Ombudsman's Commentary

SEPTEMBER 2009 REPORTS

The SPSO laid nine investigation reports before the Parliament today. Four are about the local government sector, four relate to health and one is about higher education. Our investigation reports form only one part of our work. In August, we determined 281 complaints, including 82 resolved after detailed consideration.

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

- **Upheld 11 complaints**
- **Partially upheld 1 complaint**
- **Did not uphold 10 complaints**
- **Made 25 recommendations**

Overview

Since I took office in May, one of my priorities has been to reduce the time taken to examine complaints. In my view, making decisions promptly and accurately is a crucial part of the service we are charged with delivering to the public and to service providers. I have committed the SPSO to improving our turn-around times, and have introduced specific new measures aimed at dealing with cases that have been with the office for a long time. I am pleased that over 80% of such complaints have now been completed.

At the same time as improving our own performance, I am asking organisations that deliver public services to observe new deadlines for responding to the SPSO. I have requested changes in response times for general enquiries for information, and more specifically for responses to draft investigation reports, where we sometimes see significant delay. Last week, I wrote to all Chief Executives of authorities under our jurisdiction to inform them of the changes. I believe these are important steps that will help us all deliver a better service to the public.

Last week, I also issued a press release commending Greater Glasgow and Clyde NHS Board for the actions that they have taken so far following an SPSO investigation (Case 200702913) into the post-operative care provided to an elderly patient. Amongst other issues, the man developed severe pressure sores, and in my June report I asked the Board to carry out a root cause analysis to examine the reasons for this. In last week's press release, I said:

'I am very pleased with the way the Board have started to implement the recommendations in my report. Their response has been swift, thorough and systematic. Their actions demonstrate that the report has been studied in detail, lessons have been learned and steps put in place to improve health services not only in the hospital concerned, but across NHS Glasgow and Clyde.

We will be following up with the Board to ensure that they carry through the actions to which they have committed. I commend their response to date and would encourage other bodies to adopt a similar approach when presented with the findings and recommendations of my complaint investigations.'

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overview

Our **health** cases this month include a very sad case involving the stillbirth of a baby (Case 200800763). My investigation found inadequacies in ante-natal care, although I could not say whether these affected the outcome. I was also concerned that, on top of the suffering the parents experienced at the loss of their baby, further distress was caused by failures in post-natal care and information sharing. My recommendations included asking the Board to address the issue of the care pathway for bereaved parents.

One of the reports about **local government** this month concerned how a council handled a complaint about their social work department (Case 200602756). The complaint was about a man with long-term mental health problems who died in the care of a team that included council and NHS staff. Although I found that hearings had been carried out appropriately, I was concerned that the Council failed to communicate effectively with the NHS about the complaint, which meant that elements of it remained unanswered. The Council have since taken steps to address this failing and I have asked them to keep me informed of the progress of their action plan.

Other recommendations made in this month's complaints included:

- improvements to guidance, training and record-keeping
- apologies for failures in care and complaint handling
- reviews of the security of records and of complaint handling practices.

Summaries of all the reports laid today are below and can be accessed on the SPSO website at **www.spso.org.uk/reports/index.php**

Local Government

Statutory repairs notices; communication; policy/administration

The City of Edinburgh Council (200802763)

After Ms C bought her tenement flat she was unaware for some time that the Council had issued statutory repairs notices to the owners, as the relevant notices were not sent in her name. She raised a number of concerns with me about the issue and administration of the statutory notices served on owners.

I upheld her complaints. As the Council failed to inform her about the statutory notices or to update her on the progress of works.

I recommended that the Council review their database update procedures to ensure information is current, and consider whether in the circumstances there is scope for them to commute part of Ms C's administration charge. (They have since indicated that they are prepared to waive one third of that charge.) I did not uphold a complaint that they delayed in serving the accounts and failed to give Ms C appropriate opportunity to make financial arrangements.

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case summaries

Local Government

Policy/administration; communication; complaint handling

Aberdeen City Council (200602756)

Mrs C's son, Mr A, died after suffering long-term mental health problems and alcohol dependency. At the time of his death he was under the care of a Community Mental Health Team (CMHT) made up of staff from the Council and the local Health Board. Mrs C was concerned about the care Mr A received from a Council social worker (via the CMHT) in the months before his death. Mrs C raised her concerns through the Council's complaints process, up to and including a Social Work Complaints Review Committee (CRC). The CRC made a number of resolutions but advised Mrs C that the actions and decisions of the CMHT were not a matter they could consider. Mrs C was unhappy that it appeared that her complaints should have been partially addressed through the NHS complaints procedure but the Council had not advised her of this earlier.

I did not uphold the complaint that the CRC failed to address Mrs C's concerns as I considered the hearings had been carried out appropriately. I did, however, have concerns about the way in which their decisions were reported and explained, so I recommended improvements to guidance about the way CRC minutes are in future recorded. I upheld Mrs C's complaint that the Council did not take adequate steps to work with the NHS to ensure she received a full response to her complaints. As the Council had already taken action on this deficiency in their joint processes for handling such complaints in future, I asked them to let me know about progress on their action plan. I also asked them to apologise to Mrs C for this failure, noting that too much time had now passed for this particular matter to be taken up.

Education: consultation; complaint handling

Dumfries and Galloway Council (200800457)

A primary school council (on behalf of the aggrieved, Mrs A) complained that the Council disregarded the results of the public consultation they had undertaken when, without further consultation, they amended the planned accommodation in a replacement primary school. Mrs A was also unhappy with the handling of her formal complaint. I upheld Mrs A's concerns about complaint handling as I found that the Council had not provided a full reply for a number of months after the complaint was made, nor had they kept Mrs A updated. I recommended that they ensured that their complaints handling systems provide for timely responses at each stage and updates in the event of a delay. I did not uphold the complaint about carrying out further consultation as I found there was no requirement on the Council to repeat this process.

I did not uphold the following complaint about a local authority:

Neighbour problems; anti-social behaviour

The Highland Council (200602375)

Health

Clinical treatment; support/information; record-keeping

Lanarkshire NHS Board (200800763)

Mr C and his partner, Ms C, were unhappy about the care provided to Ms C during her pregnancy. Their daughter, Baby A, was, sadly, stillborn. Mr and Ms C considered a number of warning signs were missed and, in particular, that a scan which showed the umbilical cord near Baby A's neck should have been followed up. They also complained about post-natal care and that the response to their complaint was inadequate. I upheld their complaint that the care and treatment provided to Ms C was inadequate as I found that a deceleration of the fetal heart rate was not noted or followed up. However I also noted that it was not clear from the evidence that the outcome would have been any different had follow-up taken place. I also upheld the complaint that inadequate support was provided to Mr and Ms C after their bereavement, and partially upheld the complaint about the Board's response as full information was not provided to Mr and Ms C at the time of their complaint.

case summaries

Health

I recommended that the Board review the following:

- midwives' training
- the use and purpose of telephone call records
- supervision arrangements for ante-natal clinics
- their standard care pathway for bereaved parents.

I also recommended that the Board take into account the need to provide the fullest possible information in responding to complaints. Finally, I recommended that the Board apologise to Mr and Ms C for their failures to respond appropriately to the fetal heart rate deceleration and to communicate properly with Mr and Ms C's GP, and for the time taken to provide them with information about counselling.

Delay in treatment; clinical treatment; communication

Greater Glasgow and Clyde NHS Board (200702752)

Mrs C complained that the Board did not provide reasonable care and treatment to her late husband, Mr C, in hospital before his death. Due to lack of information I could reach no finding on whether arrangements for Mr C to undergo a surgical procedure were reasonable. I did not uphold Mrs C's complaint about the Board's actions in response to her concerns that staff did not discuss resuscitation policy with Mr C's family. I did, however, recommend that the Board ensure that induction materials for medical staff clearly cover the specific requirements of their resuscitation policy. I fully upheld Mrs C's complaint that administration of steroids to her late husband was unreasonable, as my medical advisers agreed that in the circumstances they would expect an increased dosage to have been administered. I recommended that the Board apologise to Mr C's family for this and take steps to ensure that medical staff are aware of the need to increase dosage in similar circumstances.

Clinical treatment; complaint handling; communication

An Optometrist, Lothian NHS Board (200800296)

Mr C complained that his optometrist failed to provide reasonable care and treatment when giving him a new prescription. He felt that the Optometrist gave him a prescription significantly different to that which should have been prescribed. I upheld the complaint as, although I found no evidence that the reduced prescription was technically incorrect, the Optometrist could not show that he had warned Mr C of the possible impact of the change. I recommended that the Optometrist reviews how he communicates with patients in such situations, and in future warns them of the adjustment that may be required and that he records this. I also recommended that he ensures that in future he considers complaints in line with the NHS complaints procedure.

Cleanliness and hygiene; policy/administration

Tayside NHS Board (200800374)

Mr C raised a number of concerns about the standard of cleanliness of a ward in one of the Board's hospitals. He complained that the Board failed to maintain an adequate standard of cleanliness there and that systems for monitoring cleanliness were flawed. He also complained that patient records were left unattended in areas accessible to the public. I could not make a finding on cleanliness standards or adherence to hygiene policies due to lack of specific evidence. I did not uphold the complaint about monitoring systems, as I found the Board gave staff appropriate training and had appropriate systems in place. However, I recommended that the Board invite Mr C to the hospital to discuss his concerns further in the light of the information provided. On balance, I upheld the complaint about security of patient records. I recommended that the Board arrange to have the relevant procedures reviewed to ensure the security of such records in future.

Further and Higher Education

Supervision; complaint handling, record-keeping
University of Glasgow
(200700760)

Mr C was a post-graduate student studying at the University for a doctorate in a science subject. He was unsuccessful in his studies and complained about aspects of supervision and about the way his appeal and complaint were handled. I did not uphold his complaints about supervision, provision of a placement, the handling of his concerns about a reagent he was using in his research, or the handling of his academic appeal. I did, however uphold Mr C's complaints about complaints handling and the University's record-keeping about his progress. I made several recommendations including the need to reinforce the good practice of keeping records of significant events and considering whether it should be obligatory to keep written records of meetings where there are significant concerns about the progress of a student. I also recommended that the University take steps to ensure that clear and accurate advice is given on the status of complaints and apologise to Mr C for the shortcomings in their handling of his complaint.

Compliance & Follow-up

In line with SPSO practice, investigators will follow up with the organisations concerned to ensure that they implement the actions to which they have agreed.

Jim Martin, Ombudsman
23 September 2009

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.

Further details on our website at: **www.spso.org.uk**

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