



Ombudsman's Commentary

JUNE 2006 REPORTS

I laid thirty-nine reports before the Scottish Parliament today. Twenty-four relate to the local government sector; thirteen to health; and two to Scottish Executive agencies.

Local government Ombudsman's overview

Discretionary decisions and continuous improvement

Most of the complaints about local government reported on this month are about discretionary decisions. Section 7(1) of the SPSO Act 2002 states that *'The Ombudsman is not entitled to question the merits of a decision taken without maladministration by or on behalf of a listed authority in the exercise of a discretion vested in that authority'*. This means that although I cannot question a decision just because a complainant is unhappy with it, I can look at the processes that led up to the decision. This month, I upheld two such linked complaints from objectors to a development, finding that a council had failed to assess properly a planning application.

With regard to a different council, I considered a number of complaints about the reorganisation of schools. While the complainants are likely to remain unhappy with the council's decision, I found that the council had correctly followed guidelines and procedures and consequently I did not uphold the complaints.

I did not uphold eighteen of the twenty-four complaints about local government. However, this is not grounds for complacency. The fact that I did not uphold a complaint does not necessarily mean that there are no lessons for the authority to learn. Where appropriate I have and will continue to make recommendations to an authority even though I have not upheld the complaint. I do so not as a criticism but as an encouragement for continuous improvement. However, as these reports also demonstrate, there are many instances where councils take action to resolve complaints and they are to be commended for this.

Planning – complaints by objectors to development: Fife Council

This complaint was brought by Ms C on behalf of a number of residents. The complaint concerned the council's handling of a planning application for housing on a site to the rear of the complainants' homes. Ms C considered that the council mishandled aspects of the original planning application and neighbour notification. After investigation, I found that the council had not had sufficient information to properly assess the effect of the development on the complainants' houses and had not required re-notification of the proposals. The complainants' amenity and property values may have been affected. The council's ability to take enforcement action was restricted. After the matter was brought to their attention, they took appropriate action. The outgoing Chief Executive of the council accepted my recommendation that an independent valuer be instructed with a view to making appropriate payments if the properties in question have lost value.

In a separate complaint about the same issue, I also upheld a complaint of delay in handling correspondence, but did not uphold a complaint that the council had approved a subsequent planning application to the detriment of residents. The council accepted my recommendation to change the wording of their responses to complaints. I am pleased with the council's positive response to this complaint.

Reorganisation of secondary education: Inverclyde Council

In April 2005, my office received a complaint about the council's proposals to reorganise secondary education. In July and August 2005, a further 130 people made representations about the proposals and, of these, three went on to make formal complaints to this office. These are the subject of separate reports to the Scottish Parliament and all four reports have been laid today. As the complaints covered the same issue, we decided to investigate the matters raised together.

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Local government *(continued)*

As I state above, I did not uphold any aspects of the complaints, and the individual reports conclude:

'The council had a difficult situation to handle. Their responsibility in terms of the Guidance was to the wider community and current and future generations of parents and their children. At the same time, they had an obligation to manage the concerns of parents like Ms C who were anxious about the implications of the proposals for their children. This was especially so given Ms C's commitment to, and confidence in, her children's school. Regrettably in this case, it has not been possible to satisfy the interests of all those involved and Ms C is likely to be disappointed at the outcome of her complaint to this office. Nevertheless, after considering the extensive information available, I am satisfied that the council acted in accordance with established guidelines and procedures and, when the proposals were to be considered, the full council agreed by a majority to approve them. In all the circumstances, I do not uphold Ms C's complaints.'

Beetle infestation: Highland Council

The complainant, Ms C, was concerned about the council's failure to deal with a beetle infestation within a reasonable timescale; to properly maintain her property and to deal with anti-social neighbours. I upheld the first two aspects of the complaint but not the last. As a result of the complaints, the council reviewed the background to this case and suggested that:

- a) they apologise to Ms C for the delay in dealing with the beetle infestation, removal of a bird's nest and repair to her hall wall;
- b) agreed timescales for repairs will be reviewed and monitored closely to ensure better delivery of service;
- c) in respect of the delays to the repairs, they make a one off, ex-gratia payment;
- d) they will ask the new community warden to contact Ms C to try to resolve any outstanding issues concerning her neighbours on an on-going basis.

I consider that the above actions proposed by the council are appropriate redress in response to Ms C's outstanding concerns. In light of this conclusion, I have made no further recommendations.

Failure to give timely response to correspondence: Highland Council

The complaint concerned the way in which the council dealt with two planning applications for sites close to the complainant's home. Although I did not uphold her allegation that they failed to protect the amenity of listed buildings within the vicinity of the development area or to respect the sensitive nature of a nearby ancient monument, I did find that the council had failed to give timely responses to correspondence and recommended that they apologise to the complainant. They have done so and I am pleased with the council's positive response to this issue.

Failure to give timely response to correspondence Comhairle nan Eilean Siar

This complaint concerned the council's handling of two planning applications. I did not uphold the core complaints, but I did find that the council failed to respond to correspondence. I recommended that they apologise to Ms C, and reaffirm to staff their policy of replying to all correspondence within defined time limits. The council have confirmed that they will do so, and are to be commended for this.

Handling of termination of tenancy City of Edinburgh Council

The complaint was made by former council tenants, Mr and Mrs C, who alleged that when they gave up the tenancy the council's housing department failed to ensure that they completed the proper termination procedure and that as a consequence of this they incurred considerable rent arrears. In the course of the investigation, the department accepted that there was a failure to ensure completion of the proper termination procedure. They apologised to my office for this administrative failure and agreed to offer Mr and Mrs C a formal apology. The council agreed to take on board the administrative issues raised by the complaint and, in this context, they indicated in their reply to my investigator that they had put in place appropriate training procedures for staff to follow when dealing with similar cases. The council also agreed to authorise an immediate rent credit to Mr and Mrs C. I commended the action being taken by the council to resolve this issue.

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Other complaints investigated and not upheld related to the following issues:

- failure to award medical points when considering a housing application (**Argyll and Bute Council**)
- handling of a planning proposal to demolish a listed building and erect a new housing development (**East Lothian Council**)
- the condition of the kerb of a footpath (**Fife Council**)
- handling of planning applications (two about **Scottish Borders Council**, one about **Glasgow City Council**)
- playing of allegedly sectarian song at a council swimming pool (**South Lanarkshire Council**)
- a national park authority was not making information on planning applications readily available to the public (**Loch Lomond and The Trossachs National Park Authority**)
- failure to handle properly representations about council tax and failure to handle a council tax account (both **City of Edinburgh Council**)
- handling of a planning application for the construction of a telecommunications tower (**North Ayrshire Council**)
- failure to consult all interested parties in relation to a proposal, and ultimately a decision, to relocate and re-designate a nursery school and a complaint that the council had attempted to influence the outcome of a public local inquiry and had failed to consult properly on proposals to move the nursery school (both **South Ayrshire Council**)
- closure of a public toilet. The complainant was concerned that the closure of the facilities was not in the interests of public health and that the council had not considered the needs of the community, including the disabled, when reaching its decision (**South Ayrshire Council**).

Health

Ombudsman's overview

Care and treatment of a patient with severe anorexia nervosa NHS Lothian

In this distressing case the patient (Miss A) was cared for in nine different facilities in both Scotland and England and within the NHS and the independent health sector. She was first referred to hospital in 1998, aged 14, for treatment of Obsessive Compulsive Disorder. Subsequently she also developed severe anorexia nervosa. Sadly, she died when she was 20. In summary, the report concluded that there was a failure in the psychiatric and medical services provided to Miss A.

In bringing her complaint to this office, Miss A's mother stated that she hoped to prevent unnecessary suffering for other families affected by anorexia nervosa. In essence the investigation findings reached the same view as Mrs C, borne out of her own experience, and stated in her original letter of complaint to this office:

'Medical hospitals are ill equipped and ignorant of the disease [anorexia nervosa]. GPs should also be educated about this disease. I think there should be separate wards for these patients and more funding.'

Our report notes that Miss A's anorexia nervosa was particularly severe in nature. My medical advisers expressed a strong view that Miss A's treatment and care within a number of the hospitals was excellent, but that its long-term benefit was severely hampered by the necessity for treatment to be delivered so far from Miss A's home and in so many different settings. The medical records frequently reflected awareness by health professionals of the limitations of the current provision and a frustration that the options for Miss A's treatment were so far from ideal.

The report noted that a number of changes to the available psychiatric provision have occurred since these events. However, it concluded that there remains a small but vitally important unmet need for adult in-patient psychiatric and related mental health services for patients with an eating disorder. There is also a wider need for acute in-patient medical services with appropriate specialist knowledge and expertise for patients with eating disorders whose physical condition requires medical input. These needs are not limited to the Lothian area but apply to a greater or lesser extent to Scotland as a whole. Action by NHS Lothian alone cannot address the lack of provision

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Health reports (*continued*)

identified for the whole of Scotland or the problems of lack of awareness amongst health professionals.

I have, therefore, referred the need for services throughout Scotland identified in this report to the Scottish Executive Health Department for consideration as part of overall strategies in relation to Eating Disorder services throughout Scotland and to NHS Quality Improvement Scotland who are currently developing Scottish Guidelines for Eating Disorder services.

The report also commented that 'it was the complexity of the care pathway that prevented there being a clear and known communication point for the family which left them feeling unsupported and confused about where to turn to for help or information.'

I have raised this issue in previous reports as it is a problem that arises in relation to many different types of treatment. It is important that those in authority in NHSScotland ensure that the continuum of care is maintained throughout the patient's journey.

Lack of care for a woman before and after the stillbirth of her baby NHS Fife

The complainant, Mrs C, said that she received unsatisfactory care from NHS Fife and that a midwife made major mistakes during the delivery of her baby. The complaints investigated were:

- delays – in diagnosis of Group B Streptococcus, in admission to hospital, in giving antibiotics and in performing a Caesarean section;
- the midwife failed to interpret tracings accurately and failed to send for medical assistance appropriately;
- the midwife's care and attention to Mrs C was inadequate;
- lack of information and action following Mrs C's complaint.

The first two and fourth aspects of Mrs C's complaints were upheld and the third was partly upheld.

Mrs C's sad experience involved serious failures by the midwife in the care of Mrs C and her baby. In addition, NHS Fife did not explain to Mrs C what they had done as a result of her complaints. Explaining action taken to prevent a problem happening again is an important part of responding to a complaint. It is clear, however, that when handling Mrs C's complaint, and during my

investigation, NHS Fife recognised the seriousness of the clinical failures identified and took appropriate steps to address them. They also plan to adopt the Scottish Woman Held Maternity Record referred to in my March Commentary. I commend NHS Fife for this.

I recommended in my report that they should also:

- provide more information to Mrs C about what happened and what action they have taken to prevent it happening again;
- ensure that special instructions on labour ward notes are more prominently displayed and that further training is considered; and
- ensure that they strengthen midwifery management and adopt a more robust and structured approach to adverse incidents.

Repeat prescription

A GP practice in the Forth Valley area

The complaint related to the decisions of two GPs to prescribe a drug for a patient without taking proper account of her condition as a frail 92-year-old, and then to give it on repeat prescription. I did not uphold the first aspect of the complaint, but I did uphold the second. I found that the initial prescribing decision was justified but that one of the GPs should have more fully assessed the situation before prescribing the drug as a repeat. In the light of these findings, I recommend that the practice review their repeat prescribing mechanisms. The practice have accepted the recommendation and have already acted on it.

Failure to protect property and pass on patient's property NHS Highland

The complainant said that the Board had failed in their care of her grandmother while she was in hospital. The aspect of the complaint that I upheld related to the patient's missing wedding ring, and I found that the hospital failed to have adequate security policies and procedures in place to protect patients' personal property and pass on personal effects appropriately. The Board have taken action to address these issues and I commend them for this and have no recommendation to make.

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Health reports *(continued)*

Improper administration of anaesthetic by General Dental Practitioner (GDP)

Greater Glasgow and Clyde area

The complainant said that a GDP had improperly administered an anaesthetic causing her to suffer an adverse reaction and long-term illness. I upheld both aspects of the complaint and made a specific recommendation that the dentist write a personal apology to Mrs C for administering the anaesthetic against her known wishes. Following sight of the draft report, the dentist indicated that she accepted this recommendation.

Of the thirteen reports about the NHS laid this month, eight did not uphold any aspect of the complaint investigated. In one instance I did, nonetheless, make recommendations. The issues to which the complaints related were:

- policy on the provision of physiotherapy for people with long-term disabilities (**NHS Greater Glasgow and Clyde**)
- breach of confidentiality; premature termination of psychotherapy; inaccurate records (**NHS Forth Valley**)
- clinical treatment, nursing care and communication issues in hospital (**NHS Tayside**)
- maternity treatment (**NHS Lothian**)
- failure to provide dental bridgework to an acceptable standard (**a dental practitioner in the Lothian area**)
- incorrect diagnosis and inadequate standard of care (**a GP in the Grampian area**)
- inadequate care and treatment (**NHS Grampian**)

Inadequate supervision of an elderly patient: NHS Lothian

This complaint was about whether an elderly patient fell out of bed as a result of inadequate supervision by nursing staff and failure to put up the cot sides on his bed. Although I did not uphold the complaint, I drew the Board's attention to my medical adviser's comments on the quality of care planning in this case and recommended that they took action to ensure that patients are appropriately assessed and have up-to-date nursing care plans. In reply to the draft report the Board provided satisfactory evidence that measures were already being taken through their clinical governance structures that would address these issues.

Scottish Executive agencies

Student Awards Agency for Scotland (SAAS)

The complainant, Mr C, said that the SAAS were demanding a Graduate Endowment payment from him and threatening legal action if he failed to pay. Mr C felt aggrieved because, despite providing the SAAS with information which he considered showed that he was clearly not liable, they continued to pursue him for payment.

Following investigation of the matter, however, I am satisfied that Mr C is liable to pay the Graduate Endowment under the terms of the relevant regulations and, to that extent, his complaint is not upheld. However, he is justified in feeling aggrieved due to information on the SAAS website in 2005 being incomplete. This is a shortcoming that the SAAS have remedied but I recommend that they formally apologise to Mr C for any confusion that their administrative error may have caused him and acknowledge his part in bringing the matter to their attention. The SAAS have accepted the recommendations and will act on them accordingly.

The Scottish Commission for the Regulation of Care (the Care Commission)

This complaint was from the legal representatives of a housing association. It concerned the Care Commission's handling of a complaint brought against the association and the subsequent issues raised. It also related to the Care Commission's formal advice to the association that a Care Manager for the association was not considered to be a 'fit person' to hold a management position under the terms of the Regulation of Care. I partially upheld all aspects of the complaint and made a number of specific recommendations.

Compliance and Follow-up

In each complaint, all the organisations complained about have accepted my recommendations. In line with SPSO statutory responsibilities and practice, my office will follow up with the organisations to ensure that they implement the actions to which they have agreed.



Alice Brown. 27.06.2006

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
ask@spsso.org.uk