

Ombudsman's Commentary

DECEMBER 2009 REPORTS

The SPSO laid 13 investigation reports before the Scottish Parliament today. Eight relate to the health sector, two to local government, two to further and higher education and one report is about both the health and local government sectors. Our investigation reports form only one part of our work. In November, we determined 366 complaints, including 98 resolved after detailed consideration.

Each investigation may contain several complaints, and overall the 13 reports laid today:

- **Upheld 11 complaints**
- **Partially upheld 9 complaints**
- **Made no finding on 2 complaints**
- **Did not uphold 19 complaints**
- **Made 48 recommendations**

Overview

This office is charged with looking at the relatively small number of instances when things go wrong in the delivery of a public service. In the health sector, 'something going wrong' can of course have serious and sometimes tragic consequences.

On occasion, our investigation reports tell very sad stories, and at all times, but especially at this time of year, accounts of complainants' experiences can take on a particular poignancy.

The set of reports we are laying this month contain a number of distressing accounts. I upheld complaints that an NHS Board failed to provide appropriate services to a teenager (Case 200702047). The young woman, who had suffered from depression in her adolescence and later developed an eating disorder, committed suicide in 2007. The complaint was brought by her mother, and while recognising that the Board has already made some improvements, I made a number of recommendations for further action.

A complaint was made by a man about his mother's treatment in hospital (Case 200801134) where she underwent surgery. After the

operation, the man's mother suffered internal bleeding which required further surgery, and she also had a heart attack. Although she was eventually discharged from hospital, she died very shortly afterwards. The son questioned the level of information provided to his mother when she consented to the initial surgery and the appropriateness of the decision to operate. I partially upheld these complaints, but did not uphold a complaint that his mother was discharged from hospital too early. I made several recommendations to the Board for action to prevent similar failures in future. I also recommended that they ensure that a proper multi-disciplinary approach to patient care is in place and seen to be effective, and that they apologise to the complainant for the failings identified in the report.

In Case 200803057, a man complained about a Board's failure to treat his father, Mr A appropriately in hospital. The complainant, Mr C, felt that his father should have been tested for creatine kinase (CK, the enzyme liberated by damaged muscle) levels on admission as he felt this would have changed his course of treatment. Mr C believed that in turn this may

Ombudsman's Commentary

DECEMBER 2009 REPORTS

overview

have saved his father's life, leaving him with what Mr C described as an 'entirely manageable' condition. Mr C also complained that there was a delay in providing his father with urgent dialysis and that he should have received treatment for his elevated potassium levels in the interim.

I upheld the complaints that the Board failed to assess Mr A's CK levels early enough, and that they did not provide appropriate treatment for his raised potassium levels. I made a number of recommendations for review and re-evaluation of procedures, and recommended that the Board apologise to the complainant and his family and accept that there was a failure to provide Mr A with urgent medical treatment.

As is often the case, protracted or poorly managed complaint processes can contribute to personal grief or stress, whatever the subject of the complaint. This month, I made recommendations to improve complaint handling, including in both the reports we

laid about Further and Higher Education where I upheld a number of aspects relating to appeal and complaint policies and the provision of information.

I also investigated a case involving a Council and an NHS Board (Cases 200701747 & 200800670). The complainant said that the Board failed to provide a programme of intervention to meet the needs of one of his children, Child C, who has Autism Spectrum Disorder, and to properly assess his family's needs and provide appropriate support. I did not uphold most of the complaints as I found that, in the main, both the Board and the Council acted appropriately. I did find fault with one aspect of the complaint and made a recommendation to redress this. I also recommended that both the Council and the Board note my advisers' comments on the importance of multi-agency working in this case and implement their suggestions on effective collaborative working.

case reports

Further and Higher Education

Supervision; academic appeals; policy/administration

University of Strathclyde
(200702441)

Mr C's son, Mr A, was on a teacher training placement at a primary school. Mr C complained that the supervision of the placement was inadequately monitored, and that the University failed to respond appropriately to Mr A's reports of bullying by the class teacher in whose class his placement took

place. Mr C also complained about the University's handling of appeals and complaints about these matters. I did not uphold the complaints about supervision or that the University failed in their duty of care to Mr A. I did, however, uphold his complaint about the way in which they responded to the complaint about bullying and harassment and partially upheld his complaint about the conduct of Mr A's appeals. I made a number of recommendations which are laid out in full in the report. These

include recommendations about how the University might in future work with schools when a placement student gives cause for concern; reviewing relevant policies and procedures with particular regard to timescales, recording of information and adopting a holistic approach to matters where there are a number of appeal and complaint policies involved; and that the University apologise to Mr A and Mr C for the shortcomings in complaint and appeal handling.

Ombudsman's Commentary

DECEMBER 2009 REPORTS

case reports

Further and Higher Education

Academic appeals; communication; policy/administration

Edinburgh College of Art (200702367)

Mr A was a student at the College. He failed a final year module and appealed this, first to the College and then to a University under a special arrangement. Mr A's father made a number of complaints about the College's handling of these appeals. I upheld his complaint that the College's responses to the University were inadequate, and recommended that in future they should comply with requests for comment. I partially upheld complaints about the College's handling of Mr A's initial approach to them and about the time taken to deal with the appeals. I made several recommendations including providing appellants with specific appeal-related information at an early stage, ensuring that information provided by the College to the University about an appeal can be substantiated and devising a policy for managing behaviour considered unacceptable. I did not uphold three other complaints, and could not make a finding on a fourth.

Health

Delay in diagnosis; clinical treatment; complaint handling

Lothian NHS Board (200800557)
A Medical Practice, Lothian NHS Board (200800997)

Mrs A, who had been unwell for some time, was diagnosed with cancer shortly before she died. Her daughter, Mrs C, raised concerns that Mrs A was not provided with reasonable care and treatment, either by her GP Practice or by the Board in hospital. Mrs C also felt that responses from the Board and the Practice to her enquiries and complaints were inappropriate and had been unnecessarily distressing to her. I partially upheld the complaints about care and treatment as in both cases I found inadequacies, including the Board's mis-reporting of an x-ray and the Practice's failure to follow national guidelines relating to the symptoms with which Mrs A was presenting. The correct handling of these might have resulted in an earlier diagnosis of the cancer (although my medical advisers have pointed out that earlier diagnosis would not have changed the eventual outcome). I upheld the complaint about the Board's handling of Mrs C's complaints and enquiries, and partially upheld her complaint about the Practice as some of their responses, or lack of responses, were inappropriate. I recommended that both bodies apologise to Mrs C for these failings. I also made a number of significant recommendations to both the Board and the Practice, designed to learn the lessons of this complaint.

Communication; clinical treatment; consent; discharge planning

Lothian NHS Board (200801134)

Mr C raised concerns about the care and treatment of his late mother, Mrs A, in hospital, where she had a hysterectomy to remove a pelvic cyst. After the operation Mrs A suffered internal bleeding which required further surgery; she also had a heart attack. Although she was eventually discharged from hospital, she died very shortly afterwards. Mr C questioned the level of information provided to Mrs A when she consented to the initial surgery and the appropriateness of the decision to operate; the handling of the surgical complications and said that he felt that Mrs A was discharged from hospital prematurely. I upheld his complaints about surgical decision-making and how the complications were handled. I partially upheld his complaint about the process of obtaining consent for the operations, to the extent that the doctor who did this did not have the appropriate level of seniority and experience. I did not uphold the complaint about discharge. I recommended that the Board review their procedures for obtaining consent and for decisions about surgery, and that they take action to prevent similar failures in future. I also recommended that they ensure that a proper multi-disciplinary approach to patient care is in place and seen to be effective, and that they apologise to Mr C for the failings identified in my report.

Ombudsman's Commentary

DECEMBER 2009 REPORTS

case summaries

Health

Delay in treatment; complaint handling; eating disorder

Tayside NHS Board (200702047)

Mrs C's teenage daughter, Miss A, who suffered from depression in her adolescence and later developed an eating disorder, committed suicide in 2007. The complaints raised were that the Board failed to provide Miss A with access to appropriate psychology services; failed to provide Miss A with access to appropriate eating disorder services; and failed to handle Mrs C's complaint in a timely and appropriate manner. I upheld all these complaints. I noted the Board have since taken steps to improve the provision of some services and their complaint handling. I recommended that the Board take further action to review the current service provision of family therapy to adolescents with eating disorders and consider introducing an Integrated Care Pathway designed around the relevant guidelines on the management of anorexia. I also recommended that they apologise in writing to Mrs C for all the failures identified in my report.

Delay in diagnosis; complaint handling

Tayside NHS Board (200702821)

Mr and Mrs C's infant daughter, Baby C, was seen at hospital four times and was eventually diagnosed (in another Board's area) with a form of meningitis. Mr and Mrs C felt that the Board did not take their concerns for her health seriously, that she had not been adequately examined and that her condition was not

investigated appropriately. Mr and Mrs C also felt that the Board did not respond appropriately when they complained and were unhappy with a letter that the Board sent to their daughter's GP. I partially upheld the complaint about diagnosis (to the extent that further investigations should have been undertaken to ascertain the cause of the condition, and Baby C should have been admitted to hospital) and recommended that the Board apologise for these failings, and review this case with the relevant staff at their next appraisal. Although I found that the complaint responses were generally accurate and that the time taken to respond was reasonable, I also partially upheld the complaint about the way in which the Board responded to Mr and Mrs C's concerns, to the extent that the response did include an element of unsupported comment. I recommended that they apologise to Mr and Mrs C for this. I did not uphold the complaint about the letter to the GP.

Delay in clinical treatment; communication

Tayside NHS Board (200803057)

Mr C raised a number of concerns about the treatment that his late father, Mr A, received in hospital. He felt that the Board's failure to treat Mr A appropriately resulted in his premature death. Mr C said that the Board failed to assess Mr A's creatine kinase (CK) levels early enough, and that they did not provide appropriate treatment for his raised potassium levels. I upheld both of these complaints

and recommended that the Board ensure that future patients with similar symptoms have their CK level checked on admission; that the Board evaluate their policy for the determination of cardiac risks; and that they review the way in which they handled Mr C's complaint to see if there are lessons to be learned for the future. I also recommended that the Board apologise to Mr C and his family and accept that that there was a failure to provide Mr A with urgent medical treatment.

I did not uphold complaints about the following:

Clinical treatment; record-keeping

Tayside NHS Board (200701716)

Although I did not uphold this complaint about the care and treatment of a woman following the delivery of her baby by emergency caesarean section, I recommended that the Board ensure that good contemporaneous notes are in future made after such a delivery.

Removal from practice list

A Medical Practice, Lanarkshire NHS Board (200701396)

Clinical treatment, communication

Greater Glasgow and Clyde NHS Board – Acute Services Division (200703138)

Ombudsman's Commentary

DECEMBER 2009 REPORTS

case summaries

Health and Local Government

Assessment of needs; communication

Ayrshire and Arran NHS Board
(200701747)

North Ayrshire Council
(200800670)

Mr C was unhappy with the service he and his family received from the Board and the Council. Mr C has four children, and the oldest, Child C, has Autism Spectrum Disorder. Mr C said that the Board failed to provide a programme of intervention to meet Child C's needs and that this had caused considerable distress for Child C and his family because of the effects of Child C's disability. He also said that the Council did not properly assess the family's needs or provide appropriate support. I did not uphold most of Mr C's complaints as I found that, in the main, both the Board and the Council acted appropriately. I did, however, uphold his complaint that the Council failed to inform Mr C that from a particular date Child C would lose his right to all his 'banked hours' (i.e. any unused support hours allocated for Child C that had been carried over from one financial year to the next). I recommended that the Council re-instate Child C's unused hours of support for a period of time. I also recommended that both the Council and the Board note my advisers' comments on the importance of multi-agency working in this case and implement their suggestions on effective collaborative working.

In particular, I recommended that the stakeholders 'regroup' to re-establish and commit to effective future collaborative working arrangements in respect of Child C and his family, including a set of principles upon which future care should be based.

Local Government

I did not uphold complaints about the following

Planning: policy/administration

Fife Council (200703105)

Policy/administration

The Highland Council
(200801053)

Although I made no finding on this complaint about the Council failing to take appropriate action to require that problems with a building be rectified, I recommended that the Council continue to closely monitor the property and its effects on the neighbouring property.

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 December 2009

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

For further information please contact:

**SPSO, 4 Melville Street,
Edinburgh EH3 7NS**

Communications Manager:

Emma Gray

Tel: **0131 240 2974**

Email: egray@spsso.org.uk

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.spsso.org.uk**

Contact us at:

SPSO	Tel: 0800 377 7330
4 Melville Street	Fax: 0800 377 7331
Edinburgh EH3 7NS	Text: 0790 049 4372

E-mail us at: **ask@spsso.org.uk**