



Ombudsman's Commentary

FEBRUARY 2008 REPORTS

I laid 43 investigation reports before the Scottish Parliament today. Nineteen relate to the health sector, eighteen to the local government sector, four to further and higher education, and two to the Scottish Government and devolved administration.

Ombudsman's Overview

This month's reports contain many recommendations aimed at improving complaints handling processes across all the sectors, and I would draw readers' attention once more to the practical advice and guidance provided in the SPSO's Valuing Complaints website www.valuingcomplaints.org.uk.

In my Overview this month I am highlighting complaints about nursing care and drawing on a specific health case to illustrate one of the tests used by the Ombudsman when investigating cases that involve clinical judgement.

Poor nursing care is a feature of several of today's health reports. It is distressing that three of them (Case refs: 200601374, 200601565 and 200602998) concern the pain suffered by patients who developed pressure sores that were not treated or monitored adequately. Two other reports (200602963 and 200501596) are about inadequate provision of pain relief.

In all five cases, there was a failure to fulfil the duty to assess pain adequately and to consider pain relief options. Pressure sores and inappropriate pain relief cause extreme discomfort to patients and distress for their families and friends and in my reports I make several recommendations for improvements in these areas of nursing care. In the case of pressure sores, I draw attention to the Best Practice statements on Pressure Ulcer Prevention and the Treatment and Management of Pressure Ulcers issued by NHS Quality Improvement Scotland (March and November 2005 respectively).

I am highlighting one other health report this month, which I did not uphold (200600197). The complainant, Mr C, is 16 and was born with a progressive spinal deformity, for which he was reviewed in Glasgow between the ages of five months and 13 years. When he was 13, the service was transferred to Edinburgh. At review there, five months later, Mr C was told that an operation some years previously could have prevented his current permanent deformity. Mr C complained, therefore, about not having had such an operation in Glasgow at an early age.

The report includes comments from my clinical advisers who conclude that, with hindsight, Mr C should have been treated surgically at around age ten and would probably have been better treated at around the age of two to three, with possible further surgery during adolescence. However, the report goes on to explain why I, nonetheless, did not uphold Mr C's complaint.

Understandably, complainants may feel that if an investigation shows that a different clinical decision could have been made, then I should uphold the complaint. This very sad case helps to clarify my Office's approach to investigating clinical judgement issues and contains the following explanation:

'The standard by which we judge doctors' actions is whether they were reasonable, in the circumstances, at the time in question. We do not apply a standard of perfection. Rather, we consider whether the decisions and actions taken were within the boundaries of what a reasonable doctor, from a similar area of medicine, at a similar grade, would consider to have been acceptable practice in terms of knowledge and practice at that time. The fact that, in the same circumstances, one doctor might do one thing and another doctor might do something different does not necessarily mean that either is wrong – or even that one is better than the other. Both actions might be considered to fall within this range of reasonable practice – and both actions might even be equally reasonable'.

'Additionally, it would not be appropriate for the Office to judge the doctors' actions in Mr C's sad situation by using hindsight. In other words, our decision should not be based on how things had turned out for Mr C by the time of his first review in Edinburgh. The Office's approach is to consider what evidence and information (for example) was available to a patient's doctor at the time in question and whether his or her actions were reasonably based on that information. This is because that is the only information on which the doctor could have based his or her decisions at the time'.

My investigation concluded that the Glasgow surgeon had acted within the bounds of reasonableness. Finally, the report states the opinion of my clinical advisers that it is impossible to determine what the outcome would have been had surgery taken place at an early age: *'Mr C's spinal deformity was very difficult and complex, and in some cases the only way one can know the outcome is to wait and see. What is obvious now was not obvious at the time, and we do not believe that it was unsatisfactory that – without the benefit of knowing what would happen – the Glasgow surgeons did not operate... Crucially, one must never forget that this was a very difficult and complex spinal deformity; surgery would have been very far from simple – and could have killed Mr C'.*

By comparison, another complaint involving the death of a patient was upheld because I concluded that the GPs had failed to make an earlier referral and diagnosis (200501233) – in this instance, the medical staff did have the relevant experience and information, but failed to act appropriately. I hope this Overview goes some way towards clarifying how we investigate and determine complaints about clinical judgement.

Professor Alice Brown, Ombudsman 20.02.2008

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Details of the reports are summarised below and the full reports are available on the SPSO website at <http://www.spsso.org.uk/reports/index.php>

Health

Clinical treatment, nursing care

Tayside NHS Board (200602998)

I fully upheld the complaints about care and treatment of a patient's pressure sores and in the course of the investigation I also found evidence of poor record-keeping. My report states that *'The care provided ... was completely unacceptable and this resulted in further suffering for Mr A, exemplified by the fact that he was re-admitted for plastic surgery two days following discharge. The Hospital failed Mr A when delivering significant aspects of his care and this causes significant concern.'*

I made a number of recommendations to the Board in relation to record-keeping, education and training of staff, effective communication and proactive nursing in relation to the transfer of patients, and the quality of care plans for patients suffering from pressure sores. I also recommended that the Board apologise to the patient for the failings which were identified.

Clinical treatment, nursing care, complaint handling

Forth Valley NHS Board (200602963)

I fully upheld the complaint that a hospital failed to provide appropriate care and treatment to the complainants' late mother, Mrs A, who died of colonic cancer. The two sons who brought the complaint understood that an earlier diagnosis would not necessarily have prolonged their mother's life but felt it would have allowed her to receive the appropriate pain relieving treatment far sooner. I also fully upheld the complaint that the hospital failed to adequately investigate the original complaint.

By way of redress, I recommended that the Board apologise to Mrs A's family for the failures identified in my report and the hospital's Internal Review and for the additional distress caused by the failure of their original investigation to identify and

address these failures. I also recommended that they build more robust senior and independent review into the local resolution stage of the NHS Complaints Process to ensure complaints are addressed more comprehensively and that review of complaints is built into Clinical Governance to ensure lessons can be learned from them.

Diagnosis, record-keeping

A GP Practice in Greater Glasgow and Clyde NHS Board area (200501233)

I fully upheld the complaint from the parents of a 15-year old boy who died of a heart condition that two GPs failed to investigate their son's symptoms and that they should have done so, even while waiting for referral elsewhere. I also upheld the parents' complaint that the GPs failed to progress a diagnosis of their son's condition and that one GP did not take their son's pulse. I made no finding on the complaint that the GP failed to note the symptom of breathlessness in the records. I record that this is a tragic case, because, *'had an earlier referral and diagnosis been made their son may have been able to have a transplant'*.

I recommended that the GPs apologise to the parents for the shortcomings identified in the report and that they raise the aspects of the complaint relevant to each of them at their annual appraisal and take them into account in their Continuing Professional Development.

Diagnosis, complaint handling

Grampian NHS Board (200600110)

Ms C raised concerns about the diagnosis and treatment given to her father, Mr A, who died from an intraperitoneal ruptured aortic aneurysm the day after he was admitted to hospital. Medical staff acknowledged soon after his death that the wrong diagnosis was made on admission.

Whilst they failed to diagnose the aneurysm, I was unable to make a finding of clinical failure because there was not sufficient evidence of the role clinical staff made in the diagnostic process. I found that the Board have taken appropriate action as a result of lessons learned from this tragic event including an apology to Mr A's family and changes to their processes.

I upheld Ms C's complaint that the Board failed to investigate her complaint in a timely manner. I am satisfied that changes to the management of the acute sector within the Board since Ms C raised her complaint will increase accountability in ensuring a timely response to complaints and, therefore, I made no further recommendations.

Clinical treatment, nursing care, record-keeping, complaint handling

Tayside NHS Board (200601374)

Mrs C raised a number of concerns about the care given to her mother in hospital. Due to a lack of records, I was not able to make any finding on the complaint that her mother was unnecessarily prescribed morphine. I partially upheld the complaints that the hospital failed to provide appropriate nursing care. I fully upheld the complaint that the hospital failed to maintain accurate records and partially upheld the complaint that they failed to provide an adequate complaint response.

I made several recommendations to the Board including that they apologise to Mrs C for the confusion and distress caused by the apparently contradictory nature of some of the responses to her complaints. I also made recommendations in relation to record-keeping, admission assessment and complaint handling.

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Health

Palliative care

Ayrshire and Arran NHS Board
(200501596)

Mrs C raised a number of concerns about the treatment and care of her father, Mr A, who suffered from Alzheimer's Disease, during the final months of his life. I upheld the complaint that the palliative care provided was inadequate, but did not uphold the complaint that the Board's administration of a particular drug was not appropriate. I recommended that the Board apologise to Mr A's family for the inadequacy of the palliative care afforded to him to the extent that they could have used a more appropriate method of pain management.

Communication, complaint handling

Grampian NHS Board
(200502773)

Mrs C raised concerns that her husband, Mr C, who suffered from a degenerative neurological disease, had been given inappropriate advice, and that her complaint to the Board had not been adequately investigated. I made no finding on the first complaint, but I did find that there was inadequate communication between members of the clinical team involved in Mr C's care and that the Board did not appropriately investigate Mrs C's complaint. I made a number of recommendations to the Board to address the failings identified.

Delays, clinical treatment, communication

Greater Glasgow and Clyde NHS Board
(200501279)

Mr C raised a number of concerns about the care and treatment he had received over several years for erectile dysfunction. I did not uphold one aspect of his complaint, partially upheld two aspects and made no finding on one other. I did uphold the complaint that there had been failings by the Board in how they handled this case.

I recommended that the Board apologise to Mr C for the delay in providing his implant operation, for adding his name to the waiting list prematurely and not advising him of the conditions and restrictions which applied and for the delay in his follow-up appointment for a previous operation. I also recommended that the Board take steps to ensure that, early, well documented psychiatric reports are produced in future cases of this type when requested or required; and that they take appropriate steps to ensure that, in future cases of this type, patients' names are not added to waiting lists prematurely and that they are advised of any conditions or restrictions which apply.

Nursing care

Tayside NHS Board (200601565)

To the extent that the Board did not fully respond to concerns raised by the complainant, Mrs C, I partially upheld the complaint that the care and treatment received by her mother was inadequate and reduced her ability to access rehabilitation services. I recommended that the Board make an apology to Mrs C and use this case as a learning tool for staff to demonstrate the importance of good documentation and the effect that failing to complete documentation can have on patient care.

Diagnosis, delays, communication

A GP Practice in Grampian NHS Board area (200501555)

An advocacy worker complained on behalf of a man about the treatment received by his late wife, Mrs A. The complaint was that the Practice failed to promptly diagnose Mrs A's secondary cancer and that the overall treatment provided to her was inappropriate. I did not uphold, or made no finding, on the complaints about treatment, but I did find that the Practice provided inaccurate information about waiting times for an ultrasound scan. I made a recommendation to the Practice to address this failing.

Clinical treatment

A Dentist in Glasgow and Clyde NHS Board area (200501652)

The complainant raised several concerns about the care and treatment provided by her dentist. I did not uphold the majority of complaints, but I did uphold her complaint that the dentist failed to properly examine her teeth and overlooked the need for a filling. To redress failings identified in my investigation, I recommended that the dentist carry out a Clinical Audit of his own x-ray procedures to ensure that any problems with the current system can be identified and removed and carry out a similar audit in respect of his record-keeping to ensure compliance with General Dental Council Standards.

I did not uphold eight other complaints in the health sector about the following issues and bodies:

Clinical treatment

Forth Valley NHS Board
(200700845)

Clinical treatment

A GP in Fife NHS Board area
(200700972)

Clinical treatment

A Dental Practice in Lothian NHS Board area (200503203)

Clinical treatment, complaint handling

A GP Practice in Lothian NHS Board area (200601633)

Clinical treatment

Greater Glasgow and Clyde NHS Board (200600197)

Clinical treatment

Tayside NHS Board (200503133)

Although I did not uphold the complaints about a Dental Hospital, I recommended that the Board review their protocol in the light of advice that it would be best practice to take an x-ray to help identify any potential problems or infections following the re-presenting of a post-extraction patient.

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Health

Staff attitude, clinical treatment Highland NHS Board (200602824)

While I did not uphold the complaints about the conduct of a clinician during a consultation or about the appropriateness of the treatment he suggested, I did make recommendations to improve communication between the clinician and the complainant.

Care and treatment, communication, complaint handling Fife NHS Board (200601379)

I did not uphold the complaints about the care and treatment provided to the complainant's mother who died in hospital. However, I recommended that the Board use the events of this case, in particular the differing perceptions of staff and family about the events, in staff training to consider how communication in these circumstances might be improved for the future.

Local Government

Education: school boundaries South Lanarkshire Council (200502440)

I fully upheld the complaint by Mrs C who raised a number of concerns that the Council were using incorrect school boundaries when establishing school placements and deciding which children qualified for free school transport. The Council's internal enquiry into the matter was unable to clearly establish what the original boundaries were and they were unable to provide substantial evidence to prove that Mrs C's local area was not zoned for the school. In addition, the Council has a statutory duty to maintain details of school catchment areas and I found that their records did not fulfil this duty. As Mrs C did provide some evidence which suggested that her locality was included in the school's catchment area,

I upheld the complaint. I would, however, note that these issues arose as a result of a historical issue with record-keeping in the predecessor local authorities and that the current Council have inherited this difficult situation. I made no recommendations in this case as the Council have proposed actions to guarantee school transport and have also agreed to carry out a review of the school's catchment area in order to achieve a long term solution to this issue.

Parking The Highland Council (200500617)

I partially upheld the complaint by Mr C that the Council had failed over a number of years to ensure that the proprietor of the adjacent premises, Mr B, provide adequate car parking for his business, which caused access problems. Mr B had applied for planning permission to extend the rear of his premises and it was only when he made clear that he did not intend to pursue this that the Council's Planning Services were able to concentrate on ensuring that Mr B complied with the conditions of an earlier planning consent and give advice on introducing measures to secure more orderly parking. I partially upheld this complaint as I believe the Council could have been more forceful with Mr B, as it took him over a year to introduce the advised measures. In that time, I concluded that Mr C was probably inconvenienced by the overflow parking. I made no recommendations in this case.

Handling of planning application The City of Edinburgh Council (200604111)

Mr C raised a number of concerns regarding the Council's handling of an application for planning consent made by his neighbour, Mr N, to alter and extend his property. I partially upheld two aspects of the complaint in relation to neighbour notification, as I found that the notifications were incorrectly dated. Although the Council carried out their statutory duty by

confirming that Mr N's certificate of notification was correct, I believe it would have been best practice for the Council to have required Mr N or his architect to re-notify neighbours when Mr C brought the defect to their attention. As new planning legislation will transfer responsibility for neighbour notification from the applicant to the planning authority, I made no recommendation. I fully upheld another aspect of the complaint as I found that the Council had failed to respond to Mr C's request for information about when the application would be formally considered and whether he could address the relevant committee. I recommended that the Council apologise to Mr C for the failings identified.

Housing: modifications, repairs and maintenance North Lanarkshire Council (200700122)

I partially upheld two aspects of Mrs C's complaint about her housing circumstances. I found that the Council imposed an uncompromising condition on a mutual exchange by stating that no additional repairs or alterations would be undertaken as a consequence of the exchange going ahead, despite the fact that the property was not suitable for Mrs C's assessed needs. There was a failure by the Council to take reasonable care to ensure that they met their responsibilities to respond to Mrs C's needs after she moved into the property. Since the complaint was brought to my office the Council have reassessed their position. I recommended that the Council apologise to Mrs C for the inconvenience caused by their failure to have proper regard to her assessed needs.

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Local Government

Handling of planning application, complaint handling, breach of planning conditions

The Moray Council (200600408)

Mr and Mrs C raised a number of concerns about the Council's handling of an application by their neighbours to alter and extend their home. I partially upheld two aspects of the complaint. I found that the planning report lacked specific mention of the issues of daylight and sunlight raised by Mr and Mrs C. Although I note the Council's view that the loss of daylight and sunlight associated with the proposed development would not have justified a recommendation of refusal, these are material factors and should have been included in the report. As such, I recommended that the Council apologise to Mr and Mrs C. I also found that the Council should take some responsibility for delays that later occurred in addressing deviations from the planning consent, one of which concerned an oil storage tank. I recommended that action is taken to resolve the issue of the oil storage tank as soon as possible and, in light of the general issues raised in my report, that the Council review whether and how they should involve affected parties in reaching decisions on issues of privacy.

Housing: statutory repairs notices, complaint handling

The City of Edinburgh Council (200502567)

Mr C complained that the Council had not acted properly in relation to works that had been undertaken to his property. I upheld the complaint handling aspect of the complaint as I found that the Council did not properly advise or guide Mr C through their complaints process, which resulted in confusion. As such, I recommended that the Council apologise to Mr C for the confusion and omissions in their handling of his complaints. I also recommended that the Council make clear to complainants what the various stages in the complaints process are, which department they should expect to receive communication from,

how to progress their complaints through the process, indicate clearly when the Council believe that the process has been completed and advise complainants what to do if they remain dissatisfied.

Anti-social behaviour, complaint handling

Midlothian Council (200502418)

I partially upheld two aspects of Mr C's complaint that the Council failed to take appropriate action in response to complaints about anti-social behaviour by his neighbours and that there were flaws in the Council's anti-social behaviour policy. Although, in the main, I was satisfied that Council Officers acted in a reasonable manner in applying their professional judgement in this case, I found that there was a lack of clarity over the use of Neighbour Problems Diary Sheets and how the Council would determine their validity as evidence of anti-social behaviour. Overall, there was lack of a consistent message about what would be considered as acceptable corroboration of Mr C's allegation. I also found that, at the time this complaint was made, the Council did not have standards for acknowledging or responding to emails or letters in relation to complaints. My report makes a number of recommendations to improve the Council's handling of anti-social behaviour complaints.

Social Work: community care assessments, complaint handling

South Ayrshire Council (200603657)

Mrs C complained about the Council's assessment of her care needs under the Council's Direct Payments scheme and raised concerns about the Social Work Complaints Review Committee's (CRC) consideration of her complaint. Although I did not uphold Mrs C's complaint about the conduct of the CRC hearing, my investigation did highlight some issues. I noted in my report that, although the CRC were aware of the key issues in this case and had evidence of the nature of the Council's assessment, they were not

provided with background information on the relevant policy, legislation and guidance or the assessment forms. I therefore recommended that the Council ensure that staff are made aware that direct evidence should be given to the CRC, where available. I also recommended, as a point of good practice, that the Council highlight to CRC panel members that they should remain sensitive to the needs of disabled complainants. I did uphold one aspect of Mrs C's complaint, as I found that the Council did not formally consider other concerns she had about the handling of the Direct Payments application and subsequent administration, despite her repeated attempts to raise these issues. I recommended that this complaint be used as a case study with complaints handling staff to emphasise the importance of dealing with complaints as a whole and of being flexible in their approach.

Planning enforcement, guidance

The City of Edinburgh Council (200603359)

Mr C raised a number of concerns about planning and enforcement issues with the Council, in particular the conflicting advice he received about whether he was required to obtain planning permission for a fence. I upheld one aspect of this complaint as I found that there had been confusing correspondence between the Council and Mr C over the question of whether his fence required planning permission. I concluded that there had been a failure of the Council to take into account the full planning situation in relation to the fence. Mr C had been corresponding with the Council for several months over the issue, so I also considered that the case officer involved should have been aware of the sensitive nature of the situation and sought the advice of more experienced or senior staff. I recommended that the Council make a full, formal written apology for providing confusing and conflicting information and also that they consider ways of ensuring that relevant staff seek advice when complicated and sensitive situations arise.

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Local Government

Housing: capital works, complaint handling Dundee City Council (200401636)

Mr C made a complaint on behalf of his mother, Mrs A, about the Council's handling of refurbishment work carried out to her home. He also complained that the Council failed to take into account her specific circumstances in relation to decant arrangements and compensation for her period of absence from the property. I fully upheld one aspect of this complaint and partially upheld two others. I felt that the Council did not consider Mrs A's particular circumstances, which arose after the start of the refurbishment works and so could not have been initially considered or anticipated. I made recommendations to address this. Despite upholding Mr C's complaint that his mother's property was uninhabitable on completion of works, I made no recommendation in this regard as the Council have settled a sum for professional cleaning costs. Finally, I found that the Council failed to adequately respond to issues raised by Mr C and that it was unclear whether his concerns were considered as a complaint. I recommended that the Council apologise to Mr C for their failings in this regard.

Housing Application Stirling Council (200601798)

I upheld one aspect of the complaint made by Mr C on behalf of his granddaughter, Ms A, who he felt had been disadvantaged in applying for a Council property because of errors made in the application process. The Council did incorrectly suspend Ms A's housing application but they discovered this before Mr C made his complaint to my office, have apologised and taken steps to prevent a recurrence of this error. I commended them for this action and asked that they provide me with details of the actions taken. I also found that, due to a fault in the computerised housing management system, Ms A was awarded too many overcrowding points which raised her expectations as to how quickly she would be re-housed. I was, however, satisfied that Ms A did not miss out on a housing allocation that she was entitled to.

The Council have assured me that the underlying cause of these errors is being addressed and in my report I commended them for this action and for their rigour in identifying the errors that occurred. However, I recommended that they confirm that the work to correct the computer system error has been completed and that they apologise to Ms C for the distress caused by the incorrect award of overcrowding points.

Education: exclusion, school placements, complaint handling The City of Edinburgh Council (200400224)

Mr and Mrs C, the parents of a teenage son with special educational needs, Child C, raised a number of concerns about Child C's education when he attended three schools in the Council area and also about the way their complaints had been handled by the Council. I fully upheld one aspect of the complaint and partially upheld two others. My report highlighted the difficulties in providing for a child where special educational needs are compounded by behavioural difficulties and the frustrations experienced by parents striving to achieve the best possible provision of education services to meet the needs of their child. I believe that while the Education Department generally had proper regard to their obligations, the lack of local options available undoubtedly had an important bearing on their responsiveness in this situation. I recommended that the Council review the problems confronted by Mr and Mrs C in securing appropriate suitable education to meet their child's needs and apologise to them for the failures identified in my report. As I found that the Council had failed to address one of Mr and Mrs C's complaints, I also recommended that the Council review the implementation of their complaints procedure particularly with regard to services for children and young people.

Housing: private sector grants Aberdeenshire Council (200601424)

A charity worker, Mr C, complained on behalf of Mrs A that changes in the Council's policy on Housing Improvement

Grants were unreasonable and had disadvantaged Mrs A as a disabled person. He also complained about delays in processing her application for a grant, which I did not uphold. It is not the role of my office to adjudicate between competing interpretations of the law. However, whilst I accept that the Council have to make difficult decisions about how best to allocate limited resources and did not take this decision lightly, they were unable to demonstrate that they took appropriate legal advice on the changes to the policy and, therefore, I upheld this aspect of the complaint. I recommended that, where significant changes to policy are being made, advice on the legal implications should be appropriately taken and recorded. I also asked the Council to provide Mr C and me with comments on their current policy on Housing Improvement Grants in the light of the applicable legislation.

Handling of planning application West Dunbartonshire Council (200502961)

I upheld three aspects of Mr C's complaint about the Council's handling of a planning application for housing on a site adjacent to his property. In particular, I found that there were a number of errors which affected the confidence of Mr C (and others) that the representations made on this application had been properly considered by the relevant committee. I recommended that the Council review their procedures to ensure that a similar situation does not recur.

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

Handling of planning application, complaint handling Dumfries and Galloway Council (200600648)

Refuse Collection Stirling Council (200600144)

Council Tax Dundee City Council (200603214)

Parking The City of Edinburgh Council (200602550)

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Further and Higher Education

Policy / administration: placements

Langside College (200603730)

I upheld one aspect of this complaint by Ms C about the way she had been removed from a course in social care following issues surrounding her placement. In my report I expressed concerns about the lack of written protocols governing placements and about the way in which the serious decision to remove Ms C from her HNC course was reached. Specifically, I was concerned that Ms C did not receive a formal warning and that she was not given an opportunity to have the faculty's decision reviewed internally or to have her perspective considered at such a review. I recommended that the College review their guidance and practice on the removal of students from courses, draw up written guidance on work placements and apologise to Ms C.

I did not uphold or made no finding on three other complaints in the further and higher education sector about the following issues and bodies:

Admission procedures, complaint handling

Cardonald College (200602837)

Academic Appeals Process

University of Glasgow (200601521)

Although I did not uphold this complaint, I did recommend that the University should keep proper records of important decisions or exceptional arrangements made in relation to students.

Record-keeping, bursaries

Stow College (200600344)

Although I made no finding on this complaint, I did recommend that the College consider using this case as a starting point to review their procedures for confirming and recording student attendance and enrolment, and on how they communicate with students where there is doubt about their attendance or enrolment status. The College, in line with their practice, have initiated a review.

Scottish Government and Devolved Administration

Policy / administration

Scottish Legal Aid Board (200503511)

A solicitor, Mr C, complained that delays by the Board in reviewing the award of legal aid was prejudicial to his clients. I upheld one aspect of the complaint, but only to the extent that Mr C's clients experienced a period of uncertainty over the outcome of the consideration of representations. The Board have already acknowledged and apologised for the delay in considering Mr C's initial representations and I accept that they were exercising their responsibilities towards the applicants carefully and that the issues at hand were complex. I recommended that the Board apologise to Mr C for failing to update him on the progress of their considerations, and that they implement measures to ensure that information about the ongoing grant of legal aid is processed efficiently and that communication with the parties involved is clear and timely.

I did not uphold the following complaint in the Scottish Government and devolved administration sector:

Policy / administration

The Scottish Commission for the Regulation of Care (200700322)

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.

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

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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 'last resort' 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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