

# Ombudsman's Commentary

## JANUARY 2011 REPORTS

The SPSO laid three investigation reports before the Scottish Parliament today. Two relate to the health sector and one to the Scottish Government and other devolved bodies.

### Case numbers

Last month, December 2010, in addition to the five investigation reports laid before the Parliament, we **determined 230 complaints and handled 32 enquiries**. Taking complaints alone, we:

- gave advice on 150 complaints
- resolved 63 in our early resolution team
- resolved 17 by detailed consideration
- made a total of 29 recommendations in decision letters (some of these are listed at the end of this Commentary).

### Ombudsman's Overview

#### Prison complaints

We are laying our first report about the Scottish Prison Service (SPS) today. It involves the process a prison used to test for drugs, and I have upheld the prisoner's complaint that the prison failed to adapt the process properly. I found that the SPS have no policy for staff to follow when testing liquids or substances for the presence of drugs. I recommended that they put in place such a policy and take steps to make sure that prisoners are aware of the process. I also recommended that they remind prison staff to record the timings of cell searches and drug testing confirmation results accurately and that they apologise to the complainant for the failings identified in the report. There is a summary of the report below and it can be read in full on our website.

I welcome the SPS's positive response to the findings and recommendations. They have assured me that the drugs testing policy I recommend is currently being developed in one prison, and will be introduced across the SPS and communicated to all prisoners once it has been through the necessary legal and quality checks. An apology has already been issued to the prisoner for the failings identified in the report, and I also welcome the fact that the SPS are going further than my recommendation and are to reimburse the prisoner the wages deducted in the orderly room (the prison punishment) and he will have the charge removed from his records.

The SPS also assure me that the report will be discussed with the Governors in charge across the SPS and the

recommendations on accurately recording the timings of cell searches and drug testing will be cascaded to prison staff. This follows the commendable practice to date by the SPS in disseminating findings and recommendations from SPSO investigations across the prison estate.

The SPS have been a model of good practice in sharing the learning from complaints, and we look forward to building on this cooperation and continuing to contribute to improving how prisons carry out their administrative duties.

In the three and a half months since the transfer to the SPSO of responsibility for prisons complaints, a number of themes have emerged. We have discussed these with the SPS, and have been encouraged by their constructive engagement, as we are with the positive communication between our complaints teams and the SPS complaints handlers. Some of the themes that have emerged from our consideration of prisons complaints are generic to all the public service sectors we deal with, and some are specific to prisons. The main areas we have identified are:

#### **Poor Communication**

As we do in other sectors, we have emphasised the importance of full, clear, accurate communication and explanation, including evidence or reasons, whenever decisions are made. This is particularly important when communicating timescales for access to offender behaviour programmes (completing such programmes can enable prisoners to progress to open estate).

#### **Poor Complaint handling**

Again, as in other sectors, we have on occasion asked for better, fuller explanations in complaint responses from the SPS. This relates both to their initial responses to prisoners and to their responses to our enquiries. In some instances, failure to provide full, clear, accurate responses can escalate the complaint, and opportunities for early resolution may be lost.

#### **Orderly room verdicts**

We have received cases where a prisoner has had their appeal against an orderly room verdict upheld, but the punishment has already been served. While redress for maladministration in these cases is difficult, the SPS's response to today's report demonstrates that in some cases it is not impossible.

# Ombudsman's Commentary

JANUARY 2011 REPORTS

## Prisons complaints – background & casework numbers

Under the Scottish Parliamentary Commissions and Commissioners etc Act, the functions of the Scottish Prisons Complaints Commission (SPCC) were transferred to the SPSO on 1 October 2010. For several months before the transfer SPSO staff worked with the Government, the Scottish Prison Service, the SPCC and the Parliament to prepare for a smooth transition. This included ensuring IT system compatibility, communication with stakeholders, knowledge transfer, setting up archive and retrieval systems and training our staff in handling enquiries and complaints in this new area of responsibility. SPSO staff visited a number of prisons both in the lead-up to, and after, the transfer. More visits are scheduled, to further support SPSO staff in understanding the prison environment and to hear from SPS staff about the nature and challenges of their work.

A small, dedicated team of SPSO complaints reviewers handles all transferred and new complaints. We inherited a backlog of 42 cases from the SPCC, and of these, only two remain open. The team has examined a total of 157 prisons complaints since 1 October, and have determined 131 of these. We have made 17 recommendations to the SPS, some of which are listed at the end of this Commentary. All of the recommendations made to the SPS have been actioned or are in the process of being actioned.

## Health reports

There are two reports laid today, and they both speak for themselves in the sad events they describe. I hope that the family and the patient who brought the complaints can take some comfort from the knowledge that their concerns have been thoroughly investigated and that they have got some of the answers they sought. The Boards concerned have accepted my recommendations, which aim to ensure that there is no recurrence of the problems that caused such distress and pain.

## Principles of Complaints Handling approved by the Scottish Parliament

The Scottish Parliament approved the SPSO's Statement of complaints handling principles on 12 January 2011. The principles were developed in partnership with service providers and following consultation with a wide range of stakeholders.

We are publishing the principles today on our complaints standards website ([www.valuingcomplaints.org.uk](http://www.valuingcomplaints.org.uk)).

The Public Services Reform Act requires that bodies under our jurisdiction should have complaints handling procedures (CHPs) that are based on the principles. The SPSO's Complaints Standards Authority will be supporting service providers to ensure that their CHPs comply with the principles. Our analysis of the consultation responses to our proposed Guidance on a Model CHP will be made available in February.

# Ombudsman's Commentary

JANUARY 2011 REPORTS

case reports

## Scottish Government and other devolved bodies

### Policy/administration; record-keeping

Scottish Prison Service (201002487)

During a search of Mr C's prison cell a container was found, which staff suspected of containing drugs. It was tested and was found to contain methadone. To carry out the test, the prison adapted their mandatory drugs testing policy (normally used for testing prisoners' urine samples), and Mr C claimed that they failed to apply the adapted process properly. I upheld the complaint, as I found that the process normally required the prisoner to be present to witness the test being made, but this did not happen in this case. I recommended that the Scottish Prison Service put in place a policy for staff to follow when testing liquids or substances for the presence of drugs; and take steps to make prisoners aware of this process. I also recommended that they remind prison staff to record the timings of cell searches and drug testing confirmation results accurately and that they apologise to Mr C for the failings identified in this report.

## Health

### Delay in medical assessment, clinical treatment, communication

Lanarkshire NHS Board (201001239)

Mr A was suffering from chest pains and breathing difficulties when he presented at an Accident and Emergency Unit. He was examined after waiting for some time, and was eventually discharged with a diagnosis of a chest infection some three and a half hours after arriving. He presented there again, however, in the early hours of the next morning and died after an unsuccessful attempt to resuscitate him. Mr A's mother, Mrs C, complained that her son received inadequate treatment and that it was inappropriate for him to be discharged, regardless of his expressed wish to go home. I upheld both complaints. Having taken the advice of one of my medical advisers, I am satisfied that Mr A's care and treatment itself was appropriate, but I upheld that complaint because of the time it took the Unit to assess Mr C's condition, noting that he had to receive morphine during his attendance. As the Board agree that this process took too long and are considering measures to improve assessment of patients, I recommended that they consider the Manchester Triage Scale in their review. I upheld the complaint about the failure to admit Mr A for treatment as I found no evidence that staff had stressed to him the importance of a hospital admission in the circumstances. I recommended that the Board apologise to Mrs C for this.

### Clinical treatment, staff attitude, record-keeping, complaints handling

Grampian NHS Board (201000168)

Mr C complained that the Board did not provide him with appropriate care and treatment for wounds and pressure sores that developed after he was immobile for several weeks following surgery. He was also unhappy with the attitude of a consultant plastic surgeon and with the Board's investigation of his complaint. Having taken the advice of one of my medical advisers, I found that there was a lack of a co-ordinated plan to manage Mr C's wounds. I therefore upheld the complaints that the consultant did not care for and treat, and did not understand and direct vacuum assisted closure (VAC) treatment of, Mr C's wounds and pressure sores appropriately. I also upheld Mr C's complaint that the Board's handling of his original complaint was inadequate. I recommended that the Board apologise to Mr C for all the failings identified. I also recommended that they review their approach to team care for such wounds and their protocols for the use of VAC treatment; remind staff of the importance of good record keeping; and review their processes to ensure they obtain responses from relevant staff when investigating complaints; and for recording the investigation of complaints. I did not uphold the complaint about the attitude of the consultant.

## Recommendations made in decision letters in December 2010

### Recommendations to Health Boards

- that a Board remind nursing staff that instructions about the removal of patients' false teeth be followed
  - that a Board remind medical staff of the importance of carefully reviewing medical notes to ensure that concerns, queries or suggestions regarding a patients' condition are followed up timeously
  - that a Board ensure medical notes include a record of the discussion between consultants when a patient's care is transferred
  - that a Board remind staff of the need to correctly identify correspondence which is to be dealt with under the complaints procedure and that which is appropriate for enquiry and ensure that timely responses are issued
  - that a Board review their procedures to ensure the Patient Database is accurate and up-to-date; and formally apologise to a complainant for failing to respond to his letters and for incorrectly stating that his details were not on the Complaints Database
  - that a Dental Practice undertake training to ensure that all relevant staff and practitioners understand their responsibilities under the Regulations (the National Health Service (General Dental Services Contracts) (Scotland) Regulations 1996) relating to removal of a patient from a practice list
  - that a GP Practice apologise to a complainant for inappropriately contacting a relative in relation to the complaints that the complainant raised and review their complaints procedure to ensure that they give due consideration to the confidentiality of complainants.
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### Recommendations to Councils

- in a complaint about the handing of a council tax account, that a Council apologise for the lack of customer care shown and draw the case to the attention of relevant staff to ensure in similar circumstances a letter of explanation is provided
- in a complaint about incorrect advice being provided about the catchment area of a local school and refusing an application on the basis that the parent and child lived outwith the council area, despite the school being nearest to their home, that a Council:
  - provide the Ombudsman with details of the training they carry out with the Customer Contact Centre;
  - apologise for the lack of transparency and clarity in the consideration of the application;
  - review the Policy and Guidance in order that it reflects practice and that the practice reflects policy; and
  - in the event of a vacancy, the application be reconsidered (together with all others waiting) in terms of the Council's correctly stated policy.

## Recommendations made in decision letters in December 2010

### Recommendations to a Scottish Government or devolved administration body

- that a body review their complaints process to ensure that a formal process is in place to allow for complaints made against the Chief Executive to be considered
- in a complaint from a prisoner, that a body revisit their decision to place the complainant on an anti-bullying strategy and inform him of the outcome; and remind all staff of the importance of ensuring that the reasons for placing a prisoner on the anti-bullying strategy are based on full and accurate information
- that a body communicate timescales to individual prisoners on when they can expect to access identified offending behaviour programmes
- that a body action a review and issue guidance to relevant staff confirming what the process is when receiving and opening prisoner mail from external medical facilities
- that a body apologise for the failure to provide a satisfactory explanation about why a prisoner was not allowed unescorted day release; and remind staff of the importance of providing full responses to complaints
- that a body take steps to ensure that staff are aware that members of staff such as a psychologist are not agency staff and make staff aware of the requirement under the Data Protection Act to record when a prisoner considers an intelligence entry that he or she is aware of to be inaccurate
- that a body apologise to a prisoner for failing to provide clear and accurate information in their complaint response regarding the cancellation of courses; and that the body update the Ombudsman on the outcome of the consultation regarding the proposed changes to the assessment process for offender related programmes.

# Ombudsman's Commentary

## 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, 19 January 2011**

The compendium of reports can be found on our website [www.spsso.org.uk](http://www.spsso.org.uk)

For further information please contact: **SPSO, 4 Melville Street, Edinburgh EH3 7NS**

Head of Policy and External Communications: **Emma Gray**

Tel: **0131 240 2974**

Email: [egray@spsso.org.uk](mailto:egray@spsso.org.uk)



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, prisons, 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](http://www.spsso.org.uk)

Contact us at:

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|--------------------------|----------------------------|
| <b>SPSO</b>              | Tel: <b>0800 377 7330</b>  |
| <b>4 Melville Street</b> | Fax: <b>0800 377 7331</b>  |
| <b>Edinburgh EH3 7NS</b> | Text: <b>0790 049 4372</b> |