Ombudsman's **Commentary**

MAY 2007 REPORTS

I laid 50 investigation reports before the Scottish Parliament today. Twenty-two relate to local government, 18 to the health sector, six to the Scottish Executive and devolved administration, three to higher and further education and one to housing associations. Individual reports are summarised below.

Welcome to new readers of this Commentary, in particular to recently elected MSPs and their parliamentary staff, and to newly elected Councillors. By way of background information, the SPSO was set up in 2002 by an Act of Parliament[1] to investigate complaints from members of the public that they have suffered hardship or injustice as a result of maladministration or service failure by public bodies. In reaching a decision on such complaints, the Ombudsman's office forms part of the administrative justice system in Scotland and provides an alternative to the courts. Our service is free and is independent and impartial.

We lay an average of 25 reports before the Parliament each month. These are complaints that have progressed to the final investigation stage. They represent less than twenty percent of the total number of complaints determined – the rest are closed at earlier stages by, for example, an investigator contacting the body to see if informal resolution is possible. In addition, my staff give advice to members of the public as well as guidance to bodies under jurisdiction on how to prevent complaints from arising in the first place and about handling them well when they do.

The final investigation reports contain a wealth of information about how public services are working from the perspective of the user. My first obligation as Ombudsman is to determine whether or not maladministration or service failure has caused hardship or injustice, and, if it has, to recommend redress for the individual. Another important function is to try to make sure that the situation does not recur, and where appropriate my recommendations also address this aspect. The evidence drawn from our investigation reports and other work can be used as a valuable source for learning lessons and improving the delivery of public services as well as a means by which the Parliament can hold public bodies to account.

The monthly Commentary summarises the reports laid before the Parliament and is a means of feeding back the learning to a wider audience than simply the complainant and the body complained about. It is sent to the chief executives of the many bodies under my jurisdiction, to help their organisations learn from what has happened elsewhere in their sector. It is also distributed to other stakeholders including advocacy agencies and the press. Finally, and importantly, the reports are a resource for policy-makers who are charged with improving public administration and the design and delivery of public services.

I hope that you find the Commentary useful in your own work. Further information about the investigation reports and the role of the SPSO can be found on our website at: **www.spso.org.uk**

1 www.opsi.gov.uk/legislation/scotland/acts2002/20020011.htm

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Health

Clinical treatment and care

Lanarkshire NHS Board (200401686)

The complaint concerned the care and treatment of the late wife of the complainant, Mr C, by a doctor from an out-of-hours GP service during a home consultation. I upheld the complaint, which concerned matters of delay, clinical treatment and communication. I recommended that the doctor issue Mr C and his family with a full formal apology for the failures identified in the report. I stated that the apology should be in accordance with my guidance note on apology (which sets out what is meant and what is required for a 'meaningful' apology and is available at: www.spso.org.uk/advice/article.php?ssi=41). I note that there have been major changes to the GP service since the events which led to this complaint, particularly in relation to a deputising doctor being aware of a patient's condition and having ready access to a syringe driver and palliative care for a patient, which should help ensure that such circumstances do not recur.

Dental treatment

A Dentist, Forth Valley NHS Board (200501171)

I upheld the complaint that the treatment provided to a woman patient was inadequate and the compensation (which was a refund of the cost of charges she had paid for her dental treatment) was insufficient. I recommended that the Dentist make a payment to the complainant to cover the cost of remedial work that was provided privately and a further amount in respect of her pain and suffering. I also recommended that the Dentist undertake further training.

Discharge from hospital/nursing care/communication

Greater Glasgow and Clyde NHS Board (200402199)

This complaint was brought by an advocacy worker on behalf of the family of an elderly woman, Mrs A, who had been a hospital patient. She complained about a lack of communication with the family, in particular in relation to whether or not Mrs A had a stroke while in hospital (partially upheld); the standard of nursing care (not upheld); a lack of effective planning of Mrs A's discharge from hospital (upheld) and inaccuracy in communication of the cause of death (not upheld).

With regard to the discharge from hospital, I found that the planning was not well managed. *'Neither the family not the local district nursing service had adequate information about Mrs A's condition… The district nurse was not prepared for the real situation and so only visited on the third post-discharge day. No wonder the family felt they had been let down by the hospital'.*

To redress the situation, I recommended that the Board:

(i) highlight to staff the need to manage the expectations of patients' families and to be aware of the need to communicate in non-technical language and provide clear explanations;

(ii) undertake an audit of the new care plan documentation and share the results of that audit with the SPSO;

(iii) apologise to Mrs A's family for their failure to carry our their own discharge policy effectively and the inconvenience, distress and concern that this caused; and

(iv) audit their discharge policy to ensure that it is now being fully implemented.

Palliative care/communication/recordkeeping

Grampian NHS Board (200500578)

The complaint concerned the hospital's failure to admit the complainant's wife, Mrs C, who was suffering from advanced cancer, to the palliative care suite as had been agreed with her GP. She was instead admitted to a general ward, which was distressing for Mrs C, the family and other patients particularly as Mrs C was in pain. Only one member of the family was allowed to stay with Mrs C outwith visiting hours and was with her when she died.

I upheld the complaint that staff failed to communicate effectively with Mrs C's GP prior to transfer. I am satisfied that the Board took remedial action to improve communication and prevent this situation arising again, but I recommended that the Board formally apologise to the family for the distress caused by their communication failures. I did not uphold the complaint that staff had made ineffective use of the palliative care suite on a technicality because I found that the Board had taken effective remedial action as a result of this complaint when it was first made.

I made no finding on the complaint that staff failed to communicate effectively with Mrs C's family. However, I found that the nursing records were brief and inadequate. I recommended that the Board provide evidence to show that a new documentation tool has been audited to demonstrate that nursing records adhere to minimum standards required by the Nursing and Midwifery Council Guidelines for Records and Recordkeeping (2005).

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Health

Clinical treatment
Greater Glasgow and Clyde NHS Board (200501972)

I did not uphold the complaint about inadequate treatment including that a liver biopsy was not carried out, but I did find that staff should have been aware of the potential for problems to arise with the prescribing of a particular medication. The Board accepted this finding. I made no recommendation.

Surgery and nursing care
Argyll and Clyde NHS Board, now Greater Glasgow and Clyde NHS Board (200503022)

The complainant, Mr C, raised concerns about his hernia surgery and post-operative nursing care. I did not uphold the complaints that Mr C was asked by nursing staff to walk too early after his first operation, nor that his operations were not carried out with a reasonable degree of skill. I did find, however, that he was asked by nursing staff to walk unaided despite the fact that he complained of numbness in his leg. I recommended that the Board apologise to Mr C for the distress this caused, and I also suggested that staff are reminded of the importance of adequate documentation of the pre-operative consent process.

Clinical treatment/ communication
Greater Glasgow and Clyde NHS Board (200601268)

I did not uphold the complaints that treatment was inadequate or that there was a delay in carrying out a CT scan, but I did find that there was poor communication concerning the need to inform the Procurator Fiscal of a death. The Board have accepted that there was failing in this regard and have said that feedback from this case is being used to identify issues for improvement. I made no recommendations in this case. I noted that there was a lack of recording of any detailed neurological or physiotherapy assessments prior to a discharge from hospital and invited staff to reflect on this issue and consider whether there are any lessons to be learned.

Clinical treatment/ communication
Greater Glasgow and Clyde NHS Board (200601357)

I did not uphold the complainant, Mr C's, complaints about clinical treatment, but I did find that staff had failed to communicate adequately with the patient's (his mother, Mrs A's) family and that the procedure for reporting lost property was not adequately followed. There were serious and distressing failings in communication, resulting in the family being taken to the bedside of Mrs A, unaware that she had died. An unreserved apology was given for the distress caused, but the communication failures identified, particularly during shift changeover, did not appear to have been addressed and, therefore, I recommended that the Board:

(i) ensure that the investigation report is shared with the staff involved so that they are reminded of the importance of communication with relatives;

(ii) consider whether the procedure on changeover of shifts for passing information to relatives about patients who have recently died is adequate.

With regard to the loss of property, I recommended that the Board conduct a review of the availability of claim forms at ward level in the hospital and send Mr C a claim form and consider a request for reimbursement of property should he wish to consider the matter.

Clinical treatment and care
Ayrshire and Arran NHS Board (200502839)

I did not uphold the complaints that staff had handled the complainant's father, Mr A, roughly, nor that there was inadequate monitoring of his fluid intake. I partially upheld the complaint that Mr A received inappropriate oxygen therapy. I recommended that the Board share the report with the doctor who treated Mr A, and encourage him to reflect on its findings.

Treatment and care/removal from list
A Dentist, Argyll and Clyde NHS Board, now Highland NHS Board (200501331)

This complaint had eight specific aspects to it. I did not uphold, or made no finding on six of these, which related to waiting times, treatment and care and the giving of inappropriate or inadequate advice. I partially upheld the complaint that the patient, Mrs C, was unfairly removed from the dental list and I upheld the complaint that the Dentist failed to address all of the points raised by the complainant, Mr C, the patient's husband. I recommended that the Dentist make apologies for the failings identified in the report, and also that he take steps to ensure that he and his staff become conversant with the legal provisions relating to de-registration.

Clinical diagnosis
Lothian NHS Board (200501210)

The complainant, Miss C, complained that the Board failed to provide the necessary out-of-hours care to her fiancé, Mr A, contributing in his death. I did not uphold the complaints that a GP failed to make an appropriate differential diagnosis on Mr A's medical condition, nor that a different GP failed to give appropriate medical advice. I did find that the telephone receptionist failed to record and pass on all the symptoms described to him by Miss C, that a GP failed to take a comprehensive medical history and that the out-of-hours service failed to respond appropriately to Miss C's complaint. I recommended that the Board make an apology to Miss C with regard to failings in their complaint handling and use the events of this complaint as part of future training for out-of-hours staff to reiterate the vital importance of good communications skills in telephone consultation. I note in the report that the case has already been used in an education meeting organised by Lothian Unscheduled Care.

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Health

I did not uphold or made no finding in seven other complaints in the health sector about the following issues and bodies:

Policy/administration
Lanarkshire NHS Board (200501792)

Clinical treatment
A GP Practice, Lanarkshire NHS Board (200502533)

Dental treatment
A Dentist, Lothian NHS Board (200600710)

Removal from list
A Dentist, Greater Glasgow and Clyde NHS Board (200500848)

This complaint involved conflicting accounts of conversations and I made no finding about the complaint that the complainant and her children were removed improperly from the practice list. It was clear, however, that the Dentist was unaware of the regulations governing removal of NHS patients from practice lists and I recommended that he familiarise himself with them. As was the case in an earlier report about this issue (Case ref: 200502765), I raised with the Scottish Executive Health Department my view that it would be helpful for dentists and patients to have more guidance in respect of removal from dental lists. I am pleased to record that they agreed to consider this.

Nursing care
Lanarkshire NHS Board (200502016)

I did not uphold the complaint, but I did suggest that consideration be given as to when it is appropriate for patients to be shut off from observation. I also made a criticism of inaccuracies in a Therapy Prescription Chart but was satisfied with the action plan subsequently produced by the Board, which covered issues of the completeness of nursing records; the observation of patients; the incident reporting mechanism; and the administration of intravenous fluids.

Nursing care
Lanarkshire NHS Board (200600940)

I did not uphold the complaint, but I did express a concern about recording of dietary intake. The Board have informed me that a new Diabetic Recording and Administration Chart contains a section for recording dietary intake.

Dental and Orthodontic Services
An Orthodontic Practice, Greater Glasgow and Clyde NHS Board and NHS National Services Scotland (200500179 and 200602372)

From April 2005, my Office received in excess of 150 mandates from parents about delays in the approval for orthodontic treatment. In October 2005 it was decided that as the complaints were identical the best use of my Office's resources was to contact the parents for additional information and to ask for permission to obtain copies of their dependents' medical records. Most parents did not respond to that request and it was subsequently decided that I would investigate the orthodontic treatment provided to three dependents whose parents had asked my Office to consider their complaints. I did not uphold the complaint about delay by the Practice in carrying out orthodontic treatment and delay by NHSNSS in granting approval for orthodontic work to commence. I am pleased to note that NHSNSS have amended their procedures and have started a pilot project relating to approvals and that the Practice is taking part. I recommended that the bodies continue meaningful discussions to decide the circumstances where radiographs are required in individual cases which require prior approval for the Practice to commence orthodontic treatment.

Housing Associations

Repairs and maintenance
Glasgow Housing Association Ltd (200502596)

I did not uphold the complaint that the Association was responsible for repairing and redecorating damage to the complainant's home caused by water ingress.

Local Government

Policy/administration
Shetlands islands Council (200401727)

I upheld the complaint that a senior official in the Council failed to declare an interest when dealing with organisations in which his brother was involved. My investigation concluded that nothing in the documentation obtained suggested that the senior official acted with anything other than proper motives. I took the view, however, that it would have been more prudent for him to have his relationship with a member of a company's board placed on record. My recommendation to the Council was that they emphasise to staff the importance of public perception in relation to their actions.

Policy/administration
Orkney Islands Council (200601457)

I upheld the complaint that the Council failed properly to handle the complainant, Mr C's, request to reimburse his travel and accommodation requests after he turned down a job with them. I recommended that the Council reimburse Mr C's reasonable travel and accommodation requests and in correspondence with interview candidates make clear their policy on such expenses. The procedures have since been amended and the Council is to be commended for this.

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Local Government

Housing repairs
South Lanarkshire Council (200400549)

The complaint concerned the Council's refusal to replace a wooden floor that allegedly was damaged by water penetration into a living room caused by contractors acting on behalf on the Council in the course of a capital repairs programme. I upheld the complaint and recommended that the Council restore the living room to the condition it was in before the flooding occurred.

Planning application
Aberdeenshire Council (200501045)

I upheld the complaint that the Council's decision to reconsider a planning application led to unnecessary delay. I made several recommendations including that the Council issue an apology to the complainants, reimburse fees and make certain changes to their handling of applications.

Primary school: special needs
North Lanarkshire Council (200502948)

I partially upheld a complaint relating to the treatment of the mother, Mrs C, of a child with special needs who attended a main-stream school. My investigation found that the school *'could and should have done more to show a greater sensitivity and responsiveness to problems that arose'*. To redress the situation, I recommended that the Council apologise to Mrs C for not making information on home tuition available earlier, for publishing an unfavourable minute of a review meeting and for the time and trouble she spent trying to establish the circumstances under which a photograph of her son was publicly displayed. I also recommended that the Council have in place a published policy on home tuition, always provide clarification of the process required in the preparation of home tuition work and review their existing complaints procedure where it concerns head teachers, in order to exclude the possibility of them investigating complaints made against themselves.

Planning application
The City of Edinburgh Council (200402197)

The complainants, Mr C and his neighbour Mrs D, were concerned that the Council failed to require that they be re-notified when an amended planning application was received from Mr C and Mrs D's neighbour. I made no finding on this complaint, but I upheld their complaint that the Council failed to keep adequate records. The Council has introduced a new policy on keeping an audit trail of changes on a planning file in their new file retention policy. Since this new policy is sound and addresses the criticisms in the report, I made no further recommendations.

Housing benefit/council tax
Perth and Kinross Council Board (200402093 and 200500680)

I upheld the complaint that the Council delayed in attending to works which their surveyor considered necessary after an inspection at the complainant, Mr C's, home and that they unreasonably initiated legal proceedings against him. I did not uphold the complaint that the Council harassed and discriminated against Mr C. I was satisfied that apologies and a time and trouble payment offered by the Council provided a suitable remedy to the matter. However, I recommended that, when implementing repairs, the Council give careful consideration to the effects any disruption may have on those with health problems and review the channels of communication between the arrears and benefits sections of the Housing and Community Care Department.

Planning application
Scottish Borders Council (200502416)

I did not uphold the complaint that the Council did not correctly identify a planning application or deal with it appropriately and I partially upheld the complaint that there were delays in responding to the complainant's concerns. I recommended that the Council ensure that, where appropriate, planning officers include sufficient detail in their reports on planning applications to demonstrate that they have fully considered Environmental Impact Assessment Regulations and emphasise to staff the importance of keeping complainants informed of the progress of any formal complaint.

Housing repairs and Policy/administration
West Dunbartonshire Council (200500936)

I did not uphold the complaints about adequacy of repairs to the complainant's flat or the Council's addressing of her concerns about anti-social behaviour but I did find that the Council failed to respond to her formal complaint. I recommended that the Council review the system for ensuring the quality of repair work completed, and apologise to the complainant for failing to respond to her complaint.

Complaints handling
Loch Lomond and the Trossachs National park (200501913)

I upheld two aspects of the complaint about the way the Authority investigated the complainant, Mr C's, complaint about the tendering process for the distribution of the Authority's publicity material. I recommended that the Authority ensure compliance with their complaints procedure (in particular that they ensure that information about a complainant's right to bring their complaint to the SPSO is always provided) and ensure that complainants are kept informed of the progress of their complaints.

Bus Stop
Angus Council (200502742)

I did not uphold the complaints that the Council had failed to adhere to health and safety regulations or to consider the impacts on the complainant, Mr C's, privacy when deciding on the site of a bus stop. I partially upheld the complaint that the Council failed to adhere to the aims of the Customer Care Policy when deciding the location of the bus stop and I recommended that they review their procedures for locating bus stops and issue an apology to Mr C for the failure identified in the report.

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Local Government

I did not uphold eleven other complaints in the local government sector this month about the following issues and bodies:

Aids to disabled
South Lanarkshire Council (200601668)

Policy/administration
Falkirk Council (200601894)

Council Tax
The Highland Council (200502225)

Housing: Right to Buy
The Highland Council (200503214)

Sheltered housing /residential homes
Perth and Kinross Council (200600838)

Complaints handling
Angus Council (200600707)

Policy/administration
East Dunbartonshire Council (200600463)

Sale of land
The City of Edinburgh Council (200502683)

I did not uphold the complaint, but I did recommend that the Council clarify their policy on 'piecemeal' sales and clarify the maintenance arrangements for land next to the complainant's home.

Land purchase
The City of Edinburgh Council (200503204)

I did not uphold the complaint, but I did recommend that the Council ensure all relevant staff dealing with a land purchase application are informed when complaints are being considered; ensure that complainants are kept informed of the progress of their complaint and clarify the maintenance arrangements for land about which an aspect of the complaint was made.

Handling of planning application
East Ayrshire Council (200401691)

I did not uphold the complaint, but I did make two recommendations: that the Council take steps to ensure that the administrative errors which had been identified prior to my involvement are addressed to ensure they do not recur; and that they revisit their Scheme of Planning Application Delegation to see whether there is a need, in cases such as this, for a referral to committee.

Planning application
Loch Lomond and The Trossachs National Park (200601262)

I did not uphold the complaint, but I did recommend that Planning staff take care before issuing standard letters to ensure that their terms apply to the circumstances pertaining.

Scottish Executive and devolved administration

Handling of application for grant assistance
Highlands and Islands Enterprise (200401189)

I upheld the complaint from a solicitor, Mr C, that a company he represented was misled by a local enterprise company giving a reasonable expectation that an application for grant assistance would be successful and that the company unjustly incurred costs as a result of the subsequent rejection of the application. I upheld two other aspects of Mr C's complaint and did not uphold one other aspect. To redress the matter, I recommended that the Board apologise to the company; review the way applications for financial assistance are supported to ensure clarity of expectations and address the need for clear, documented advice to applicants throughout that process. I also recommended that the Board ensure that all eligibility criteria are clearly addressed at the beginning and throughout the application process.

Handling of appeal
Scottish Executive Inquiry Reporters Unit (200501921)

I did not uphold the complaint that the body failed to follow their own procedures or that they failed to explain decisions, but I did find that there was poor communication from the body. I made recommendations to the body regarding the clarity of their communication with complainants and about developing guidelines for Reporters on recording measurements and their presentation in letters and reports.

I did not uphold complaints about the following organisations and issues:

Complaint handing
Crown Office (200501535)

Termination of legal aid
Scottish Legal Aid Board (200501593)

Failure to provide information
Scottish Executive (200600617)

Handling of application for civil legal aid
Scottish Legal Aid Board (200501343)

I did not uphold the complaint, but I did make a general recommendation that the Scottish Legal Aid Board (SLAB) should consider whether the documents it produces are clear enough on how members of the public can seek a review of SLAB decisions and how to give appropriate procedural advice (not legal representation) about this to the public. I note that SLAB should of course do this without compromising its obligations under statute.

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Further and Higher Education

Admissions/complaint handling

Dundee University (200503232)

I did not uphold the aspects of the complaint about lack of clarity in information provided by the University and about their admissions procedure, but I did find fault with their complaint handling. I made two recommendations: that the University request that the University and Colleges Admissions Service (UCAS) review information on conditional offers provided to students on the University's behalf and that the University review their complaints procedures and information provided to complainants in the light of concerns raised in the report.

Policy/administration

UHI Millennium Institute (200502175)

I did not uphold the complaint, but I did recommend that UHIMI, in relation to making arrangements for Board of Governors Complaints Appeal Committee meetings, and given the importance of this stage of the internal appeals process, consider making small changes to their procedures for inviting students to attend such meetings.

Appeals Process

The Robert Gordon University (200502845)

I did not uphold the complaint, but I made a general recommendation that the University include, in the final letter issued to appellants by the Academic Registrar, an explanation of why a decision has been reached that there are no prima facie grounds for an appeal to proceed.

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.

Professor Alice Brown
23.05.2007

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

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