



Ombudsman's Commentary

AUGUST 2008 REPORTS

I laid 16 investigation reports before the Scottish Parliament today. Eight are about the health sector, six about local government, one about a housing association and one about a Scottish Government body.

Ombudsman's Overview

In this month's Overview, I highlight a range of concerns, reflecting my office's wide jurisdiction which covers almost all organisations delivering public services in Scotland. I draw attention to issues relating to planning decisions and also to complaints from homeless people. From the health sector, a complaint highlights important issues about the role of the ambulance service in responding to a 999 call when an event is serviced by private medical cover. And, once again, and with increasing concern, I am highlighting poor nursing care.

In one report published this month (Ref: 200501923) I partially upheld a complaint that a Council did not take account of local residents' views when handling planning applications for a Private Public Partnership (PPP) project for a new school and housing. This was an important and contentious local development that deviated from the Local Plan for the area, yet the Committee papers did not refer directly to a petition signed by more than 1000 objectors. I made recommendations to the Council to ensure that they make the scale of such objections very clear in future reports, including differentiating between individual correspondence and petitions signed by many objectors.

The handling of planning applications is one of the main areas of complaint to this office. It is frequently a matter of frustration and disappointment to complainants that it is not within the power of the Ombudsman to stop development or amend

planning decisions. Responsibility for making such decisions properly lies with democratically accountable local authorities and there are established appeals procedures in relation to them. As I made clear in the introduction to the report mentioned above, when I consider complaints relating to planning applications it is not my role to assess or challenge the merits of decisions. My function is to judge whether Councils have fulfilled their administrative duties and functions in a reasonable manner. Our leaflets about the SPSO and planning issues, which are available on our website, explain this in more detail.

Two complaints about local authorities concerned homeless people. A man, who became homeless after his marriage broke down, raised a number of issues about how the Council handled the storage and, ultimately, the disposal of his belongings. I partially upheld his complaint (Ref: 200603331) and made two recommendations to improve the inventory aspects of the Council's storage procedures. I partially upheld another complaint about a different Council from a homeless man living in temporary accommodation, who complained that the Council did not properly investigate his complaint about the circumstances in which he was asked to leave that accommodation (Ref: 200700283).

Several of the health cases this month, as they do most months, make for some distressing reading. Like many in the health professions, I wholeheartedly welcome the recent Royal College of Nursing's 'Dignity' campaign which aims to provide support and direction to the UK's nursing workforce.

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One investigation this month (Ref: 200702695) catalogues numerous failings in nursing care endured by a hospital patient, including lack of change of dressings, lack of assessment which led to a scalding incident, the patient's falling when he walked to the toilet unaided (resulting in a wound that required stitches), a delay in administering pain relief medication, failures in communication with relatives and poor ward cleaning regime.

My office can only investigate individual cases raised by members of the public who have taken the considerable amount of emotional energy and time required to pursue a complaint all the way to the Ombudsman. It is not possible for me to determine whether there is a systemic failure in nursing care, but I am increasingly concerned about the frequency with which I report poor nursing care and its devastating impact on patients and their loved ones.

The distress caused to patients and their families by a lack of informed consent in relation to treatment including surgery is raised in one of my reports (Ref: 200700519). In this context, I would draw attention once again to the booklet *Consent: patients and doctors making decisions together*, issued in June 2008 by the General Medical Council. I would urge health professionals to ensure that they are fully conversant with the latest guidance in order to reduce as far as possible the likelihood of a repeat of upsetting experiences of the kind that are described in this report.

Finally in the health sector this month, an unusual complaint highlights confusion in the Scottish Ambulance Service over whether or not an ambulance should be sent when it is called for from an event that is serviced by private medical cover. The details of the complaint brought by the parents of a 15 year old young man, who sustained head and facial injuries during a motor cross event are summarised below (Ref: 200700008). I concluded that there was a tension over the Service's 'historical and constrictive position not to respond to 999 calls from private hire events' and that this led to 'an unacceptable situation for both staff and public'. I fully upheld the complaint, and welcome the steps that the Service has taken since the events of this case to amend its guidance and practice to respond to all 999 calls from private hire events.



Professor Alice Brown, Ombudsman 20.08.2008

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The reports are summarised below and the full reports are available on the SPSO website at <http://www.spsso.org.uk/reports/index.php>

Health

Diagnosis, failure to arrange appropriate appointments

Greater Glasgow and Clyde NHS Board (200600914)

Mr C was unhappy about the way he was treated at a hospital and at a clinic to which the hospital referred him. I partially upheld his complaint about the hospital, to the extent that they did not fully complete initial investigations of Mr C's condition before referring him to the clinic. I recommended that they apologise to Mr C for this and offer him a further appointment with their new consultant. I fully upheld the complaint about Mr C's treatment at the clinic. I found that the way his initial appointments were handled was poor and that there had been internal breakdowns of communication, causing Mr C unnecessary embarrassment and distress when he attended the clinic. Although the director of the clinic has taken some steps to try to ensure that Mr C's experience will not be repeated, I recommended that the Board also audit the clinic's system of dealing with referrals and that they offer Mr C further appropriate appointments.

Consent

Highland NHS Board (200700519)

Mr C raised a number of concerns about the care and treatment of his late wife, Mrs C, in hospital in the weeks leading up to her death. These caused considerable distress to Mrs C and further prolonged distress for Mr C after his wife's death. I upheld complaints that the Board failed to obtain properly informed consent from Mrs C before carrying out an operation and failed to properly manage a 'Do Not Attempt Resuscitation' order. In both cases the procedures in place are clearly adequate when properly followed. However, in this case, the procedures were not followed, and I, therefore, recommended that the Board audit both procedures and reflect on whether they need to take further action in the light of the audit results. I did not uphold a complaint about the

care and treatment of Mrs C, but pointed out that my professional advisers raised some concerns about two treatment choices made by those caring for her. As, however, the Board were already aware of these from their own independent review of Mr C's complaint, I noted this in my investigation report and reflected that on the whole my advisers were satisfied that Mrs C's care and treatment was reasonable.

Accident and Emergency

Grampian NHS Board (200701937)

Mrs C raised concerns about treatment of a wrist fracture at her local community hospital. In particular she complained that no follow-up x-ray was arranged, and that her injury was inappropriately managed. I upheld both complaints as I found that Mrs C was not referred elsewhere even when it became clear that her injury was not healing as originally expected. I commented in my report that Community Hospitals (which provide a localised but reduced range of services to rural communities) should have protocols to ensure specialist referral elsewhere in such situations. I recommended that the Board apologise to Mrs C for failing to carry out a repeat x-ray, and that they develop a protocol for the management of patients who attend Community Hospitals with fractures.

Nursing care

Borders NHS Board (200702695)

Mrs C complained about the level of nursing care that her late husband, Mr C, received in hospital. She described incidents where she said that he was injured or the care provided was insufficient. She also raised concerns about the cleaning regime in the ward. I found that the Board had taken Mrs C's complaints seriously, had identified what happened and explained as much as they could to her for each of the issues about which she had complained. They also apologised appropriately to Mrs C for the failings in Mr C's care. They had not, however, said that they were taking

action to minimise the chances of similar incidents for other patients, which caused Mrs C further concern. Because of that, I upheld the complaint and made five recommendations to the Board in respect of future actions. These included an audit of the hospital cleaning regime and actions in respect of record keeping and compliance with the Administration of Medicines Policy. I also recommended that the Board share my report with the Senior Charge Nurse of the Ward concerned to consider whether any additional education or development is required.

Failure to provide an ambulance, complaint handling Scottish Ambulance Service (200700008)

Mr and Mrs C complained on behalf of their 15 year old son, Mr A, who sustained head and facial injuries during a motor cross event. They said that a Service duty manager refused to send an ambulance to take Mr A to hospital because the event was serviced by private emergency cover. Mr A was eventually taken to hospital by private vehicle. Mr and Mrs C were concerned that the delay jeopardised Mr A's safety and were unhappy with the Service's handling of their complaint. I found that the decision not to send the ambulance was not in keeping with the Service's staff guidance, but also that there was confusion within the Service about the interpretation of that guidance (although this has since been amended). I also found that the Service's complaint handling was inadequate, and that in fact their investigation concluded that an ambulance should have been sent, although they failed to mention this to Mr and Mrs C. I recommended that the Service apologise to Mr and Mrs C for these failures and confirm their conclusion that the wrong decision was made. In light of the confusion over the staff guidance, I also recommended that the Service write to me outlining the steps that it has taken to implement its new guidance in order that I be reassured that the relevant Service personnel, local authorities and organisers of private hire events are clear on the Service's role.

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Health

Urology: care and treatment

Fife NHS Board (200602258)

Mr C complained that the Board failed to refer him for surgery, that they did not provide timely follow-up in his care and treatment and that unnecessary investigations were carried out on him. He had had urinary difficulties for a number of years, culminating in a very acute problem of urine retention. I found that after an appointment with a consultant in 2002 Mr C was not listed for surgery, as he had expected and been told would happen. Although Mr C did not enquire why he had not been approached with a date for surgery, the hospital should have taken steps to review his status, and, therefore, I upheld the complaint that they failed to refer him appropriately. I did not uphold Mr C's other complaints.

Hospital: record keeping, complaint handling

Tayside NHS Board (200600407)

Mrs C raised a number of concerns about the care and treatment of her husband when he was suddenly admitted to hospital for an unplanned overnight stay. She was also unhappy about the way in which the Board handled her complaint about these events. Due to lack of evidence, I could make no finding on Mrs C's complaints about the nursing staff's responses to Mr C's cardiac monitor alarm and call button. I did not uphold a complaint that nursing staff were not appropriately qualified. I upheld the complaint that staff failed to record Mr C's personal belongings on admission, and that the Board's complaints handling failed to meet the relevant timescales. By way of redress, I recommended that the Board remind staff of the need to comply with the 'Patients' Funds and Property Procedure' when admitting patients to the ward, ensure that all staff are reminded of the importance of accurate record keeping. I also recommended that the Board remind staff of the need to comply with timescales in relation to handling complaints.

I did not uphold or made no finding in the following complaint about health.

Complaints handling

A Dentist, Fife NHS Board (200701692)

Although I did not uphold the complaint about refusal of treatment, I drew the Dentist's attention to the General Dental Council's guidance on Standards for Dental Professionals, in particular the section on publishing a public version of the Practice's complaints procedure that can be prominently displayed and made easily available to patients.

Housing Associations

Anti-social behaviour, complaint handling

Shire Housing Association (200503558)

Mrs C asked me to investigate the Association's handling of her complaints about escalating anti-social behaviour. There was ongoing tension between Mrs C's family and another local family, culminating in damage to her property. Investigation showed that although the Association took proper steps when told about the problem, there was little independently corroborated evidence to enable them to take action, although they did appropriately offer her a transfer. I did not, therefore, uphold her complaints that the Association failed to take appropriate action, that they took too long to offer Mrs C alternative accommodation or that the accommodation offered was unsuitable. Mrs C also complained that she was improperly pressured to resign from the Association's Management Committee following allegations that she had abused the position. She interpreted this as being because she had complained to the Association. I partially upheld the complaint to the extent that the Chairperson wrote asking for Mrs C's resignation without giving Mrs C the chance to answer the allegations. I recommended that the Association send Mrs C a formal written apology for this.

Local Government

Planning: failure to clearly report objections to application

Stirling Council (200501923)

Mr C complained that the Council did not take account of local residents' views when handling planning applications for a new school and housing. He also felt that the Council failed to maintain the appropriate 'standards in public life' in handling the applications. I partially upheld the complaint about the views of residents, in that the Council were not rigorous enough in ensuring balance in the Committee report. This was an important but contentious local development that deviated from the Local Plan for the area, yet the Committee papers did not refer directly to a petition signed by more than 1000 objectors. I recommended that the Council ensure that they make the scale of such objections very clear in future reports, including differentiating between individual correspondence and petitions signed by many objectors. Although, given the failings described above, I could understand why Mr C felt that standards had not been adhered to I did not uphold the complaint about the handling of the applications.

Failure to handle complaints about abandoned vehicles

The City of Edinburgh Council (200503556)

I upheld this complaint about the Council's failure over a number of years to action Mr C's enquiries and complaints about vehicles abandoned on a piece of ground opposite his garage. The position of the vehicles meant he had difficulty in getting his car in and out of his property. I found that the Council had not handled his complaints well, and that by accepting un-evidenced information they failed to properly conclude their enquiries, leaving Mr C with a continuing access problem. I, therefore, recommended that the Council apologise to Mr C for this, and review their procedures on investigation of complaints of abandoned vehicles to ensure that in future information about such vehicles is properly verified.

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Homelessness: complaint investigation

The City of Edinburgh Council (200700283)

Mr C, a homeless man living in temporary accommodation, complained that the Council did not properly investigate his complaint about the circumstances in which he was asked to leave that accommodation. I found that the Council's initial investigation of the complaint was unsatisfactory, in that it contained no specific witness evidence, but that after Mr C escalated his complaint appropriate enquiries were made and recorded. I, therefore, partially upheld the complaint and recommended that the Council apologise to Mr C for the failures in the initial handling of the complaint. I also recommended that they review the handling of the case and take action to ensure that a similar failing does not recur.

Homelessness: storage and disposal of belongings

North Lanarkshire Council (200603331)

Mr C, who became homeless after his marriage broke down, raised a number of issues about how the Council handled the storage and, ultimately, the disposal of his belongings. When he did not claim his belongings after being allocated a house, the Council department concerned followed their procedures and tried to contact him about his property. They sent one letter and left two telephone messages. I found that this procedure did not give Mr C sufficient notification that the Council intended to dispose of his belongings kept in storage. I noted, however, that Mr C also had a responsibility to keep in touch with the appropriate section of the Council, but did not do so. I, therefore, partially upheld the complaint. Although the Council have already taken significant steps to amend their Storage Procedures I recommended that they also include in these advice to applicants to detail valuable items on inventories, and that they ensure that a copy of the signed inventory is kept on file.

I did not uphold the following complaints about the following Local Authorities:

Housing: modification of stock for disabled

Dundee City Council (200603559)

Mrs C is a disabled tenant of the Council and her complaint concerned difficulties she had in accessing her home. Although I did not uphold the complaint, I was concerned that no resolution of Mrs C's concerns has been found and, therefore, I have recommended that the Council now fully consider all the options that may exist for them to assist her.

Marketing and selling of land

Fife Council (200600298)

Although I did not uphold this complaint, the Council acknowledged during the investigation that there were some gaps in their record of events. I, therefore, recommended that the Council consider what lessons they may learn from this complaint, and inform me of the outcome.

Scottish Government and Devolved Administration

I did not uphold the following complaint about the following authority

Policy/administration

Forest Enterprise Scotland (200501177)

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.

The compendium of reports can be found on our website, www.spsso.org.uk

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SPSO

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 in handling complaints about councils, housing associations, the National Health Service, the Scottish Government and its agencies and departments, the Scottish Parliamentary Corporate Body, colleges and universities and most Scottish public authorities.

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

The Scottish Public Services Ombudsman was set up in 2002, replacing three previous offices – the Scottish Parliamentary and Health Service Ombudsman, the Local Government Ombudsman for Scotland and the Housing Association Ombudsman for Scotland. Our role was also extended to include other bodies delivering public services.

We aim not only to provide justice for the individual, but also to share the learning from our work in order to improve the delivery of public services in Scotland. We have a programme of outreach activities that raise awareness of our service among the general public and promote good complaint handling in bodies under our jurisdiction.

Further details on our website at: **www.spsso.org.uk**

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