

Monthly news from the Scottish Public Services Ombudsman

The SPSO laid four investigation reports, all about health boards, before the Scottish Parliament today. We also laid a report on 63 decisions about all of the sectors under our remit. All the reports can be read on the 'Our findings' section of our website at www.spsso.org.uk/our-findings.

Case numbers

Last month (in July), we received 405 complaints. In addition to the two reports we laid before Parliament, we determined 401 complaints and of these we:

- gave advice on 273 complaints
- handled 80 complaints in our early resolution team
- decided 48 complaints through detailed consideration
- made a total of 77 recommendations in decision letters.

Ombudsman's Overview



Involving the public

We are making progress with two initiatives that aim to increase our engagement with the public. The first is our customer sounding board, a forum through which we will hear from organisations and individuals representing different public service user groups on how we can continue to improve our services for the customers they represent. This forum will help us in projects such as the current review of our customers' journey to ensure that we continue to build clarity, transparency, timeliness and empathy into our communications with them.

Another current project aims to build our links with advisers and advocates who work with the public. We met with the national coordinator and members of Citizens Advice Scotland to seek their views on the information their advisers and clients would find most useful and how we can best pass this on. In response to their feedback, we produced a list of our key information leaflets, and sent this to all the bureau managers in Scotland. It will soon be available on Advisernet, the website that their advisers use when assisting clients. It will also be available through the Scottish Independent Advocacy Alliance.

Public reports

The four public investigation reports that I am laying before parliament today are all about health boards, and they make very distressing reading.

In the first (case 201201732), a couple's baby daughter died shortly after birth. The mother had complex health issues during pregnancy and her baby had not been growing. She was taken into hospital, and eventually had a caesarean section to deliver the baby. The baby's chances of survival were slim – she was delivered weighing only 400 grams, and died within the hour. In this case there were some very serious questions about how the team monitored her mother during her stay in hospital, the decision they made about the delivery, and their communication with the parents. In addition to this, our investigations into the complaint were hampered by the fact that the board did not provide all documents when asked to do so. I commented in December 2011 (case 201003783) that I was disappointed in another board's failure to provide all information at the start of an investigation, as they are required by law to do. In this month's case, the board produced important information, including a post-mortem report, only after we had issued our draft investigation report to both parties. This is unacceptable and I make comment on it in my report.

In another case (201200092), a woman was detained, ostensibly under the Mental Health (Care and Treatment) (Scotland) Act 2003, after a suicide attempt. In fact, her detention was based on incorrect paperwork, and was not authorised by a mental health officer. Although it is not for me to look at whether such detention was in itself appropriate, I can look at the processes that led up to it. In this case, the wrong form was used, processes were clearly not followed, and the requirements of mental health legislation were at best not understood or, at worst, ignored. I also noted that those who took the woman to a second hospital, and those who received her there did not notice that the incorrect form had been used. I am very concerned about this case, and the patient rights issues that it raises – so much so that I have recommended to the board that they consider my report at one of their meetings. The hospital involved were in touch with the Mental Welfare Commission for Scotland as a result of this complaint, and I have also drawn my report to the Commission's attention.

The third case (201103125) is about a man with an infected toe, which had become gangrenous. Doctors decided to operate to bypass a blocked artery, but not to amputate the toe. The man later died from a severe infection. His family felt that his condition was not appropriately treated, and that staff ignored concerns that family members raised about his pain and confusion. The medical records indicate that there was little consideration given to the reasons for the man's pain, or to explain or discuss some of the treatment options. Three different hospitals were involved, and I also took the view that staff in one of them – a community hospital, where he was transferred for rehabilitation – should have recognised that there were problems, and transferred him back to a hospital where he could receive more specialised care earlier than they did.

Finally, yet again I see a case (201204498) before me where staff failed to assess a patient's capacity to make decisions, as required by the Adults with Incapacity (Scotland) Act 2000, and failed to fully explore the options for his discharge from hospital. In this case, a 60-year-old man with early onset dementia, who also had sight and hearing difficulties, was in hospital when his wife noticed signs that he might have had a stroke. Although she alerted staff, nothing was done about this for some days. Eventually a scan showed that he had suffered a stroke. Staff halted plans to send him to another hospital for rehabilitation and instead he was discharged to a care home, where he has had no physiotherapy care. His wife, quite understandably, felt that he has been 'left to vegetate'. In the report, I note that she has welfare power of attorney for her husband, but the board gave little consideration to this when making decisions about his care and treatment. His care needs were not adequately assessed, there were no meaningful attempts at rehabilitation or to discharge him home, and his dignity was not respected. The man was treated and discharged without appropriate specialist care of his dementia and without regard to Adults with Incapacity legislation. This also raises important issues under the Charter of Rights for people with dementia and their carers in Scotland – these rights were clearly not enacted in this case.

Investigation Reports



Investigation report ref: 201201732

Maternity care; clinical treatment; communication

Grampian NHS Board

Summary

Mrs C was admitted to hospital for monitoring two weeks before her daughter was born by caesarean section. The baby, however, died shortly after birth, having been born prematurely and weighing only 400 grams. Her husband (Mr C) complained to me that the board's care and treatment of his wife and baby daughter was inadequate. In particular, he was concerned that they were not monitored properly before the birth, and that medical staff refused to continue to resuscitate his daughter after birth. He felt that his daughter had been 'allowed to die' against his wishes.

The board had explained that it was known before birth, and the couple were told, that their daughter had a low chance of survival. She had not grown, her weight was extremely low, and there was a high risk that if she survived she would be severely disabled. Mrs C had a complex gynaecological history and a particular problem with her sugar levels, and because of this senior staff had seen her regularly before she was admitted. While she was in hospital the baby had not grown at all. At first, medical staff had not intervened, but after an ultrasound scan they had decided that the best chance of survival was the operation, even though the chances of survival at such a low weight were very slim.

I took independent advice from two clinical advisers who are consultants – an obstetrician and a neonatologist (a doctor trained to handle the special health needs of new-born children, especially those that are critically ill). The obstetrician said that the main issue before birth was the assessment carried out by the obstetric team, which he felt was below the standard expected of this kind of unit – for example, measurement records were poorly kept, and the monitoring strategy that appeared to be in place was not appropriate given the baby's weight. He was also concerned that the team might not have had the required skills or equipment in certain areas, including advanced screening techniques. The neonatologist agreed, and said that the baby had a very low chance of survival in the circumstances. Both advisers felt that the decision to operate was controversial. There was also concern about whether proper consent had been given, or whether some of the care and treatment details had been discussed with Mr and Mrs C.

We did not uphold the complaint about resuscitation, as the neonatologist said that the board acted appropriately to assess the chances of success, and decided that this would not be possible given the baby's poor condition and size. I did, however, uphold the complaints about care and treatment and communication.

This was always going to be an extremely traumatic experience for Mr and Mrs C, and when compounded by the failures in care described above, it must have been exceptionally difficult for them. The medical notes suggest that many discussions about the baby's chances of survival took place with only Mrs C present, and that no hospital neonatologist spoke to Mr C before the birth. This was made worse by the fact that some important issues (such as resuscitation, or the options available around the operation, and its possible outcome) were not explained or were not clearly explained. This meant that, at times, the element of choice was removed from Mr and Mrs C.

Investigation Reports



Investigation report ref: 201201732

Summary continued

It is also of concern to me that the board did not provide some important clinical documents, including reference to a post mortem examination, until my complaints reviewer issued a draft version of this report. In my report, I say 'I expect all bodies to ensure that their responses to my office's enquiries are thorough and include all information which is of relevance to the complaints under investigation. The board's omissions in this case undoubtedly hampered our investigations, caused increased stress and distress for the family involved, and are totally unacceptable, as well as unprofessional.'

I made eight recommendations as a result of this distressing case, which can be read in full in my report. I made these to ensure that the board have clearly identified areas for improvement to ensure that similar cases will in future receive a more appropriate standard of care.

Investigation report ref: 201200092

Mental health care; consent; policy/administration

Lothian NHS Board – University Hospitals Division

Summary

Ms A was admitted to hospital after a suicide attempt. When it was decided that she did not need surgery, staff decided that she should be detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 and transferred to another hospital. Ms A said she was given no warning of this. She resisted being moved and was injected twice with haloperidol (a drug prescribed for treatment of acute psychosis and other mental illness) before being removed to the other hospital.

The board said that a doctor had completed a short term detention certificate. However, the certificate was invalid as the doctor had not asked a Mental Health Officer to sign it. The doctor who signed the certificate was aware of this and said that he had used the wrong form – he had intended to use an emergency detention certificate. He said that Ms A had still required admission under the strict clinical criteria, as she had attempted suicide. Our mental health adviser took the view, however, that Ms A had not been properly detained, even though she might have met the relevant criteria.

I was extremely critical of these events, as there was clearly a complete failure to follow due process, compounded by a failure to check the accuracy of the detention order. I was not satisfied that appropriate discussions had taken place, nor that Ms A had properly consented to the use of haloperidol. I also found that there was a significant lack of record-keeping. I made a number of recommendations, which can be read in full in my report. These included ensuring that staff discuss detention and treatment with the patient and record this in the medical notes, ensuring that staff understand the requirements of mental health legislation, and adhere to the correct processes. I also recommended that the board feed back the learning from the complaint to relevant staff and that my report is considered at a board meeting, given the patient rights issues that this complaint raises.

Investigation Reports



Investigation report ref: 201103125

Clinical treatment; care of the elderly; record-keeping

Lanarkshire NHS Board

Summary

Mr A, who was 74 years old, was admitted to hospital as an emergency, with gangrene (a serious condition in which a loss of blood supply causes tissue to die) in his toe. He was admitted, then transferred ten days later to another hospital, where he had an operation to bypass a blocked artery. After six weeks, he was transferred to another hospital for rehabilitation, but his health significantly deteriorated there and he was transferred back to the first hospital. Mr A died that day from severe sepsis (bacterial infection in the bloodstream). His wife (Mrs C) and family felt that he developed the sepsis because his toe and the infection were not properly treated. Mr A's family had also raised concerns with staff about his confusion and pain management but felt these were ignored. Mrs C complained to the board and then to me about a number of related issues. In considering the complaint, I obtained independent medical advice from a consultant vascular surgeon and a consultant geriatrician.

The board had told Mrs C that the presence of gangrene did not necessarily mean amputation, as this decision is dependent on the type of gangrene. After the operation it was not felt that infection was becoming a major concern, so amputation of the toe was considered unnecessary. They acknowledged that Mr A had not suffered from confusion before he was admitted. They noted, however, that in patients of his age the combination of gangrene and a major operation could cause confusion, which could be made worse by the painkillers needed at the time of the operation. They also commented on later medical procedures and decisions, including Mr A's final transfer between hospitals.

My medical adviser said that the operation was appropriate but follow-up seemed inadequate. This was because in the second hospital there seemed to be no consideration that a blood clot might have caused Mr A's pain, and the options of a further bypass or amputation did not appear to have been considered or discussed with him or his family. Mr A's pain appeared to have been appropriately managed at first, but in the third hospital, despite his symptoms, staff did not appear to fully consider that he might have been suffering from an excess of opiate painkiller. It is likely that these drugs contributed to Mr A's confusion and drowsiness, which in turn contributed to the development of severe sepsis. The third hospital is a community hospital caring for elderly long term patients, and its facilities will differ from those of an acute hospital (where people receive specialised support and care). However, I consider that staff should have identified Mr A's deteriorating condition and the need to transfer him sooner, when he became unresponsive. I upheld four of Mrs C's five complaints. While noting that the board took action as a result of the complaint, including training and identifying areas for improvement, I made a number of recommendations for further improvement, which can be read in full in my report.

I did not uphold a complaint about communication with Mr A's family while he was in the third hospital, as the evidence showed that when they reported their concerns to staff, this resulted in either action or explanation.

Investigation Reports



Investigation report ref: 201204498

Clinical treatment; delay in medical assessment; capacity issues; discharge planning

Highland NHS Board

Summary

Mr C, who is sixty years old, has sight and hearing problems, as well as early onset dementia. He was admitted to hospital following a seizure. His wife (Mrs C) said that, a week after he was admitted, she noticed that his left arm was swollen and he could not use his left leg. She told nursing staff that she thought he had had a stroke. However, it was not until two days after that, when a physiotherapist noticed a problem, that this was reported to medical staff. Nothing happened until another three days had passed, when a doctor saw Mr C and referred him for a scan, which confirmed a possible recent stroke.

Medical and physiotherapy staff then decided that Mr C had poor rehabilitation potential. Instead of going to a hospital for rehabilitation as planned, he was discharged to a nursing home. Mrs C then complained that her husband was not given appropriate care and treatment, nor was he properly assessed for rehabilitation before discharge. She told us that staff did not show him patience and compassion and made no effort to communicate with him. She said that nursing staff took a dim view of his lack of cooperation when they tried to get him mobile and that she was constantly told that he was not helping himself. She said that he was now in residential care without any physiotherapy, has been given no chance of a future and that she has been deprived of his companionship.

The board reviewed the case after Mrs C complained and explained that he had difficulty following instructions and staff had found it difficult to communicate with him. They had tried to address this by arranging a hearing assessment. The board agreed that he should have been reviewed when the physiotherapist told medical staff that Mr C had a new problem, although in their view the result would have been the same. Mr C then needed a high level of nursing care, and had poor rehabilitation potential because of the difficulties with communication and cooperation. They had discussed transfer to a rehabilitation unit, but took the view that this was not appropriate. Although Mrs C still wanted him to have rehabilitation, they said she eventually agreed that social work would make contact about transfer to a nursing home. They said that staff had tried to understand and be sympathetic to his needs, and were sorry if this had not been apparent.

I took independent advice from two advisers – one a medical adviser, the other a physiotherapy adviser – about this case. Both said that aspects of Mr C's care gave cause for concern. There were omissions – for example, the severity of his dementia and his capacity to make decisions were not assessed as required by the Adults with Incapacity Act. There was little appreciation of the fact that Mr C suffered from dementia and that this was not a matter under his control. Similarly, there was no recognition that he may have been afraid and disorientated, and there seems to have been little done to reassure him. My medical adviser said that after his wife suspected that he had had a stroke, Mr C would likely have received better care if this had happened when he was at home, rather than in the hospital. There was also little attempt to provide any sort of rehabilitation. My physiotherapy adviser said that, as a stroke generally has a degree of recovery over time, it was premature to decide that Mr C would not benefit from rehabilitation and send him to a nursing home.

I upheld Mrs C's complaints, and recommended that the board apologise and ensure that the doctor concerned discusses the case at their next appraisal review, with a particular emphasis on the care of those with dementia, and that the board ensure that staff on the ward understand the Adults with Incapacity legislation. I also recommended that, with Mrs C's agreement, the board assess Mr C to find out whether he would benefit from physiotherapy and if so, that they arrange this.

Complaints Standards Authority update



Further and higher education

All colleges and universities are required to implement the relevant model complaints handling procedures (CHPs) for these sectors from 1 September 2013.

We have received responses from all further and higher education institutions, providing a statement of assurance that they will be compliant by 1 September 2013. We are currently assessing these and will respond directly to each institution advising of the outcome of our assessment. We will also provide a summary of compliance to the Scottish Funding Council in due course.

Further education – online complaints handling tool

As previously reported, Cumbernauld College, supported and guided by the Quality Development Network and Colleges Scotland, have developed an online complaints handling tool. This will be available for use by all colleges, allowing consistency of recording and reporting across the sector. Cumbernauld College have worked with the CSA to ensure that the tool complies with the requirements of the model CHP and we have welcomed this positive innovation.

The online tool was launched on 12 August, and we commend the sector for its progress in this important area. For further information on this, please contact chpsoftware@cumbernauld.ac.uk.

Further and higher education – e-learning modules

E-learning modules for college and university frontline staff are now available free online at the SPSO training centre www.spsotraining.org.uk.

The seven short modules in each course have been designed to support staff awareness of the model CHP and good practice in frontline complaints handling in general. They contain examples most relevant to colleges and universities, and provide an opportunity for staff to think about complaints and how they handle them.

To register and gain immediate access to the e-learning modules visit the SPSO training centre at www.spsotraining.org.uk.

For further information about our training unit, including the direct delivery courses we offer, please contact training@spso.org.uk.

Housing Model CHP

The CSA are carrying out monitoring work on CHPs in the housing sector. The aim is to provide a more detailed assessment of compliance across the sector to complement the statements of assurance that each registered social landlord (RSL) provided before implementation in April 2013. The work will assess the implementation of CHPs by a selected number of RSLs, based on a random sample.

After discussion with the selected RSLs, we will report the information to the Scottish Housing Regulator.

Housing complaints handlers network – August meeting

A meeting of the housing complaints handlers network will take place on 28 August in Glasgow with agenda items covering standardised categories, reporting performance and managing unacceptable actions.

For further information please contact csa@spsso.org.uk and we will provide your details to Queens Cross Housing Association and Castle Rock Edinvar Housing Association who are chairing and co-ordinating the network.

Local authority complaints handlers network

The next meeting of the network is on 20 September, and will again be hosted by Glasgow City Council. If you are interested in joining the network please contact csa@spsso.org.uk and we will provide your details to North Lanarkshire Council, who chair and co-ordinate the network.

Model CHP for the Scottish Government, Scottish Parliament and associated public authorities in Scotland

Each organisation covered by this model CHP is required to provide a return to the CSA by 30 September 2013 with a compliance statement and a self-assessment of compliance to confirm that their CHP complies with the published model CHP, or will do so by the end of March 2014.

The model CHP and associated documents are available on the CSA website:

www.valuingcomplaints.org.uk. A word version of the compliance statement and self-assessment is available at <http://www.valuingcomplaints.org.uk/news/model-chp-for-scottish-government-scottish-parliament-associated-bodies-compliance-statement-and-self-assessment-document/>.

Please contact csa@spsso.org.uk if you have any questions about the model CHP, or your organisation's duty to implement.

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.

Jim Martin, Ombudsman, 21 August 2013

The compendium of reports can be found on our website: <http://www.spsso.org.uk/our-findings>

For further information please contact:

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The 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 for handling complaints about councils, housing associations, the National Health Service, prisons, the Scottish Government and its agencies and departments, the Scottish Parliamentary Corporate Body, water and sewerage providers, colleges and universities and most Scottish public authorities.

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

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 complaints handling in bodies under our jurisdiction.



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