had re-testing been routinely provided when more accurate tests became available, much stress would have been avoided and different decisions made about their daughters' future. Although I found that the general position of the Board on re-testing was reasonable, I found that in Mr C's particular case it was far too long before he was offered a re-test, especially as he was not displaying symptoms of HD. I therefore upheld the complaint that the Board did not act reasonably in failing to re-test Mr C for HD after the introduction of more accurate tests. I recommended that the Board remind clinicians of the importance of open discussions of new genetic tests with affected

patients in order to enable them to make informed choices and of the importance of recording such discussions and the information provided to patients.

Clinical treatment; communication; policy/administration

Lothian NHS Board (200801828)

Mr C's wife, Ms A, was 29 weeks pregnant when, on two consecutive days, they attended the Board's Centre for Reproductive Health (the Centre) because of their concerns about the pregnancy. Although Ms A was certain that foetal movement was reduced, on both occasions staff did not detect any problems and said the pregnancy was normal. A week later, following advice from their community midwife, the couple attended the centre again because of their continuing concerns. Their daughter was eventually delivered by emergency caesarean section that day. Mr C complained that Ms A did not receive appropriate care and treatment when they attended the Centre. He said that as a result of the Board's failures their daughter suffered severe medical complications. I upheld Mr C's complaints in full and recommended that the Board inform me of the measures they have taken to address all the issues identified in my report, including failure in communications; failure to identify that there were problems with the pregnancy; and delay in performing the caesarean section. I also recommended that they send a formal written apology to Mr C and Ms A for the inadequate care and treatment received.

Ombudsman's Commentary

JANUARY 2010 REPORTS

case reports

Health

Clinical treatment; communication

Forth Valley NHS Board (200801143)

Mr C was involved in a motor cycle accident in which his right tibia was fractured. He had an operation but complained that the nail inserted in his bone was excessively long and resulted in him suffering unnecessary pain and inconvenience. I upheld his complaint on the grounds that the surgical technique was inappropriate and the correct size of nail was not available in the hospital at the time of the operation. I also found that communication with Mr C about this was inadequate but noted that the Board had already taken steps to address both this and to improve their supply of such nails. I therefore recommended only that the Board apologise to Mr C for the failings identified in my report.

Clinical treatment; follow-up care

Lothian NHS Board (200802225)

Mr C had carpal tunnel release surgery performed on his left hand, following which he suffered pain, numbness and swelling. He was subsequently told that he has permanent nerve damage. He raised concerns about the way the operation was performed and that he was not referred back to the surgeon to be re-examined as soon as possible after he complained of these symptoms. My medical adviser said that it was not possible to determine the exact cause of the damage, but was of the view that the operation had been inadequately performed and that a consultant had not reassessed Mr C following his reports of

adverse post-operative symptoms. I, therefore, upheld the complaint that the Board did not provide reasonable care and treatment to Mr C during and after his operation. I recommended that they reinforce with staff the importance of referring patients back for a consultant review as soon as possible if there are complications or adverse symptoms which need attention, and that they apologise to Mr C for the failings identified in my report.

Delay in diagnosis; clinical treatment; communication; record-keeping

Borders NHS Board (200801583)
Lothian NHS Board (200801582)

Ms A suffered from painful symptoms in her jaw, and was on a number of occasions referred to specialists, firstly in Borders NHS Board area then in Lothian NHS Board area, over a three year period. Neither Board identified the cause of the problem. At a private hospital, however, she was subsequently diagnosed with a rare condition where the main bone of the upper jaw had become inflamed and damaged by infection. Ms A's MSP complained on her behalf that she had not been correctly diagnosed by the NHS and, as a result, had to pay for private treatment. My medical adviser noted that there had been issues with referrals and that further investigation of Ms A's symptoms should have been made. I therefore upheld the complaint that Ms A was not properly investigated by the Boards involved, and that they could have diagnosed her condition sooner. I made a number of recommendations, including a review of the referral process of both Boards, the need for clinicians to take careful account of referral

information, and that the Boards consider my medical adviser's best practice advice as outlined in the report. I also made further specific recommendations to both Boards, including that Lothian NHS Board reimburse Ms A for the costs of the private treatment required to identify her condition.

Local Government

Planning: enforcement

Fife Council (200801806)

Mr C complained that the Council had failed to take effective enforcement action against unauthorised works by the owners of a disused quarry site next to his home. In particular, he was concerned that the Council had failed to ensure that the owners of the site complied with the conditions of a Planning Enforcement Notice issued by the Council in 2004. I found that, although the Council had been actively involved in these issues over many years and despite the serving of the Enforcement Notice, the terms of which had to some extent been complied with, they had in fact failed to take effective enforcement action. I upheld Mr C's complaint and recorded my serious concerns about this failure. I recommended that the Council take immediate action to obtain and act upon an independent consultant's report, which should recommend steps to ensure final compliance with the Enforcement Notice. I further recommended that they write to those neighbouring the site to apologise for these failures and carry out a full review of their enforcement practice taking into account the relevant planning circulars and advice.

Ombudsman's Commentary

JANUARY 2010 REPORTS

case summaries

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
20 January 2010

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**

Communications Manager: **Emma Gray**
Tel: **0131 240 2974**
Email: egray@spsso.org.uk



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

Contact us at:

SPSO Tel: **0800 377 7330**
4 Melville Street Fax: **0800 377 7331**
Edinburgh EH3 7NS Text: **0790 049 4372**

E-mail us at: ask@spsso.org.uk