

Monthly news from the Scottish Public Services Ombudsman

The SPSO laid four investigation reports before the Scottish Parliament today. We also laid a report on 88 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 August), we received 414 complaints. In addition to the four reports we laid before Parliament, we determined 404 complaints and of these we:

- gave advice on 289 complaints
- handled 71 complaints in our early resolution team
- decided 44 complaints through detailed consideration
- made a total of 60 recommendations in decision letters.

Ombudsman's Overview



Children, young people and complaints

This month, I am drawing attention to complaints about children. One of my investigation reports is about two young people who were unable to visit their father in prison because of confusion on the part of the prison concerned and the Scottish Prison Service as a whole about whether or not they were of an age to visit without an accompanying adult. Children are also the subject of decision reports I am publishing today about two different schools. One is about bullying in a primary school and the other is about how a school handled a complaint about the enrolment of a girl with severe and complex additional support needs. I have anonymised the councils in which the schools are situated, in order to protect the identity of the children concerned.

It is timely that I highlight complaints involving children, given current discussions about increasing the role of Scotland's Commissioner for Children and Young People (SCYPP) in complaints handling. As our evidence on the bill proposing these changes makes clear, we welcome the focus on reducing the barriers to children and young people complaining.

My office receives few complaints from representatives of children, and even fewer from children themselves. We do though have some experience of children, young people and complaints. In the last 18 months, amongst other issues, we have considered complaints about failures to protect children from bullying; to provide a teenager with appropriate psychiatric care for an eating disorder; decisions to remove respite care; and failures to properly investigate child protection concerns. We have looked at school admission arrangements and we have also had complaints from those unhappy that their involvement in their child's life has been limited in some way. As the organisation that looks at complaints from prisoners and about prisons, we can also take complaints from young offenders and today's report (case ref 201101687) highlights failings in the way prisons are treating children visiting in prison.

In today's complaint about bullying (case ref 201204677), I did not find that the school had failed to take appropriate action after a series of reported incidents. I found that they had taken the matter seriously and took appropriate action with reference to the sanctions and advice in their policy. I did, however, find failings in their complaints handling and I made a recommendation to remedy this. The complaint about enrolment (case ref 201205187) was also upheld on the complaints handling aspects and I made recommendations to remedy this and also to ensure that appropriate learning from the complaint about equality and diversity is identified and available to staff.

In each of these cases, as is almost invariably the case, the children's parent or parents made the complaint on the children's behalf. In my evidence on the bill, as well as highlighting barriers to children and young people complaining, I also raise a recurrent theme of my responses to proposed legislation which is the complexity raised by multi-agency working. Often in providing services to children, many agencies are involved and cooperation is essential to provide joined-up services focusing on the user rather than the needs of the organisations. However, when someone wants to raise a concern they may need to go through a number of different complaints processes because, while care may have been provided jointly, each organisation may still retain their own complaints process for their own area of responsibility. It is my view that the approach to multi-agency complaints should be integrated into the service at the design stage so that procedures – and the right culture – are embedded long before any problems arise.

Inaugural complaints reports

Over the past month I have published themed reports about the main areas under our remit. The first three were about local government, water and health complaints, which together account for over 75% of our caseload. Each report includes:

- key complaints figures
- issues and themes arising from the complaints we see
- how we share learning and how we work with other organisations
- an overview of the relevant activities of our complaints standards authority
- our policy engagement.

The next reports will be about housing, further and higher education, prisons and other Scottish Government complaints. To read the reports and access other sectoral information, visit <http://www.spsso.org.uk/sector-specific-information>.

Combined with each report launch, we are sending annual letters to the relevant sectoral stakeholders and posting these online. The letters provide service providers, regulators and others with details of complaints received and dealt with about their organisation or sector, along with premature and uphold rates, compared with the previous year. These statistics are used by organisations to assess and benchmark complaints performance.

Annual statistics for 2012/13 for all sectors were published on our website in mid-September and can be seen at <http://www.spsso.org.uk/statistics>.

SPSO website redesign

We recently re-launched our website. The new site incorporates the recommendations of an accessibility review and key changes are improvements to layout and navigation, segmentation of sectors, and enhancements to accessibility. We have significantly simplified and reordered how we display our corporate information and improved the search facility on the 'Our findings' section (<http://www.spsso.org.uk/our-findings>) where we publish all our investigation decisions.

Investigation Reports



Investigation report ref: 201101687

Prison visits

Scottish Prison Service

Summary

Mr C, who is a prisoner, arranged for his son, who was 16, and his daughter, who was 15, to visit him. He booked their visit and the children were given access to the prison and their identities were checked. Mr C said his daughter set off the metal detection alarm and because of that, she was searched. Mr C said an officer asked her who her accompanying adult was and she told the officer that it was her brother. Mr C said his daughter was then searched by a female officer in her brother's presence. Then, when his children got to the door of the visit room, they were denied access by another officer because they were not with an accompanying adult. Mr C noted that the prison had allowed his children to book in for the visit, have their identities checked and go through the metal detector before being told that they needed to have an accompanying adult.

In his complaint to the prison, Mr C additionally said that he had spoken with the visits manager who had shown him the relevant policy which stated that an accompanying adult had to be at least 18 years old. Mr C said the visits manager agreed that the prison had made an error. The prison's internal complaints committee (ICC) noted that following his discussion with the visits manager and the apology he had already received, there was nothing more internally that could be done or said. The ICC confirmed that Mr C agreed with this position and a further apology was provided.

Mr C made a further complaint to the prison's director in which he said it was not the case that he accepted the apology. He said the situation had caused upset and distress to himself and his children and it was clear the prison had breached policy by searching his daughter without an adult being present. Unhappy with the director's response, Mr C complained to us.

I found that the policy being operated by the prison is that a person under the age of 16 would not be permitted access to the prison unless they were accompanied by a person who was at least 18. In Mr C's case, his daughter was 15 and she was accompanied by her brother, who was 16. In respect of the policy being operated by the prison, it appears that Mr C's daughter was not accompanied inside the prison with an appropriate adult and I therefore upheld Mr C's complaint that his daughter was inappropriately searched in the absence of an appropriate adult.

More widely, however, my investigation, which included my complaints reviewer going to the prison and walking through the visit process, found that there is no standard policy in place in relation to the age a person must be to accompany a child under the age of 16 to a prison. After repeated requests to the Scottish Prison Service (SPS), they confirmed they did not have a national policy in place in relation to this issue although they also said that they would not allow a child under the age of 16 to enter a prison without an adult aged at least 16 years old being present. In the course of my investigation, they undertook to check the local policies being operated by several prisons. The outcome of those checks confirmed that some prisons allowed a person who was aged at least 18 to accompany a child to a visit but others allowed a person who was aged at least 16 to do that.

Investigation Reports



Investigation report ref: 201101687

Summary continued

So, the evidence available suggests that because of this, prisons across Scotland have been operating inconsistently. I made a number of recommendations to address this, including that the SPS update my office on the steps taken to implement a relevant policy in relation to the age a person must be to accompany a child under the age of 16 to a visit within a prison. I also asked the SPS to consider seeking the views of the Commissioner for Children and Young People before implementing their new policy and thereafter to take immediate steps to ensure prison staff are fully aware of the policy in place.

I did not uphold Mr C's other complaint that the ICC written response to his prisoner complaint form did not accurately reflect the discussion held.

Investigation report ref: 201202957

Clinical treatment; policy/administration

Forth Valley NHS Board

Summary

After falling from a horse, Ms C was admitted to a hospital emergency department. A controlled roll (a log roll) was performed and she was also examined by the on-call orthopaedic surgeon. An x-ray of her pelvis showed no bony injury and the diagnosis made at this point was muscular back-pain following trauma. That evening, she was admitted to an orthopaedic ward and she was reviewed the next day by an orthopaedic consultant surgeon. Ms C had severe pain over the pelvis and lower back and had a catheter inserted into the bladder for urinary retention. The orthopaedic consultant surgeon ordered a CT scan. The scan, which was only visualised up to the lumbar 3 vertebrae, showed fractures and Ms C was transferred to a rehabilitation ward a week later. She was reviewed by a consultant in ageing and health who, in light of Ms C's continuing and worsening symptoms, ordered an MRI scan which showed a severe lumbar 2 vertebrae fracture causing cauda equina syndrome. This is a serious condition caused by compression of the nerves in the lower spine which can lead to nerve damage and paralysis. Ms C was subsequently transferred to a spinal unit.

Ms C's complaint was that the board failed to properly investigate her spinal injury until her transfer to the rehabilitation ward. She said that her injury was not properly assessed by staff at the emergency department and that the log roll was performed improperly leading to further injuries. She complained about further delays by staff at the orthopaedic ward in fully investigating and identifying her spinal injury, in particular the delay in diagnosing the severe lumbar 2 fracture. She said that as a result of the board's failures, she suffered physical, emotional and psychological consequences; she has post-traumatic stress disorder and problems with her bladder, bowel and sexual function.

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Investigation Reports



Investigation report ref: 201202957

Summary continued

In investigating this case, I took independent advice from two advisers. The first is a consultant in emergency medicine who concluded that while there was no evidence that the log roll was carried out improperly, there were significant shortcomings in the care and treatment provided after this initial assessment. These failures led to a significant personal injustice to Ms C in that she suffered significant pain and possible further and permanent neurological damage.

My second adviser, a consultant in orthopaedic surgery, was also highly critical of the investigation and management of Ms C's spinal injury. His view was that this was a reasonably straightforward trauma case. Given that Ms C had fallen from a horse and experienced significant back pain, a spinal injury should have been suspected from when she was first admitted to hospital. The surgical adviser explained that a clinician following the standard approach to trauma patients would have carried out an x-ray of the spine. This would have revealed the severe lumbar 2 fracture which was causing cauda equina compression. The surgical adviser said that there were a number of extremely significant failures which he described as '*a case of serious basic mistakes in the primary assessment and investigation of a very significant injury, which should have been evident from the start*' and a '*prime example of gross basic errors in ... this reasonably straightforward trauma case*'.

I accepted this advice and upheld the complaint, finding that there were significant failures by healthcare professionals in their investigation of this spinal injury. Significantly, the evidence suggests systemic failures within and between the emergency department and the orthopaedic ward which may impact on the future care of patients with similar injuries. The failures in the emergency department concerned two missed opportunities for review by a senior doctor and request for appropriate x-rays. Had the healthcare professionals in the emergency department followed standard practice, then an x-ray of Ms C's spine would have been carried out and the seriousness of her injury would have been identified much sooner. I am extremely concerned about the orthopaedic consultant surgeon's failure to properly assess and investigate Ms C's injury. The advice I have accepted is that they made serious and basic mistakes. This raises questions about their competence, which I have told the board to address as a matter of urgency.

I made several recommendations for redress, including that the board carry out an audit of the standard of their trauma management; ensure that the findings of the National confidential enquiry into patient outcome and health report *Trauma who cares?* are implemented and amend their protocol accordingly, in particular to ensure that senior emergency department doctors will be available to initially assess and provide on-going advice for all victims of trauma; review the actions of the orthopaedic consultant in light of this report and take appropriate action; and make a further formal apology to Ms C for the failures identified.

Investigation Reports



Investigation report ref: 201202271

Delay in diagnosis; communication

Lothian NHS Board

Summary

Mr C attended a hospital Ear, Nose and Throat (ENT) department on numerous occasions following referral by his GP in June 2010. During this period his symptoms, which included bleeding from the throat, worsened. After each examination, he was discharged and re-referred to his GP. In late September 2011, he was diagnosed with stage 2 cancer of the right tonsil (throat cancer). He complained to the board that his symptoms had not been investigated appropriately, leading to a delayed diagnosis. Unhappy with their response, he complained to us in August 2012.

In his complaint to the board, Mr C set out in detail his numerous referrals to the ENT department. He said that he felt he had not been listened to by doctors or nurses in the department and that an incorrect initial diagnosis had been followed without question until the mass in his throat became too big to be dismissed. He said that at his first appointment at the department, he had felt that the blood that he was coughing up was coming from his throat. Mr C said that he felt strongly that the registrar who saw him was focusing on his nasal passages, despite what Mr C was saying to him. Mr C said that he raised the possibility of cancer with the registrar but was told that his symptoms did not correspond with those of throat cancer.

Mr C's symptoms continued to worsen and the prescribed nasal spray increased the bleeding and soreness in his throat. He continued to see his GP about his problems and was referred to the ENT department again and his next appointment was told that he had congested nasal passages which appeared inflamed, and that these were likely to be the cause of the bleeding. Mr C was told there were no polyps present and no abnormal swellings in his neck. He was prescribed a drug used to treat asthma and inflammation of the throat, and told he would be reviewed in a few months' time.

At the review Mr C was again diagnosed with nasal congestion. He underwent a flexible endoscopy, where a video camera is used to examine an area of the body. He was told the results were unremarkable. Mr C questioned this and was told again that the problem lay in his inflamed nasal passages. Two more referrals were made by Mr C's GP practice requesting reviews for Mr C as his tonsils were visibly enlarged and more painful than ever. The second referral was urgent, due to a diagnosis of suspected cancer, as Mr C's neck was now visibly swollen. He was seen in early September 2011 by a new consultant who organised urgent biopsies and a detailed examination. Mr C was diagnosed with throat cancer at the end of that month.

My investigation included examining Mr C's clinical records, all the complaints correspondence, SIGN 90 (*Scottish Intercollegiate Guidelines Network on the Diagnosis and management of head and neck cancer*) and obtaining independent clinical advice from an adviser (an ENT consultant). My adviser said that cancer in the oropharynx (the region containing the tonsils and especially the back of the tongue) is difficult to diagnose. It is common for patients to present in the advanced stages of the disease, due to a failure to refer for specialist examination. The bleeding Mr C had described suggested ulceration, but this may well not have been visible. The cancerous tonsil would have increased in size and surface ulceration would have become more obvious. With each successive visit by Mr C, the chances of detection through observation alone would have increased.

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Investigation Reports



Investigation report ref: 201202271

Summary continued

The adviser said that the first consultation was very thorough, and discharge to the care of his GP was appropriate. With regard to the second consultation, however, the adviser found that given the number of referrals, there should have been increased suspicion of the symptoms and consideration given to examining the tonsils. By the third consultation, in June 2011, the cancer could have been identified had a better examination been carried out, and this delayed the diagnosis. I conclude that this led to an injustice for Mr C and meant that he was not able to start treatment for his cancer at the earliest opportunity.

I am concerned that had Mr C's GP practice not been so persistent in pursuing his case his cancer could have been left undiagnosed until the prognosis for him was significantly worse. I am also concerned that the appropriate examination required to diagnose the cancer was not carried out, given that it was a simple one, involving careful examination of the mouth and tonsils with a tongue depressor. I therefore upheld the complaint and made a number of recommendations. I asked the board to apologise to Mr C for the failings identified, carry out a Serious Clinical Incident Review and review the procedure for GP referrals to ensure that where there have been repeated referrals this is taken into account by ENT clinicians when assessing and examining the patient.

Investigation report ref: 201201259

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

Ayrshire and Arran NHS Board

Summary

Mr C was 80 years old when he fell, breaking his hip. He had a number of conditions – type 2 diabetes, hypertension, ischaemic heart disease and urinary incontinence – and was on several medications before his fall prompted a series of hospital admissions. He had an operation at the hospital the day after his admission following the fall. Almost three weeks later, he was discharged to a care home for rehabilitation, but was readmitted to the hospital two days later, as he had vomited and could not eat. He was discharged to the care home again a few days later. However, after returning to the care home, Mr C was not able to eat or drink without feeling sick. After a few days there, he was readmitted to the hospital and was later placed under the care of a consultant gastroenterologist. During this admission, the Acute Medical Receiving Unit stopped all of Mr C's medication and said that this was being kept under review.

Mr C was discharged home two and a half weeks later. His GP visited him at home and Mr C's family told the GP that his medication had been withheld for several weeks prior to discharge. Mr C died eight days after going home. The hospital's discharge letter was not issued until nearly three weeks after Mr C's death.

Investigation Reports



Investigation report ref: 201201259

Summary continued

My investigation looked at a number of areas of concern raised by Mr C's wife (Mrs C) about her husband's care and treatment and I upheld all three of her complaints. I found that the board failed to adequately manage Mr C's complex medical conditions during his third admission to hospital. Although it was reasonable to stop his medication, there was no decision-making documented in relation to restarting the medication. I also upheld Mrs C's complaint that they failed to provide her husband's GP with sufficient and timely information about his condition on discharge from hospital.

In investigating this complaint I examined all of the complaints correspondence between Mrs C and the board, and the relevant guidance on standards of medical record-keeping and good medical practice. I also obtained independent advice from an adviser who is a consultant physician and gastroenterologist. I concluded that the clinical records for the first two admissions did not show deficiencies in the management of Mr C's medical conditions. I also found that Mr C was appropriately investigated on being admitted to the hospital for a third time. However, I agreed with my adviser that the board's actions in respect of the management of Mr C and the clinical documentation during and after the third admission were unreasonable. There was a failure to adequately manage his diabetes and he should have at least been referred to the diabetic liaison nurse, who would have involved the diabetic consultant if appropriate.

I also found that after Mr C was stabilised and he received treatment for stomach issues, there should have been specific management decisions in relation to the multiple admission diagnoses and problems including the renal failure, the cardiovascular problems and the diabetes. There was a failure to adequately monitor Mr C and to complete adequate clinical records. The nutritional assessment and food charts were also deficient. Mr C should have been referred to a dietician, who should have taken appropriate action in respect of both deficient oral intake and diabetes.

On the issue of withholding Mr C's numerous types of medication and failing to keep his medication under review, I agreed with the advice I received that it was reasonable to stop some of Mr C's medication on his second admission and all of his medication on the third admission. However, there is no documentation in the records regarding any decision-making in relation to restarting the medication and for this reason I upheld the complaint.

I also upheld the complaint about the delay in issuing the discharge letter to Mr C's GP. A handwritten discharge form had been completed on the day of discharge, but the full discharge letter was not issued until almost a month later and nearly three weeks after Mr C's death. My adviser said that the information contained in the handwritten form was totally inadequate for the GP to understand the problems on admission or to base management plans in the light of Mr C's known medical conditions. He also said that there was no advice to the GP as to why Mr C's medication had been stopped or whether the GP needed to review and consider restarting them.

In their response to Mrs C's complaint about this, the board said that they had upheld this aspect of the complaint. They stated that ideally full clinical discharge information should be available sooner to supplement the summarised information in the immediate discharge letter. They also said that the turnaround time was not as quick as it would have been in normal circumstances. The board have also sent us documentation showing that it was recommended that they re-introduce a target to issue discharge letters within seven days.

In light of these failings, I made five recommendations to the board to provide redress and to ensure that the same issues will not recur.

Complaints Standards Authority update



Higher and further education

We are pleased to report that all colleges and universities in Scotland have now confirmed implementation of the model complaints handling procedures (model CHP) for their sector. In addition to the requirement to adopt the model CHP under the SPSO Act 2002 (as amended), adopting the model CHP will be a requirement of the Scottish Funding Council's Financial Memorandum. Ongoing compliance with the model CHPs will, therefore, be monitored by the CSA in conjunction with the Scottish Funding Council.

Building on the work already completed in both sectors to adopt the CHPs, we are now looking to coordinate and support complaints handling network groups in each sector. The remit of the network groups will include identifying, developing and evaluating best practice, supporting complaints handling practitioners and providing a forum for benchmarking complaints performance within and across the respective sectors. The network groups will also help take forward the ongoing work of the CSA in areas such as developing standardised complaints recording categories and performance indicators.

We have already received expressions of interest from both sectors to join the complaints handling network groups and we will be pursuing the development and introduction of the networks in the coming weeks. If you are interested in joining the network group for your sector, please contact the CSA at CSA@spsso.org.uk, who will keep you updated of progress.

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

We have received some early returns from organisations providing their compliance statement and self-assessment of compliance. As a reminder, each organisation is required to provide the SPSO with a compliance statement, and a self-assessment of compliance by 30 September 2013, notifying of their progress towards the introduction of the model CHP. All organisations are required to have implemented the model CHP by 31 March 2014.

The model CHP and associated documents is available on our Valuing Complaints website:

www.valuingcomplaints.org.uk. The compliance statement and self-assessment is also available in word format on that website allowing organisations to submit their return electronically, and directly to csa@spsso.org.uk. If you have any questions about the model CHP or your obligation to implement, please contact the CSA directly.

Local authority complaints handlers network

The local authority complaints handlers network met on 20 September, hosted once again by Glasgow City Council. The morning session featured speakers from the SPSO who provided a detailed overview of SPSO's end-to-end complaints handling process, with presentations on the respective roles of our advice, early resolution and investigation teams.

The afternoon session included helpful presentations from East Lothian Council on meeting the needs of children in the complaints process and North Lanarkshire Council on handling education service complaints. The complaints surgery discussion provided the opportunity to share and exchange good practices in complaints handling, and the network undertook to work on issuing a *Learning from complaints* publication towards the end of the calendar year.

The network group meets regularly and has provided the opportunity to get to know complaints handlers from other councils and to learn from each other. 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 co-ordinate the network.

Housing complaints handlers network

The housing complaints handlers network met on 28 August, hosted by Queens Cross Housing Association. The network explored the possibility of standardising complaints categories to help benchmark performance. It also looked at the reporting of complaints performance which provided an opportunity to learn about what other RSLs are doing in this area to meet the requirements of the model CHP.

Queens Cross Housing Association shared information from its first annual complaints report, developed to capture statistical data on the Association's performance in handling complaints for 2012/2013. The report provides comprehensive detail and analysis of complaints handling performance across a range of areas and indicators including the types of complaints made by tenants and other customers, learning outcomes identified from complaints and service improvements implemented as a result of effective complaints handling. Further information about the report can be obtained from the Association's Policy and Performance Officer Des Phee at DPhee@qcha.org.uk.

The housing complaints handlers network also considered ways of managing unacceptable behaviour following a presentation on the subject by SPSO's training coordinator, Kerry Barker.

If you are interested in joining the network please contact CSA@spsso.org.uk and we will provide your details to the appropriate sector representatives.

SPSO training – investigation skills open course

We are running an open course in investigation skills (Stage 2 of the model CHP), on 4 November in Edinburgh. The course is open to all sectors and is run on a cost recovery basis at £150 per person. We will use a variety of case studies and while examples will be mainly drawn from housing and local authority areas, delegates from other sectors will have an opportunity to discuss their specific issues.

We have a maximum number of 20 for the course and will allocate places on a first come first served basis. If we fill this course we will open a waiting list and arrange a further course date in early 2014. For more details about the course including about booking please visit www.valuingcomplaints.org.uk/training-centre/open-courses or contact us at training@spsso.org.uk.

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, 25 September 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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