

## Monthly news from the Scottish Public Services Ombudsman

The SPSO laid four investigation reports before the Scottish Parliament today, about four different health boards. We also laid a report on 69 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](http://www.spsso.org.uk/our-findings).

### Case numbers

Case numbers

Last month (in May), we received 422 complaints. In addition to the seven reports we laid before Parliament, we determined 392 complaints and of these we:

- gave advice on 251 complaints
- resolved 99 in our early resolution team
- resolved 42 by detailed consideration
- made a total of 78 recommendations in decision letters.

## Ombudsman's Overview



### Redress

Where I find that something has gone wrong, my role is to make recommendations for improvement to try to ensure that the same thing does not happen again, and to provide redress for the individual who has suffered the injustice. Every year, I make several hundred recommendations for redress to public authorities. For the individual, ideally the aim is to provide redress that, as far as possible, puts them back in the position they would have been in had the injustice not happened. In some cases, that is not possible, and a complaint I report on today (201200390), where the couple concerned had sought fertility treatment, is one of these. The case is described in detail below, but essentially because the health board concerned did not take into account all the factors involved and provide treatment within a reasonable time, the couple were denied an opportunity for a possible second cycle of fertility treatment that they might otherwise have had. In the circumstances, it was not possible to put the couple back in the position they would have been in, as the chance for treatment by the board had passed. I decided that the only meaningful way to provide redress for them was to recommend that the board make a financial payment for the amount that another cycle of treatment might cost should the couple seek treatment elsewhere.

In reaching this decision, I explained that I fully recognise that the NHS is not required to fund every treatment available, and that not providing certain treatments is not in itself unreasonable. It is also only rarely that I recommend financial payments in health-related cases. I took the view I did on this case because of the combination of very particular factors involved – the delays that occurred, linked to the time-limited nature of the medical procedures concerned, and the specific personal circumstances.

## Record-keeping

The other three reports contain issues about record-keeping. This subject often crops up during investigations into complaints, particularly those about healthcare, although it is rarely the subject of the complaint itself. Poor medical records make it difficult to know exactly what has happened, and sometimes mean that I cannot reach a finding. More importantly they do not provide a full record of what has happened to a patient during their NHS journey, which is often needed by other staff later in that journey.

In one of the cases, I was particularly concerned that a midwife did not keep detailed records, and I describe the records in this case as 'scant'. My independent adviser, who has worked extensively across maternity services, was very surprised by the lack of detail in them. In another case, although I did not uphold a complaint about diagnosis, as the decision was not unreasonable, another of my medical advisers was concerned about a lack of detail in the notes made by an out-of-hours doctor who assessed a young girl who later died after suffering a cardiac arrest. In the third case, I was concerned about deficiencies in the systems and record-keeping in a medical practice where a woman was seen by two GPs over a period of time. Although one of the GPs noted a lump on the woman's neck and arranged for tests, it was only after she moved to another area and registered with a new medical practice that this was followed up and she was diagnosed with thyroid cancer.

I am most often guided by my medical advisers in this area. In the absence of certain information that I, or they, would expect to see. I am likely to tend towards upholding a complaint that something 'did not happen'. This is because no evidence has been presented to confirm that it did happen (for example that observations have been taken, nutrition levels monitored, or that a patient's relatives were kept informed). There are many more examples of the sorts of things that should be, but often are not, included in records. While I appreciate that medical staff have to complete a significant amount of paperwork for each patient, it is vitally important that they keep adequate records, and include notes of what happened or why a decision was taken. I would ask all health boards to ensure that they can satisfy themselves, by auditing such records where necessary, that staff are following the record-keeping guidelines for their profession.

## SPSO annual report

This is my final e-newsletter before the Parliament closes for recess. I am pleased to inform MSPs and Parliamentary staff that I will be laying our annual report before the Parliament in the summer. This is several months earlier than usual. It will allow us to provide more timely and effective information in the 2012–13 annual report, which will be the first to chart progress against our 2012–16 strategic plan. The report will link closely to the plan objectives and highlight the governance, performance, equalities and audit aspects of our work. As it does each year, it will also include external reports from our Audit Advisory Committee Chair and Independent Service Delivery Reviewer, our 2013–14 business plan and an appendix of statistics.

I am also taking a different approach to reporting on individual areas under my office's jurisdiction (such as local government, health, housing, higher and further education, prisons, water and the Scottish Government). Instead of including complaints information about these in the annual report, I will publish separate sectoral reports on a rolling basis from July onwards. This will allow more detailed and relevant information to be made available to stakeholders including the public, the organisations, regulators, policy makers, academics and of course the Parliament to whom we are accountable.

I have discussed this new approach with Scottish Parliamentary Corporate Body officials and anticipate that Holyrood committees and others will find this an effective means of enhancing the learning we provide about our work and about complaints from different sectors. I look forward to receiving feedback on how we are doing and on how we are communicating our progress and our findings.

## **Complaints Standards Authority update**

### **Higher and further education – reminder of requirement to provide returns**

We have received some early returns from colleges and universities with statements of compliance and self-assessment confirming that they will comply with the published model complaints handling procedure (CHP) by 30 August 2013.

As a reminder, each university and college is required, by 28th June 2013, to provide the SPSO with a compliance statement to confirm that they will adopt the published model CHP by the August deadline. Institutions may use the appropriate online self-assessment and pro-forma documents on the CSA's Valuing Complaints website [www.valuingcomplaints.org.uk/further-and-higher-education/](http://www.valuingcomplaints.org.uk/further-and-higher-education/).

---

### **Further education**

Through the College Development Network, Cumbernauld College (in conjunction with a small advisory group) have taken the lead for developing a complaints logging and reporting tool. The CSA team welcomed the opportunity to provide input to the development of this before it was shared at the Quality Development Network meeting in May 2013. Based on feedback from that event, work is ongoing to finalise this product before the implementation of the model CHP across the sector.

If you would like further information on this work please contact [CSA@spsso.org.uk](mailto:CSA@spsso.org.uk).

---

### **Further and higher education – e-learning materials**

We are finalising the e-learning modules on frontline complaints handling for the further and higher education sectors. These are being developed in consultation with a small group of representatives from each sector on the basis of the modules currently available for local authority and housing sector staff (available at [www.spsotraining.org.uk](http://www.spsotraining.org.uk)). We expect the education modules to be available in the coming weeks – they will be free for all relevant staff and organisations to access.

Further information will be available at [www.valuingcomplaints.org.uk](http://www.valuingcomplaints.org.uk).

---

### **NHS e-learning modules**

On 31 May 2013 the SPSO and NHS Education for Scotland (NES – the national body responsible for educating and training healthcare staff) launched e-learning training modules for all NHSScotland staff dealing with patient feedback, concerns and complaints. This resource will help support NHSScotland meet the requirements of the Patient Rights (Scotland) Act 2011 in relation to feedback and complaints.

These interactive learning modules raise awareness of topics such as the value of apology and of encouraging feedback from patients, their families and carers. They also provide staff with knowledge of the NHS complaints procedure. There is a real emphasis on the importance of frontline staff resolving problems to avoid escalation. There is also a focus on person-centred care, placing people at the heart of all decisions in health and social care.

Further information, including access to the modules, is available at <http://www.spsso.org.uk/media-centre/news-releases/spsso-and-nes-join-forces-help-staff-deal-patient-feedback-concerns-and-co>

### **Local authority complaints handlers network**

The next meeting of the network will take place on 21 June 2013, 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 co-ordinate the network.

---

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

As a reminder, each organisation is required to comply with the model CHP by the end of March 2014. By 30 September 2013 each organisation should provide the SPSO with a compliance statement, and a self-assessment of compliance to confirm that their CHP complies with the published model, or will comply by the end of March.

The model CHP and associated documents are available on our Valuing Complaints website: **www.valuingcomplaints.org.uk**. Please contact [csa@spsso.org.uk](mailto:csa@spsso.org.uk) if you have any questions about the model CHP, or your obligation to implement it.

### **Contact the CSA**

The CSA is always available to provide specific advice or support to complaints handlers across the public sector. Please address any questions about the model CHPs, or the requirement to implement, to the CSA at **csa@spsso.org.uk**.

# Investigation Reports



Investigation report ref: 201103956

## Maternity care; communication; record-keeping

Lothian NHS Board – University Hospitals Division

### Summary

Mrs C, who had one child, was pregnant again. Since having her first child, she had lost two babies before they reached full-term, and she was anxious about her pregnancy. She told me that her son was born with a damaged shoulder and vocal chords, and he also had blood on the brain. She and her husband are worried about their son's future health, and Mrs C said that she believes his health problems were due to failings in care by her community midwife during the pregnancy.

Mrs C said that she had been terrified of having a large baby. She explained that when she learned that this might be the case, she asked for a caesarean section, but the midwife made light of her anxieties. Mrs C also said that the midwife unreasonably refused her antenatal appointments and misled her about when she would have labour induced, if it did not start naturally. (Mrs C was keen to be induced early, given her concerns about the size of her baby.) When labour was eventually induced, as Mrs C had passed her full-term date, her baby was born in an emergency situation, because one of his shoulders had become stuck, delaying the birth (this is known as shoulder dystocia). Immediately after her son was born, Mrs C haemorrhaged, and had to be taken for a procedure to have this stopped. She said that there was a delay in taking her to the operating theatre, as there were not enough staff available to push her bed there, and that although her husband offered to help, this offer was refused.

The board acknowledged that there had been problems during the birth. However, they said that shoulder dystocia had not been expected, as pre-birth measurements had indicated that the baby's size was within acceptable limits. Amongst other things, they also said that the baby was now doing well, his vocal chords had recovered, and that a small subdural bleed (bleeding in the head between the skull and the brain) was not uncommon following a traumatic birth. They said that although there was a delay in delivering the baby's shoulders, all emergency procedures were followed correctly and appropriately, and a full debriefing discussion had later taken place with Mr and Mrs C.

As part of my investigation, I obtained independent advice from one of my advisers, who is an experienced midwife. My adviser noted that, in addition to Mrs C's understandable anxieties, she had needed a scan because her baby was not moving as much as expected. During the scan a member of staff had said that the baby was as large as a full-term baby, although Mrs C was five weeks short of her expected term. My adviser said she could see why all this added to Mrs C's concerns and that a mother to be with this type of complicated history would have needed time to express her feelings and anxieties. The adviser said she would expect a competent community midwife to have helped with these concerns by arranging for Mrs C to discuss the delivery with her consultant. The midwife's notes, however, were scant, and provided no explanation of why she did not arrange this. My adviser took the view that, although the midwife had provided care according to local guidelines, she had not followed the National Midwifery Council's *Midwives Rules and Standards*. She also noted that, although the midwife told Mrs C that she was having a normal sized baby, at birth her son weighed almost 2 kilos more than an average full term baby. Shoulder dystocia is regarded as a high risk situation, given its unpredictability, and mothers with a larger than expected baby should be reviewed by an obstetrician to discuss the delivery and associated risks.

*continued*

## Investigation report ref: 201103956

I accepted this advice, and upheld the complaint about the care provided by the midwife. I noted that the board have already apologised to Mrs C that the care and information she received during her pregnancy did not meet her expectations or help with her anxieties. I recommended that the board ensure that my adviser's comments are shared with community midwives, particularly in regard to referral to a specialist where there is any apparent deviation from a normal pregnancy.

Although I appreciated that both parents were going through a distressing experience, I did not uphold the complaint that Mrs C's husband was not allowed to take her to theatre. Accounts differed significantly, and there was a lack of evidence to allow me to reach a conclusion about this. I also did not uphold the complaints about ante-natal classes, as there was no evidence to suggest that these were unreasonably refused, or that Mrs C was misled about her induction date. However, my adviser had concerns that the midwife's records were particularly scant. She said that Mrs C's medical history and anxieties about the pregnancy did not appear to have been taken into account, and that the time for induction should have been agreed between Mrs C and her consultant. I, therefore, recommended that the board ensure that these comments are also shared with community midwives.

Finally, although not part of Mrs C's direct complaints, my investigation found failures in record-keeping and the board's complaints handling. My adviser said that, in all her experience, she had never encountered the situation where a mother-to-be requesting intervention had not had the request clearly documented in her medical notes. No requests were recorded in Mrs C's medical notes; and the board's responses to her complaint did not fully answer her concerns, and failed to provide transparent evidence about the midwife's decisions. It is of concern to me that the board failed to appropriately address Mrs C's concerns about events that she clearly found traumatic. I recommended that the board apologise to Mrs C for all these failings, and that they also review community midwives' record-keeping processes, to ensure that relevant details are properly documented in medical records.

Investigation report ref: 201200405

## **Patient dignity; delay in treatment; record-keeping; hospital admission**

Highland NHS Board

### **Summary**

Miss A was an eight-year-old girl, who became unwell with sickness, diarrhoea, earache and a sore throat. Her mother (Ms C) took her to a hospital accident and emergency department (A&E) where Miss A saw an out-of-hours (OOH) GP. She was diagnosed with gastroenteritis (inflammation of the stomach and intestine) and an ear infection. The OOH GP prescribed medication and advised Ms C to return if her daughter's symptoms worsened. Miss A's condition deteriorated, and Ms C took her back there the next day. After she arrived, Miss A collapsed and her heart stopped. She was admitted, and transferred to a children's hospital the next day, but died two days later. The main cause of her death was lack of oxygen to the brain and, secondary to this, cardiac arrest, Influenza B and staphylococcus aureus (bacteria that can be found in the human respiratory tract and on the skin) in the lungs.

Ms C felt that her daughter's death could have been prevented if the OOH GP had admitted her when she first went to hospital. She also complained that hospital reception staff were rude and unhelpful when she asked for help after Miss A was sick and soiled herself, and that after Miss A was admitted staff failed to monitor her properly. The board met Ms C about her complaints, and also wrote to her. They said that they felt it was reasonable for the OOH GP to have diagnosed gastroenteritis, given Miss A's symptoms, and that there was nothing to suggest an incorrect diagnosis. They also carried out a significant event analysis (SEA) as a result of the complaint, with the aim of examining Miss A's care and identifying any learning points or recommendations for improvement.

While investigating this complaint, I took independent advice from two of my medical advisers; a general medical practitioner (the first adviser) and an emergency medical consultant with experience in paediatrics (the second adviser). The first adviser considered that, generally, Miss A had been assessed and treated appropriately on the basis of her symptoms, although the notes could have been more detailed. He explained that the clinical condition of children with infections can change very quickly, but it is often impossible to identify those who will deteriorate and need more intensive treatment. Hospital admission would not have been appropriate on the first occasion, as there was in fact a risk that an infection could have spread to other children and staff. Although, therefore, I understand Ms C's concerns and note that Miss A later did deteriorate very quickly and was admitted, I did not find evidence to suggest that she should have been admitted when she first went there. Given my adviser's concerns about the detail in the notes, however, I recommended that the board remind the OOH GP of the General Medical Council's guidance in relation to record-keeping.

On monitoring, Ms C was concerned that Miss A was vomiting while lying on her back wearing an oxygen mask. The medical notes said that her daughter might have inhaled vomit, and she thought this might be why. The board said that several members of staff had repositioned Miss A, and that it is possible to manage a patient on their back when tests and procedures need to be carried out. My second adviser said that the hospital followed the appropriate national guidance for an unwell child with breathing difficulties who subsequently went into cardiac arrest, and was doubtful that the outcome would have been any different had Miss A been treated in a different emergency department. The reasons for this are explained in some detail in my report. The adviser also said that there was little option but to nurse Miss A on her back in the circumstances, and that the oxygen mask was necessary. Ms C felt that had her daughter been intubated (had a tube passed into the respiratory or gastrointestinal tract) earlier than she was, she might not have inhaled vomit. The adviser said, however, that having studied Miss A's case notes he did not consider that intubation should or could have been done any sooner.

## Investigation report ref: 201200405

Again, the detailed reasons for this are explained in my report, along with further advice obtained from a consultant anaesthetist. I did not uphold this complaint, as I found that when Miss A arrived at the hospital for the second time she was seriously ill, and after considering the medical advice I received, I concluded that she was given appropriate and timely treatment. However, I criticised the board and made recommendations about their procedures, because I took the view that the SEA should have explored Miss A's eventual intubation in detail. The clinical records lack detail of the procedure, and it became a point of concern during my investigation, including the possibility that the intubation tube may have been misplaced.

I upheld the complaint about the lack of help provided in reception. When the board met Ms C they explained that in such circumstances a patient would normally be made as comfortable as possible by providing something, such as a gown, so that they could clean up and change into that. They had spoken with the receptionist involved, and she was sorry for the distress this had caused. The board acknowledged that Ms C's experience was unacceptable and said that they would review gown supplies in A&E and ensure staff know what to do when alternative clothing is required. I recommended that they provide me with evidence that this has happened.

I conclude my report by saying *'This has been a finely balanced decision in which I have sought more than the usual amount of clinical advice. On the basis of further advice, I revised my findings as set out in the initial draft report that was sent to all interested parties. Reaching a decision would have been easier and, more importantly, the family of Miss A would have been clearer about this critical period in their daughter's care, had the SEA been conducted in a more thorough fashion. I recognise the impact this whole process will have had on Miss A's family.'*



Investigation report ref: 201200492

## **Clinical treatment; delay in diagnosis; communication; record-keeping**

Borders NHS Board

### **Summary**

Between July and December 2010, Ms A had appointments at her then medical practice, during which she saw two doctors – her own doctor (the first doctor) and another doctor who worked part-time at the practice (the second doctor). On 30 July Ms A had an appointment with the second doctor, to discuss a minor medical procedure. During the consultation, he noticed a lump on her neck. Ms A also had symptoms of irregular periods, tiredness and dizziness. The second doctor arranged for blood tests to check Ms A's thyroid (a gland in the neck that produces hormones that keep the body functioning properly), and said she should make an appointment to have these followed up. Although Ms A continued to attend the practice and saw both doctors, her symptoms were not followed up, including at an appointment on 10 August, which appears to have been intended to discuss the results of the tests. In early 2011, Ms A registered at a new medical practice as she had moved house. After further investigation, she was found to have thyroid cancer that had spread to her lymph glands, and for which she needed surgery. Ms A's mother (Mrs C) complained that the first practice provided inadequate care and treatment. She felt that, had the first doctor fully investigated her daughter's symptoms, Ms A might have needed less invasive surgery. Although, normally, a medical practice will investigate and respond to complaints themselves, in this case the board agreed to investigate the complaint as the practice had closed since the events complained about.

My investigation uncovered concerns about the actions of both doctors. Consultations were recorded in handwritten medical records, rather than on computer. At the consultation on 30 July, the second doctor had noted that Ms A's symptoms should be followed up. This note was on the same page as that on which the first doctor wrote during the next appointment. A receptionist's note on the practice's computerised appointments system also mentioned the neck lump in connection with that next appointment (as well as for a later appointment). However, there was nothing about it in the notes that the first doctor wrote during the next appointment. The doctor said that she could not remember Ms A mentioning the lump or symptoms, either then, or at later appointments, although Ms A was sure that she had done so. One of my medical advisers – a GP – provided me with independent advice after looking at Ms A's medical records. He commented that the main contact between the GPs would be through the medical records, and he would expect the second doctor to have checked and followed up on this. The second doctor also saw Ms A at later appointments but did not follow-up, although she had continuing symptoms. The second doctor said that he had asked Ms A about the lump but she said that she had already seen the first doctor and discussed the results and ongoing symptoms, and would see the first doctor for further review. The second doctor, therefore, said he decided not to pursue this. My adviser was concerned that, although the blood tests had been noted as normal, both doctors failed Ms A. He said that deficiencies in practice systems (including use of computer systems) may have allowed messages to go unnoticed and led to a delay in further investigating the cause of the lump. I agreed with my adviser's view that the second doctor should have been more proactive in caring for Ms A, and that the first doctor should have consulted all the handwritten records and computer entries from the previous consultation.

I recognise the distress that these events have caused Ms A and her family. I upheld Mrs C's complaint, as I found no evidence that either doctor followed up on Ms A's continuing symptoms as they should have done. In line with national guidelines, it would have been appropriate to have referred Ms A for further assessment of the lump. I recommended that both doctors apologise to Ms A for the failings identified in my report; and that the board ensure that both doctors reflect on these failings at their next appraisal.

Investigation report ref: 201200390

**Policy/administration; delay in treatment; communication**

Greater Glasgow and Clyde NHS Board – Acute Services Division

**Summary**

Mr C has a life-threatening genetic disease. A side effect is male infertility, and he and his wife (Mrs C) wanted to start a family. Mr C's consultant referred the couple for assisted conception in February 2009. A doctor in the fertility unit saw Mr and Mrs C in November 2009; backdated their referral to February 2009 and referred Mr C to an urologist for sperm retrieval, but also wrote to the consultant saying that there was a 22 month wait for treatment.

Mr and Mrs C eventually had a cycle of infertility treatment towards the end of 2011, but it did not lead to a pregnancy. After this, the board said that, because tests suggested Mrs C's ovarian reserve (i.e. the number of eggs available for fertilisation) was low, the couple would not be offered further treatment using her eggs, but would be offered a further cycle with a donated egg. Mr C felt that this went against their right of access to NHS treatment and the relevant guidelines. He pointed out the delays in the process, which he felt reduced their chances of success, and said that, until November 2011, staff had said they would be entitled to a second cycle of treatment.

Evidence considered in my investigation included the board's policies on assisted conception treatment and a report by the Expert Advisory Group on Infertility Services in Scotland (EAGISS). I also obtained independent advice from a consultant in obstetrics and gynaecology who specialises in assisted conception. The EAGISS report outlines a framework for infertility services, developed to provide equity of access and to improve the quality and effectiveness of services. It includes recommended eligibility criteria for assisted conception funded by the NHS, and says eligible couples should meet all the criteria. The criteria do not, however, mention ovarian reserve. The Scottish Government accepted these recommendations and asked health boards to work towards implementing them within existing resources.

Detail of the treatments provided and the board's responses and explanations are outlined in my report, but essentially changes in the sperm retrieval service resulted in significant delays in meeting the demand for fertility treatment. Patients were put on the waiting list in date order, and were not fast-tracked through the system. My adviser noted that the board did not initially deny Mr and Mrs C treatment because of reduced ovarian reserve. Nor had they completely denied further treatment after the first cycle was unsuccessful, as they offered an alternative, albeit not one that the couple were happy with. The adviser agreed that it would not have been clinically appropriate for the board to offer a further cycle using Mrs C's eggs. However, the adviser also said that there was significant delay in starting Mr and Mrs C's treatment. It was nine months before they were even seen in the fertility unit. They were then immediately referred for sperm retrieval, but in the event sperm was not retrieved until some 20 months later. The adviser was surprised that, given the indication of Mrs C's low ovarian reserve, the couple were not given a higher treatment priority. He said that he could not predict what would have happened had there been no delay, but noted that a poor ovarian reserve would not improve with time.

*continued*

**Investigation report ref: 201200390**

In reaching my decision on this complaint, I recognise that the NHS is not required to fund every treatment available. Failure to provide certain treatments is not, therefore, in itself unreasonable, and I concluded that the board's decision was clinically sound and within the framework accepted by the Scottish Government. However, I upheld Mr C's complaint. This is because I am concerned about other failures in this case. Patients should be told about criteria for treatment when they begin that treatment. The board said they normally told patients that a second cycle would depend upon their response to treatment, but there was no evidence that Mr and Mrs C knew this until November 2011. I note that the board have since introduced an information form, for patients to sign to show they understand the criteria. Secondly, and more significantly, I am concerned about delays in the sperm retrieval process and that the board did not fast-track Mr and Mrs C's treatment when they became aware of Mrs C's low reserve of eggs. I have accepted my medical adviser's view that these delays may have contributed to the poor outcome.

I found that Mr and Mrs C suffered an injustice as because of this they could not have another cycle of fertility treatment using Mrs C's eggs. In deciding on appropriate redress, my aim is to put the person in the position he or she would have been in had something not gone wrong. That cannot happen in this case, given the nature of the situation, but I consider that Mr and Mrs C should have another opportunity for treatment in light of this injustice. I have, therefore, recommended that the board apologise and offer Mr C financial redress if they wish to seek assisted conception treatment privately. In deciding that this redress should be £6000, I have been guided by the cost of privately provided fertility treatment. I also recommended that the board amend their policy on assisted conception to clarify that patients may not be eligible for further NHS treatment if response to treatment is poor and consider introducing a protocol to fast-track patients with a potentially poor ovarian reserve.

## 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, 19 June 2013**

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

For further information please contact:

**SPSO**

**4 Melville Street**

**Edinburgh EH3 7NS**

Emma Gray

Tel: **0131 240 2974**

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

## 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.



**COMMUNICATIONS TEAM**

T **0131 240 8849**



**SPSO WEBSITE**

W [www.spsso.org.uk](http://www.spsso.org.uk)



**CONTACT US**

T **0800 377 7330**

W [www.spsso.org.uk/contact-us](http://www.spsso.org.uk/contact-us)

**VALUING COMPLAINTS WEBSITE**

W [www.valuingcomplaints.org.uk](http://www.valuingcomplaints.org.uk)