

Ombudsman's Commentary

MARCH 2010 REPORTS

The SPSO laid seven investigation reports before the Scottish Parliament today. Five relate to the health sector, and two to the local government sector. Our investigation reports form only one part of our work. In February, we determined 282 complaints, including 44 resolved after detailed consideration.

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

- **Upheld 13 complaints**
- **Did not uphold 3 complaints**
- **Made 37 recommendations**

Ombudsman's Overview

This month, I wish to draw attention to public bodies' duty to take the special needs of individuals into account when delivering a service. Two relatively young people died: a 28-year-old woman with learning difficulties (Case 200802400) and a man of 27 whose heart problem was not detected (Case 200901358). In each case, I found fault with the treatment and care of the patients, and attributed some of the failings to the fact that health professionals did not take into account the patients' special needs.

In these cases I made recommendations to the Boards concerned designed to ensure no repetition of the failings, including:

- providing a copy of the appropriate action plans which specifically contain details of how the Board will implement and meet two particular NHS Quality Improvement Scotland policies relating to people with learning difficulties;
- providing a copy of their education and training strategy, including the specific requirement relating to patients with learning disabilities;
- reviewing and evaluate the current arrangements for pre-operative admission for people with learning disabilities and provide the Ombudsman with a report of the findings;
- confirming the specific action taken to clarify the terms 'special nursing' and 'routine monitoring' to avoid ambiguity over what level of nursing support is required when caring for people with learning difficulties;
- reflecting on the medical lessons to be learned and consider appropriate action; and
- producing an action plan, to include education and training, to address the equality, diversity and person-centred care failings identified.

There are also lessons to be learned about treating patients as individuals from a report into the treatment and care of an elderly woman suffering from dementia. Poor nursing care, inadequate record-keeping and poor communication between hospital staff and a patient's

relative were all concerns raised in a complaint brought by a man whose wife, a dementia sufferer, died in hospital (Case 200901408). I made eight recommendations to the Board to improve their practices, particularly with regard to the issue of consent to medication in circumstances where the patient is unable to make such a decision.

I upheld a complaint about delay in diagnosis in a further health complaint (Case 200802662), brought by a mother, Mrs C, who was unhappy with the care and treatment that her daughter received when she attended hospital with back pain. I did not uphold Mrs C's complaint that her daughter did not receive surgical treatment as I found that surgery would not have been the normal treatment for a spinal infection.

Record-keeping was an issue in a complaint about a dental practice (Case 200802819) where I comment that: *'The creation and maintenance of adequate clinical records are fundamental to providing appropriate care and treatment. The security of these records is also important to maintaining patients' trust in dental professionals.'* In addition to poor record-keeping, the practice did not have a complaints procedure, and I recommended that they establish one as a matter of urgency.

In the local government sector, I found fault with a council in their handling of planning applications. In the report (Cases 200801197 & 200801300), which concerned the siting of a new school, I upheld the complainants' concerns that alternative sites for the school were not properly considered and that the number and wording of planning consents were inappropriate. I made recommendations to the Council to improve their policies and apologise to the complainants.

The other local government complaint (Case 200801246) was about a mother's concerns about the accessibility of further education for her son, who is blind and has learning difficulties. Although I did not uphold the specific complaint, I recognised that, as a result of the events described in my report, the complainant's son encountered significant delay to the provision of his personal care package resulting in a gap in his personal development. I made a number of recommendations to redress the situation.

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MARCH 2010 REPORTS

case reports

Health

Clinical treatment; communication; policy/administration

Tayside NHS Board (200802400)

Miss C suffered from myotonic dystrophy; she also had learning difficulties. She died in hospital after minor surgery on her parotid gland. Her father, Mr C, complained about the care provided to his 28-year-old daughter before and after surgery. He said that she was not properly assessed by a consultant anaesthetist before her operation and that her post-operative care and treatment was inadequate. He was also unhappy about the way in which staff communicated with the family. I upheld all of Mr C's complaints as I found that there had been significant failings by staff, especially given Miss C's learning difficulties. I made a number of detailed recommendations about the Board's arrangements, policies and procedures, particularly in relation to people with learning difficulties, and these are described in full in my report. I also recommended that the Board provide an explicit, unambiguous and meaningful apology to Miss C's family for all the failings identified in this report, detailing the steps they have put into place to ensure that a similar occurrence is not repeated.

Diagnosis; complaint handling; communication

Greater Glasgow and Clyde NHS Board (200901358)

Mr A was referred to hospital by his GP, with various symptoms including urinary incontinence, a sore throat, a cough, shortness of breath and facial swelling. He had been dizzy for two days and had

diarrhoea and faecal incontinence the night before admission. He was discharged the following day and died suddenly four days later. A post mortem examination revealed heart muscle disease and evidence of heart failure. Mr A's mother, Mrs C, complained through the Citizens' Advice Bureau that the standard of care her 27-year-old son received fell beneath the level expected of medical practitioners, and that the Board's responses to the complaint were poor. I upheld both complaints. I found that the Board had failed to review and comment at senior level on the available clues to the presence of heart disease. I recommended that they reflect on the medical lessons to be learned from this and produce an action plan to address the failings identified. I recommended that they produce a further action plan to address the equality, diversity and person-centred care failings identified in the report. I found that the Board's responses were inadequate, defensive in tone and contradictory. I recommended that the Board reflect on their handling and investigation of complaints relating to a sudden unexpected death, or where the family involves a medical advocacy organisation, as happened in Mr A's case. Finally, I recommended that the Board apologise to Mrs C for the serious failings identified in my report and also apologise to her and to the Citizens' Advice Bureau for the shortcomings in their correspondence with them identified in my report.

Care of the elderly; clinical treatment; communication; record-keeping

Lothian NHS Board (200901408)

Mr C was unhappy with the care provided to his late wife, Mrs C. She had multiple health problems, including dementia. When her health began to deteriorate after a fall she attended a hospital Accident and Emergency unit. She was admitted to the hospital, but was transferred to a second hospital the following day. She was given a course of antibiotics, some of which she refused. No assessment was made of Mrs C's ability to make that decision, and the antibiotics were subsequently discontinued. Mrs C's condition continued to deteriorate and she died in the second hospital just over a week later. I upheld all Mr C's complaints as I found that the Board had not provided appropriate treatment or antibiotics, nor had they communicated effectively with Mr C about his wife's condition or treatment, especially given that Mrs C herself did not seem to be competent to refuse treatment. I made eight recommendations to the Board, including reviews of policy and procedures, and the provision of guidance and information to staff, all of which can be read in full in my report. I also recommended that the Board apologise to Mr C for the failings identified in my report.

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MARCH 2010 REPORTS

case reports

Health

Delay in diagnosis; clinical treatment; policy/administration; communication

Greater Glasgow and Clyde NHS Board (200802662)

Mrs C was unhappy with the care and treatment that her daughter, Miss A, received when she attended hospital with back pain. Miss A was treated for a chest infection and referred for physiotherapy, but was later diagnosed with a spinal infection. Mrs C complained that the infection was not diagnosed earlier. Mrs C was also concerned that surgical treatment could not be carried out, as Miss A had been provided with an anti-coagulant medicine because of a history of deep vein thrombosis. I upheld the complaint about delay in diagnosis and recommended that the Board apologise to Miss A for this and review their process for identifying and acting upon warning indicators in patients. I also recommended that they ensure that officers handling complaints accurately reflect clinicians' feedback in their response to complainants. I did not uphold the complaint about medication, as I found that treatment was appropriate and surgery would not have been the normal treatment for a spinal infection.

Clinical treatment; complaint handling; policy/administration

A Dental Practice, Forth Valley NHS Board (200802819)

Mr C complained that his dental practice did not provide him with appropriate treatment, and that when he complained they acted unprofessionally and unhelpfully.

I upheld both his complaints as I found that information about Mr C's treatment was not adequately recorded or protected within the practice; details of his clinical treatment were missing; there was no complaints procedure in place; and the NHS complaints procedure was not followed. I recommended that the Practice urgently establish a complaints procedure and implement policies to record and protect all clinical information in future; that they ensure staff understand these; that they identify and retrieve the missing information about Mr C's treatment; and that they apologise to Mr C for the failures identified and for their poor handling of his complaint.

Local Government

Handling of planning application

South Lanarkshire Council (200801197 and 200801300)

When planning applications for a new school were submitted, Mr and Mrs C and Mr D objected to the siting of the building. When the Council approved the applications, the complainants remained concerned about the way the planning conditions were enforced and, in particular, about measures designed to minimise flooding. I upheld their complaints that alternative sites for the school were not properly considered and that the number and wording of planning consents were inappropriate. I recommended that the Council remind staff of the need to use evaluation tools appropriately and that they apologise to the complainants for the failings identified in my report. I also recommended that they review their policies on both

standard planning conditions (and provide relevant guidance to planning officers) and appointment of consultants. I did not uphold the complaint about monitoring and approval of the conditions relating to flood prevention.

Education: personal care; learning difficulties; policy/administration

South Lanarkshire Council (200801246)

Mrs C raised a number of concerns about the accessibility of further education for her son, Mr A, who is blind and has learning difficulties. She complained that the Council failed to take her son's specific needs into account when deciding on the further education and personal care package they would fund. She felt that the Council had unreasonably dismissed funding a residential placement at a specialist college in England in favour of a local option, which she considered less suitable. Although I did not uphold the specific complaint made to me, I recognise that, as a result of the events described in my report, Mr A encountered significant delay to the provision of his personal care package resulting in a gap in his personal development. I therefore recommended that the Council apologise for this and pay Mr A a sum that adequately reflects the hardship and injustice caused to him and his family by the considerable delay in putting in place his care package. I also recommended that the Council review their procedures to ensure that in future service users are provided with details of proposed packages before they are asked for acceptance.

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MARCH 2010 REPORTS

case reports

Compliance & 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.

Jim Martin, Ombudsman
24 March 2010

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 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

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