Ombudsman's **Commentary**

MAY 2008 REPORTS

I laid 27 investigation reports before the Scottish Parliament today. Seventeen relate to the health sector, eight to the local government sector, one to the Scottish Government and one to both a council and a government agency.

Ombudsman's Overview

In this month's Overview, I am highlighting two recent events – a lecture about 'Apology' at the Scottish Parliament and our hosting of the British and Irish Ombudsman Association's (BIOA) Annual Meeting in Edinburgh.

The lecture, entitled **'The Power of Apology'** and held under the auspices of the Royal Society of Arts in Scotland, is part of my continuing work to encourage legislation that would allow public bodies to apologise without fear of admitting liability. It was hosted by Mike Rumbles, MSP, and several other MSPs also attended or expressed interest in the issue.

As I have frequently underlined, there is much evidence from my office and from numerous research projects, that a meaningful apology can be a powerful tool in rebuilding trust between service deliverers and the public on those occasions when things go wrong. I believe that changes to current legislation and a lessening of the culture of blame would benefit individuals, service providers and society as a whole.

My lecture explored the benefits of and the barriers to apology. I highlighted the experience of other countries that have changed legislation to empower frontline staff to apologise without fear of admitting liability and the resultant drop in civil actions against public bodies.

I was delighted that Kenny MacAskill, the Cabinet Secretary for Justice, gave the opening speech at the **BIOA Annual Meeting**. His remarks about the importance of the work of Ombudsmen and the "progressive articulation of the 'one-stop-shop' approach in Scotland" were welcomed by the 150 delegates. He echoed the conference theme of 'The Changing Context in which we Operate' by describing some of the developments taking place in society such as human rights legislation and changing attitudes and practice in education and labour. Other speakers fleshed out these themes in presentations about the role of consumers, issues of self-regulation, conduct and the balance of proof, and the new administrative justice framework.

Both events provided opportunities to share information and practice about key issues such as providing individual justice, ensuring the highest standards of service, supporting the staff of public bodies and helping to build a safer and fairer society.

Professor Alice Brown, Ombudsman 21.05.2008

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The reports are summarised below and the full reports are available on the SPSO website at http://www.spso.org.uk/reports/index.php

Health

Hospital discharge
Lanarkshire NHS Board (200700635)

Ms C raised concerns that her brother, Mr A's, mobility was not adequately assessed prior to his discharge from hospital. Mr A was a 37-year-old man with known learning disabilities and severe epilepsy. He was admitted to hospital with pneumonia and discharged six weeks later. Upon his return home, it was discovered that he could no longer weight-bear, which he could do prior to admission. This appeared to be due to foot drop and persisted, necessitating the use of a wheelchair. I upheld the complaint and recommended that the Board remind relevant staff of the need to take measures to prevent foot drop and to record all relevant information in patients' clinical records.

Diagnosis, communication, record-keeping
Lanarkshire NHS Board and NHS24 (200600457 & 200502301)

Mrs C raised a number of concerns that her husband, Mr C, had been wrongly diagnosed as having Bells Palsy by an NHS24 Nurse Adviser after he contacted NHS24 complaining of numbness in his face and index finger, slurred speech and a headache. Mrs C also complained that Mr C had been informed of the diagnosis inappropriately by the NHS24 Adviser and that he should have arranged for an ambulance for Mr C and treated him as a medical emergency. Instead, Mr C was advised by the NHS24 Adviser to attend the Primary Care Emergency Centre (PCEC) and an appointment made for him there.

Mr C drove to the PCEC himself and was seen by a GP, who made a diagnosis of Transient Ischaemic Attack (TIA). After this consultation, he was allowed home and advised to see his own GP if he did not begin to feel better. Mr C then waited in the PCEC car park until Mrs C arrived. He re-attended the PCEC where, after a 30 minute wait, he was seen by a second GP. Mr C was then admitted to hospital and found to have suffered a stroke. Mrs C complained about the consultation with the first GP and the care offered to Mr C by the PCEC and the Board.

I upheld the complaint that Mr C was wrongly diagnosed and informed inappropriately of the diagnosis over the telephone by the NHS24 Adviser. I also upheld that complaint that the Adviser failed to treat Mr C as a medical emergency and should have arranged an ambulance, instead of sending Mr C to an out-of-hours GP practice. I upheld the complaint that the first GP diagnosed Mr C wrongly and, therefore, treated him inappropriately, and made no finding on the complaint that the GP did not offer to admit Mr C to hospital. I upheld the complaint that the GP failed to record sufficient data about his consultation with Mr C but not that he rushed his consultation with Mr C, nor that Mr C waited an unreasonably long time on re-attending the PCEC.

I made no recommendations in relation to NHS24 because I am satisfied that the remedial action taken by the service is appropriate. I did, however, recommend that the Board ensure that the first GP shares my investigation report with his appraiser at annual review and that he reflects on the comments made in the report regarding the diagnosis of a TIA; review the GP's record-keeping to ensure it meets the required standards of the regulatory bodies; and write to Mr C with an apology for the failures which have been identified.

Delay in diagnosis, clinical treatment
Forth Valley NHS Board (200602374)

I upheld the complaint that the treatment and care provided in hospital to Miss C's mother, Mrs A, was inadequate. My report concluded that there was clinical failure to diagnosis acute appendicitis, and that Mrs A's subsequent death of multiple organ failure was probably a result of this failure. There were related issues of record-keeping.

By way of redress, I recommended that the Board apologise to Miss C for the failures identified; remind all their doctors of the importance of appropriate recording of working and differential diagnosis; and ensure that two consultant surgeons reflect on these events at their next annual review.

Communication, hospital discharge, delay in diagnosis
Greater Glasgow and Clyde NHS Board (200600345)

The complainant, Ms C, an advocacy worker complaining on behalf of a woman, Mrs A, raised concerns regarding the care and treatment provided to Mrs A in respect of a bowel operation. Mrs A was unhappy with the lack of information provided to her, her family and her GP, the timing of her discharge, the failure to timeously diagnose an abscess in her bowel and the failure to arrange a follow-up appointment.

I upheld the complaint that there was insufficient communication by the surgical team with regard to operative risks, the complications that arose and the information provided to the GP following discharge. I also upheld the complaint that following the operation, Mrs A was discharged prematurely from the Hospital and that the clinicians involved failed to diagnose an abscess in Mrs A's bowel within a reasonable time-frame. I did not uphold the complaint that a follow-up appointment was not arranged after Mrs A was discharged. On this last aspect I found that there was an administrative error or oversight or breakdown in communication which caused the proposed follow-up appointment to have been overlooked but I am satisfied that the changes subsequently implemented by the Board will guard against a similar future oversight. I concluded that, prior to my involvement, the Board had accepted that there were errors, apologised to Mrs A and taken reasonable steps to ensure that similar errors do not re-occur.

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I made several recommendations to the Board to address the failings indentified in my report, including about recording episodes of communication and the recording of information on discharge sheets and the sending of the sheets to patients' GPs in a timely manner. I also made recommendations relating to the issue of consent and about introducing measures to ensure that biopsy results following local trans-anal surgery are reviewed urgently, that any full thickness perforation is specifically recorded in the case notes and appropriate follow-up action taken.

Care of the elderly: clinical treatment, hygiene

Greater Glasgow and Clyde NHS Board (200601594)

Ms C raised a number of concerns about the care and treatment that her 74-year-old uncle, Mr A, received in one hospital, between his admission there and his transfer to another hospital where he died.

I upheld the complaint that Mr A's pain was not managed effectively; that his pressure sore could have been avoided and that he should have been referred to vascular surgeons more quickly. I made no finding on the complaint that Mr A was given inconsistent advice, and did not uphold two other complaints.

I recommended that the Board remind staff of the need to ensure they respond in full to formal complaints; ensure that the clinical team responsible for Mr A's care in Hospital 1: (a) review my investigation report; consider what lessons can be learned from Mr A's experience and review how pain is managed effectively; (b) are aware of the need for accurate records to be kept; and utilise best practice statements on Pressure Ulcer Prevention and the Treatment and Management of Pressure Ulcers issued by NHS Quality Improvement Scotland. I also recommended that the Board audit the use of MRSA screening on a particular ward and report back to me proof of review and change in practice; that they ensure that the clinical team consider the lessons to be learned as a result of the failings identified in my report and report back to me changes in practice put in place as a result; and apologise to Ms C fully and formally for the failings identified.

Clinical treatment

Greater Glasgow and Clyde NHS Board (200700709)

Mr C complained on behalf of his wife, Mrs C, concerning the care and treatment she received prior to being diagnosed as having ovarian cancer. I upheld the complaint that Mrs C's care and treatment were inadequate and, despite her history of breast cancer and an ovarian cyst, no follow-up appointment was made for her. I did not uphold two other aspects of the complaint.

I recommended that the Board offer a sincere apology to Mrs C for the failure to treat her properly. Further, I requested that the Board provide me with a copy of the 2008 audit of Guideline 34 of the Royal College of Obstetricians and Gynaecologists. The Guideline is entitled 'Ovarian Cysts in Post Menopausal Women' and one of its recommendations is that ovarian cysts in post-menopausal women should be assessed both with ultrasound and with the tumour marker CA125.

Clinical treatment, communication

Highland NHS Board (200600377)

Mr C raised a number of concerns in respect of the treatment provided to his wife by a consultant surgeon prior to her death. He also stated that neither he nor his wife were given a clear picture of her condition and the options for treatment available to her. I did not uphold the complaint that the consultant did not fully consider the surgical options, including seeking opinions of specialists where necessary but I did find that the communication from the consultant was unacceptable.

By way of redress, I recommended that the Board apologise to Mr C for the failure to effectively communicate with both him and his wife; consider using the events of this complaint to inform practice in communicating with patients, particularly when a number of different specialists are involved in care. This consideration should include both communication with patients and family and the recording of such communication in the clinical records; and review their procedures to ensure that all responses provided by them, or on their behalf, to complainants are factually accurate.

Policy / administration, communication

Scottish Ambulance Service and Western Isles NHS Board (200701012 & 200701348)

Mr C's brother, Mr A, collapsed suddenly and was taken to hospital by ambulance. Mr C raised a number of concerns: that a GP working for the Board out-of-hours service did not attend, although the Scottish Ambulance Service (the Service) requested he do so; a First Responders Unit (FRU) was not correctly called; and information about the incident was released to the press inappropriately. The Service accepted the problem with the FRU but Mr C remained concerned about the actions taken to remedy this.

I partially upheld the complaint that the GP unreasonably did not attend, to the extent that there were clear issues with communication on the night concerned. I did not uphold the complaint that a FRU was not correctly called and actions taken to remedy this were insufficient. I upheld the complaint that information was released to the press inappropriately.

By way of redress, I recommended that the Board review the equipment provided to out-of-hours GPs, in the light of the problems identified in my report; the Board and the Service meet to consider how best to respond to the communication failures identified and ensure that lines of responsibility and procedures are clearly in place where appropriate; the Service undertake a short review of emergency calls in FRU areas, to see if they can identify cases where FRUs could have been called but were not and consider if any lessons can be learned from this; the Service apologise to Mr C for the release of inaccurate information; and the Board and the Service use this complaint as a case study with press staff, in order to encourage learning from the problems identified.

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Health

Removal from practice list
A Medical Practice in Fife NHS Board (200700345)

Mr C raised concerns regarding his removal from his GP's list of patients. I upheld the complaint that the Practice did not follow the correct procedures in removing Mr C from their list of patients and made recommendations to prevent a recurrence of this failing. I also recommended that the Practice apologise to Mr C.

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

Diagnosis, clinical treatment
A Medical Practice in Lanarkshire NHS Board; Lanarkshire NHS Board; and Greater Glasgow and Clyde NHS Board (200503162, 200602726 & 200700502)

Mr C was concerned that health professionals he consulted had not detected that the lumps in his leg were evidence of a rare form of cancer. Although I did not uphold the complaints about misdiagnosis by a GP and inadequate care and treatment at two hospitals and a specialist cancer centre, I did make a number of recommendations. My recommendations concerned the GP practice and the hospitals, which are in the Lanarkshire Board area, but not the cancer centre which is in the Greater Glasgow and Clyde NHS Board area.

I recommended that the Practice feed back to clinical staff my Adviser's comments in connection with note keeping and referral letters; my investigation report be shared with the clinical staff involved in Mr C's care and treatment by the Board to consider whether the learning identified could be shared more widely; and that the Board consider whether the procedures in place are adequate to ensure that the outcomes of tests are appropriately communicated to GP Practices.

Clinical treatment, removal from practice list
A Medical Practice in Fife NHS Board (200501879)

I did not uphold this complaint, but I did strongly criticise the Practice for their inadequate response to the initial complaint. I recommended that the Practice apologise to the complainant for the shortcomings identified in my report; undertake training on complaint handling and the guidance and Regulations governing the removal of patients from the Practice list and, following this training, the GPs and the Practice Manager meet to discuss and draw up a Practice protocol for complaint handling and, specifically, for removal of patients from their list, a copy of which to be sent to the Board's Medical Director for approval and to me for my information; and that the GP concerned discuss the issue of how he dealt with this complaint at his next annual appraisal as part of his continuing professional development.

Community dental care and treatment, communication
A Dentist in Tayside NHS Board (200602298)

Mr and Mrs C raised a number of concerns about a sequence of events which occurred when they attended a dental appointment. I did not uphold two aspects of the complaint and made no finding on the complaint that the Dentist told Mr C to go to a private dentist.

Clinical treatment, consent
Ayrshire and Arran NHS Board (200600373)

I did not uphold the complaint that the Consultant operated on the wrong eye, and I made no finding on the complaint that the patient, Mrs C, was asked to sign a consent form for the operation which she could not see and that the contents of the form were not read out to her. I recommended, however, that the Board ensure that discussions with patients about treatment is recorded, particularly where a change to the planned operation is made. I also recommended that the Board ensure that the recognised complications arising from surgery are discussed with the patient and a record of the discussion made.

Diagnosis
Highland NHS Board (200701928)

House calls, communication
A Medical Practice in Lothian NHS Board (200600902)

Clinical treatment
Lothian NHS Board (200701335)

Communication, ward visits
Forth Valley NHS Board (200601583)

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Local Government

Complaint handling
Angus Council (200601848)

Mr C raised concerns about the Council's handling of his complaint about the selection process for a vacant post. Mr C believed it was inappropriate for the Chief Executive to have handled the complaint as he was also involved in the selection process. Matters relating to the selection process itself were subject to an Employment Tribunal and outwith the scope of my investigation, which focused on the Council's handling of Mr C's complaint. I found that there was no evidence to show that the Council did not follow the relevant complaints procedures when handling Mr C's complaint and I also noted the Council's comments that the Chief Executive was an adviser to elected members of the selection panel and not on the panel himself. He still, however, clearly had an involvement in the selection process and this fact was not openly communicated to Mr C. As a result, a conflict of interest could have reasonably been seen to exist and so I fully upheld the complaint. It is my view that, where a conflict of interest could be perceived, those concerned should act with caution and I felt it would have been more suitable for Mr C's concerns to have been passed to a senior person who was entirely independent of the selection process. I did, however, note in my report that there was no evidence to suggest that the Chief Executive acted with anything other than proper motives. I recommended that the Council remind their staff to act with caution in such situations and introduce a procedure for complaints against the Chief Executive, which could also be used where the Chief Executive is unable to investigate a complaint due to a conflict of interest.

Consultation
Midlothian Council (200600586)

Mr C complained that the Council had failed to consult with the relevant community council about the closure of leisure centres in the area. The Code of Conduct for the Exchange of Information requires that, before making decisions on matters of importance to a particular area, the Council gives community councils an opportunity to provide their views. There is no definition of what is to be considered as a matter of importance. In this case the Council decided that consultation was not necessary.

I note in my report that it is not for me to substitute my judgement for that of the Council, I must decide whether there is evidence of maladministration in the process by which the decision not to consult was reached. As the Council did not provide me with any information on how they reached their decision, I upheld the complaint. I recommended that the Council properly consider whether it is necessary to consult with community councils when taking decisions which could reasonably be viewed as matters of importance to a particular area.

Building services: repairs, complaint handling
The City of Edinburgh Council (200600755)

Mr C raised concerns about a failure by the Council to carry out an inspection and repair to a communal aerial following a fire. He also had concerns about how his subsequent complaint was handled and felt information was withheld from him. I upheld the aspect of the complaint about the inspection, as the Council accepted that a communication failure resulted in an electrician being provided with inaccurate information. This then resulted in an unnecessary delay in the electrician carrying out an inspection to the communal loft. I recommended that the Council apologise for not responding adequately to the request for an electrician in the first instance. The Council's initial responses to Mr C's complaint maintained that they had responded properly to the request for an electrician to attend and it took some months for the miscommunication to be identified. Once the error became clear, the Council apologised to Mr C for their initial misinterpretation of the records. As the Council have identified this shortcoming and apologised, I did not uphold this aspect of the complaint.

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

Anti-social behaviour, complaint handling
Aberdeen City Council (200502524)

Education: complaint handling
Dumfries and Galloway Council (200402038)

Housing: capital works
North Lanarkshire Council (200701770)

Although I did not uphold this complaint, I did recommend that the Council should consider whether they should review their policy on decoration / disturbance allowances as the existing policy had been formulated some 11 years ago when the policies of three predecessor housing authorities were brought together. The Council have stated that they intend to carry out a review and will report to a future meeting of the appropriate committee.

Handling of planning application, complaint handling
South Lanarkshire Council (200501028)

Although I did not uphold this complaint, I did recommend that the Council apologise to Mr C for not responding appropriately to a point made in three letters to them advising that Mr C had not received a letter that had been promised to him.

Housing improvement grants
The Highland Council (200600141)

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Local Government and Scottish Government and devolved administration

Handling of planning application, enforcement, policy / administration

Scottish Borders Council and Forestry Commission (200601037 200602206 200602601)

Mr and Mrs C formerly lived in a detached house adjacent to a Forestry Commission Depot. Mr C complained about a number of planning proposals submitted by the Commission and the Council's handling of those applications and what he considered to be breaches of development control. Together, Mr and Mrs C also raised a number of concerns regarding the Commission's management of the Depot and related development. I did not uphold the complaint against the Council as I found no evidence of maladministration. I did, however, find evidence of errors made by the Commission who have accepted that local officers were inexperienced in relation to planning legislation at that time and that development activity at the Depot should not have started before planning consent was obtained. I partially upheld this aspect of the complaint for that reason. The Commission have apologised and given assurances that they will follow planning procedures more carefully in future.

Scottish Government and devolved administration

Complaint handling, communication

Scottish Environment Protection Agency (SEPA) (200600312)

I partially upheld one aspect of Mr C and Mrs C's complaint about SEPA's handling of their complaints about issues relating to their planning proposals and SEPA's role as a consultee in the planning process. Although I found nothing to suggest that the panel set up to consider Mr and Mrs C's complaints did not give the complaints due consideration, I did have some criticism about how the panel's investigation was handled. There was a failure from the outset to inform Mr and Mrs C of the remit of the panel's investigation and its progress, including implementation of any recommendations, which I would consider to be best practice. I recommended that SEPA apologise to Mr and Mrs C for this shortcoming and review their investigation process to ensure that, in future, all parties are made fully aware at the outset of the scope of an investigation, its remit and what can be expected at the end of the process. My investigation also highlighted the fact that while SEPA were prepared to act on complaints about service failure and learn lessons, they had no mechanism to consider whether redress might be appropriate to the service users affected by acknowledged failings. Although not specific to this case, in general, I believe that there are situations where it is appropriate for a public body to consider making a payment to a service user in recognition of the time and trouble it took to pursue a complaint, especially if there is no alternative to setting right what went wrong. Therefore, I also recommended that SEPA take steps to review their policy on redress and SEPA have accepted my recommendations.

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.spso.org.uk**

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SPSO Scottish Public Services Ombudsman

The Scottish Public Services Ombudsman (SPSO) provides a 'one-stop-shop' for individuals making complaints about organisations providing public services in Scotland. Our service is **independent, impartial** and **free**.

We are the final stage in handling complaints about councils, housing associations, the National Health Service, the Scottish Government and its agencies and departments, the Scottish Parliamentary Corporate Body, colleges and universities and most Scottish public authorities.

We normally consider complaints only after they have been through the formal complaints process of the organisation concerned. Members of the public can then bring a complaint to us by visiting our office, calling or texting us, writing to us, or filling out our online complaint form.

The Scottish Public Services Ombudsman was set up in 2002, replacing three previous offices – the Scottish Parliamentary and Health Service Ombudsman, the Local Government Ombudsman for Scotland and the Housing Association Ombudsman for Scotland. Our role was also extended to include other bodies delivering public services.

We aim not only to provide justice for the individual, but also to share the learning from our work in order to improve the delivery of public services in Scotland. We have a programme of outreach activities that raise awareness of our service among the general public and promote good complaint handling in bodies under our jurisdiction.

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