



Ombudsman's Commentary

JULY 2007 REPORTS

I laid 31 investigation reports before the Scottish Parliament today. Sixteen relate to the local government sector, 14 to the health sector, and one to the Scottish Executive and devolved administration. Details of the reports are summarised below and the full reports are available on the SPSO website at www.spsso.org.uk/reports/index.php

In this month's Overview I am highlighting the valuable complaint handling work we carry out that does not reach the full investigation and report stage. I am also outlining our expanding support for public bodies in dealing with complaints and an initiative we have introduced to improve the frontline service we provide to complainants.

Ombudsman's Overview

In the first three months of this financial year, I laid **88** investigation reports before the Scottish Parliament. These represent an important aspect of our work – they illustrate the wide range of complaints received by the SPSO, demonstrate the thoroughness and impartiality of our investigation process and enable my office to highlight trends and areas of particular concern to the Parliament, the Scottish Executive and other bodies concerned with improving the delivery of public services in Scotland.

In addition to these investigations, however, my staff carry out a large volume of work that is less visible but no less important. Between 1 April and 30 June 2007, SPSO investigators considered and determined **686** complaints that did not reach the full investigation stage. Often, this involves a significant amount of background work as well as offering advice and support to complainants on the most appropriate way to try to take forward their complaint. Time and again, my staff work with public bodies to try to provide resolution for those complaints where a full investigation is inappropriate.

Outreach and Valuing Complaints

During the same three month period, my frontline staff dealt with over **570** enquiries from the general public and from bodies under jurisdiction, mainly about our function and remit. My office also engages in an active programme of Outreach work – facilitating or participating in a growing number of presentations, workshops and conferences to help raise awareness of the SPSO and to support public bodies in improving their complaint handling. The SPSO remains committed to developing initiatives to drive improvement in complaint handling, spearheaded by our **Valuing Complaints** initiative (www.valuingcomplaints.org.uk) which demonstrates the general principles that underpin good complaint handling and provides practical information and advice to public bodies.

Gateway Project

We are continually looking at ways to improve the service we provide. In April this year we introduced a three month pilot to try to deal more effectively with the large number of 'premature' complaints that we receive. Premature complaints are those that we receive too early, i.e. before the complainant has been through the full complaints procedure of the public body concerned. In line with a provision in our legislation, we firmly believe that the body should be given an opportunity to put the matter right first, and that the SPSO should be involved only if local resolution is not achieved.

Of the **785** complaints determined this quarter alone, **326** were premature – over 40% of the total. The Gateway project aims to improve our service by dealing more promptly and proportionately with such complaints. Our frontline staff are sifting out premature complaints (and also those that are clearly out-of-jurisdiction) and providing tailored advice and support to complainants about how to progress their complaint appropriately. They are also bringing the matter to the attention of the relevant body to encourage early, local resolution. Our statistics show that the 'first contact' service for these complainants is speedier, and the new system also allows my investigators to concentrate on the in-depth research required to deal with complaints that progress to the consideration and full investigation stages. An added advantage is that we are gathering better intelligence about why complaints are brought to us too early and this will better inform our external work.

Given the success of the pilot, we plan to continue Gateway and integrate it fully into our complaint handling process.

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Local Government

Education, communication, complaint handling

Comhairle nan Eilean Siar (200503386)

The complainant, Ms C, raised concerns about the Council's standard of communication and their complaint handling process following her children's removal from a school. The Council have accepted that aspects of their initial communication with Ms C were not good and have sought to prevent this from recurring by ensuring all exclusion and school transfers are confirmed in writing in the future.

I also found errors in the handling of Ms C's complaint and I recommended that the Council:

- (i) ensure that information given to complainants at the end of each stage of the complaints process is sufficient to allow them to consider whether or not to proceed;
- (ii) emphasise in guidance to relevant staff that when faults have been identified, consideration is given to making an appropriate apology and information given of any action taken to improve Council process and procedures as a result of their complaint; and
- (iii) formally apologise to Ms C for a specific failing.

Policy/administration: burial ground

North Lanarkshire Council (200503076)

The complainants, Mr and Mrs C, complained that information on a sign at the gates of a cemetery was inaccurate. The information on this sign and other information supplied by the Council had played a large part in Mr and Mrs C's decision to have their child interred there. They had believed that the cemetery gates would be locked each evening and were

considerably distressed to discover that this was not the case and that the Council had decided to end cemetery gate closure throughout North Lanarkshire.

I upheld the complaint and recommended that the Council reconsider their decision not to close the cemetery gates in light of the discrepancy between the decision and the Rules (the rules and regulations for the management of burial grounds), and thereafter install signage that accurately reflects the security of the cemeteries and ensure that the Rules are compatible with the outcome of the decision. I also recommended that the Council address the specific injustice caused to Mr and Mrs C by apologising to them for the distress caused by the misleading signage and whilst reconsidering its decision, take action to ensure that a particular aspect of the Rules is properly enforced. This action could take the form of regular security checks being made in cemeteries outside manned hours or further liaison with the Police to ensure adequate patrols are made of cemeteries.

Planning: enforcement action

The City of Edinburgh Council (200600946)

I upheld the complaint that the Council failed to deal with the complainant, Mrs C's, concerns about the removal of an original fireplace from a listed building. I recommended that the Council:

- (i) within three months, follow up the evidence disclosed in the investigation report and consider whether there are grounds to review their decision to take no further enforcement action;
- (ii) emphasise to Enforcement Officers the importance of obtaining entry and making proper enquiries; and
- (iii) apologise to Ms C for failing to deal with her concerns appropriately.

Housing: repairs and maintenance charges

East Lothian Council (200601472)

I partially upheld the complaint from Ms C who was aggrieved at the Council's decision to require her to pay an access charge in order to allow her gas appliances to receive an annual check. She complained that the new procedure was not properly explained to tenants and that the Council was being unreasonable as she had made attempts to provide access to her property. While I did not find that the Council had been unreasonable in requiring Ms C to pay the access charge, I found that there was some confusion over the new procedure and recommended that they reconsider their decision under the particular circumstances. As there appeared to be confusion about access visits, I also suggested that the Council review the terms of their standard letters and those of British Gas. The Council have declined to accept the recommendations.

Housing: tenancy rights and conditions, policy/administration

North Lanarkshire Council (200601380)

I made no finding or did not uphold three aspects of this complaint regarding the allocation of land between the tenancy of the complainant, Mrs C, and that of her adjacent neighbours and the erection of a fence by the Council which she believed created difficulties in presenting her domestic refuse bin for uplift. I did, however, uphold one aspect of this complaint in that the Council's Area Housing Manager failed to keep an undertaking to get back to Mrs C after consulting with the Council's Cartographic Services. Accordingly, I recommended that the Council issue an appropriate letter of apology to Mrs C.

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Local Government

Planning: policy/administration, complaint handling

South Lanarkshire Council
(200501980)

I partially upheld one aspect of this complaint in that the Council failed to properly deal with the complainant, Mr C's, complaints but made no recommendation in this regard.

I made no finding or did not uphold ten other complaints in the local government sector about the following issues and bodies:

Housing: capital works

East Dunbartonshire Council
(200500815)

Handling of planning application

East Lothian Council
(200601118)

Handling of planning application

East Lothian Council
(200601169)

Planning: development plans

Fife Council (200501891)

Planning: development plans

Fife Council (200501975)

Planning: development plans

Fife Council (200502032)

Policy/administration, complaint handling

Fife Council (200600918)

Handling of planning application

North Lanarkshire Council
(200600085)

Handling of planning application

North Lanarkshire Council
(200600970)

Planning: policy/administration

The City of Edinburgh Council
(200601372, 200601373,
200602604)

Health

Delay in diagnosis

Lanarkshire NHS Board
(200503060)

This complaint concerned a delay by hospital doctors in diagnosing that the complainant, Mrs C, had cancer of the cervix. In light of Mrs C's returning symptoms and medical history I upheld the complaint. However, I concluded that even if appropriate treatment had been provided at an earlier stage it is possible that the cancer would not have been present or identified. I recommended that the Board apologise to Mrs C for the failings identified in the report and share the report with the gynaecologist concerned and his staff and encourage them to reflect on its findings.

Complaint handling

Greater Glasgow and Clyde
NHS Board (200602165)

I upheld the complaint made by the complainant, Mrs C, concerning the Board's delay in dealing with her complaint about the distressing circumstances surrounding her visit to the hospital mortuary to view her son's body. I found that there had been an unacceptable delay in the Board's handling of her complaint and that the proper procedure was not followed. I recommended that the Board re-emphasise to staff the importance of following the stated complaints procedure.

Clinical treatment, diagnosis

Lothian NHS Board
(200601874)

A GP Practice in Lothian NHS
Board (200602086)

These two complaints were brought by a mother, Mrs C, on behalf of her son, Mr A. She complained about the treatment that her son received from a GP from NHS Lothian Unscheduled Care Service (LUCS) and also from another GP Practice. Her complaints were that the GPs involved failed to diagnose that Mr A was suffering from pneumonia, which then resulted in an emergency hospital admission.

Mr A had communication difficulties and this affected his ability to accurately describe his symptoms. However, I found that his carer provided a reasonable history and coupled with the GP's examination this should have resulted in the GP reaching a reasonable diagnosis. I upheld Mrs C's complaint in relation to the GP from LUCS and partially upheld her complaint about the other GP Practice. I recommended that the Board share the investigation report with the GPs to reflect on the lessons learned in relation to the importance of chest examination in diagnosing chest disease and the difficulties of assessing patients with communication difficulties and to share the case with their appraisers at annual appraisal if this has not already been done.

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Health

Clinical treatment, communication

Greater Glasgow and Clyde NHS Board (TS0106_03)

The complainant, Ms C, made a complaint that the Board failed to provide her with an appropriate level of care during her stay in hospital. Specifically, that she was not supported to the bathroom and had to lie on a bed pad; that this resulted in a deterioration in her skin condition and that the convenor (of the then Independent Review Panel) failed to take professional advice on the nursing and clinical aspects of her complaints. I did not uphold the complaint that Ms C's skin condition deteriorated as a result of her stay in hospital but I did uphold the other two aspects of her complaint.

The complaint concerned the specific needs of a patient who had a significant level of disability and I found that a clinical view should have been sought from the Panel convenor. Also, while it is clear that Ms C did receive good nursing care in many areas, there did not appear to be special emphasis placed on establishing what Ms C's changing needs were at any particular time or evidence of action taken to help improve her continence. In upholding these aspects I recommended that the Board apologise to Ms C for failing to take sufficient account of her needs when considering her care provision; and ensure that they now have appropriate training in place to ensure staff are aware of potential issues which may arise when treating patients who have communication difficulties. The Board have accepted my recommendations.

Clinical treatment, referrals

A GP Practice in Forth Valley NHS Board (200502165)

The complaint concerned the care and treatment provided by two GPs to the complainant, Mr C's, mother, Mrs A, prior to her death from cancer. I did not uphold the complaint that one of the GPs failed to refer Mrs A to the pain clinic quickly enough, but I upheld the complaints that the GPs had failed to respond appropriately to Mrs A's symptoms and that a GP referral letter was inadequate.

I found that the GPs failed to act appropriately on receipt of the results of tests, focussing on attempts to control Mrs A's pain rather than seeking further investigation to discover its cause. My report concluded that it must have been extremely distressing for Mrs A to have suffered such pain and for her family to have watched her try to cope with it. It was also clear that not all of the relevant facts were included in the GP's referral letter to the pain clinic. It is not possible to say for sure what difference a fully informed referral letter would have made but the clinic was unable to make a fully informed decision regarding Mrs A's clinical priority on the information given.

I recommended that both GPs raise this case at their annual appraisal with a view to incorporating further training on recognising the progress of cancer into their continued professional development. I also recommended that GP 1 raises this case at her annual appraisal to ensure that she fully understands what information should appropriately be included in referral letters and that the Practice apologise to Mr C for the shortcomings identified in the investigation report.

Clinical treatment, diagnosis, communication

Greater Glasgow and Clyde NHS Board (200500470)

The complainants, Mr and Mrs C, raised a number of concerns that their relative, Mrs A, had suffered due to inadequate monitoring and treatment of a break in the skin of her heel. They also raised concerns about a communication breakdown between two hospitals when Mrs A was transferred from one hospital to the other. I made no finding or did not uphold the aspects of the complaint about clinical treatment, diagnosis and the breakdown in communication between the two hospitals. However, I did find that there were inadequate nursing notes and upheld the aspect of the complaint that staff had failed to inform Mrs A that she was suffering from a potential pressure sore on her heel. I recommended that the Board reiterate to the staff involved the importance of making clear notes after assessments.

Clinical treatment, referrals, complaint handling

Lanarkshire NHS Board and a Medical Practice in Lanarkshire NHS Board (200600429, 200601152)

An MSP, Ms C, made a complaint about the referral process that her constituent, Mr A, had been through after he was diagnosed with cancer. Specifically, she complained that the Board failed to properly administer Mr A's referral to a Medical Oncology Unit (the Unit) and to follow up when Mr A did not attend his appointment; that the GP Practice failed to identify that Mr A was not aware of his referral to the Unit; and, finally, that the Board did not respond appropriately to Mr A's complaint about its failings. Mr A died during the course of the complaint and his wife, Mrs A, pursued the complaint on his behalf.

I did not uphold the complaint about the GP Practice. I did, however, uphold the complaints about the failings of the Board, both in its administration of the referral and its complaint handling. The Board have acknowledged that there were significant failings in the referral process which had tragic consequences for Mr A and his family. The Board have carried out a thorough investigation into the failings in the process and have taken action to change the process. The action taken by the Board to ensure that the referral process functions correctly is appropriate and I commend them for this action. However, given the seriousness of the failings in this case, I upheld these aspects of the complaint and recommended that the Board apologise to Mr A's family for their failings and confirm that they have gained assurance that the new system for referrals functions properly.

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Clinical treatment, communication, complaint handling

Lothian NHS Board (200503137)

There were four different aspects to this complaint about the dental treatment the complainant, Mrs C, received prior to and following the surgical extraction of teeth. I did not uphold the aspects relating to clinical treatment and the failure of staff to obtain informed consent. However, I did find that there were communication failures and I found fault with the Board's complaint handling. I recommended that the Board remind staff of the timescales in the NHS Complaints Procedure Guidance and offer Mrs C an apology for the failings that were identified. The Board have accepted my recommendations.

Clinical treatment, diagnosis, delays

Scottish Ambulance Service, A GP Practice in Tayside NHS Board and NHS 24 (200502049, 200502361, 200502362)

The complainant, Mr C, raised a number of concerns regarding the delay in diagnosing his sister, Mrs D's, stroke and admitting her to hospital. I did not uphold the complaints that NHS 24 failed to make a correct diagnosis, failed to give the case a high priority and incorrectly called for an out-of-hours GP rather than an ambulance. I also did not uphold the complaint that the GP failed to provide a referral note to the hospital. However, I did find failings with the actions of the GP and the Scottish Ambulance Service. I found that the GP should have recognised the severe and rapid deterioration in Mrs D's condition, requested an urgent ambulance and stayed with the patient while waiting for the ambulance to arrive. The degree of weight given to this aspect of the complaint must be tempered by the difficulty in making a clear judgment on the basis of the information available and the situation at the time for the GP. As such, I recommended that the Board reflect on what lessons could be learned from this case and consider how to communicate these lessons to practitioners and advise me of their conclusions. I also upheld the complaint

that the ambulance took an unreasonable time to attend, partly due to confusion over agreed attendance times. This delay has been acknowledged by the Ambulance Service and an apology has been offered. However, I further recommended that the Ambulance Service issue a further apology to Mr C and his nephew Mr D in respect of the additional delays in responding to the call from the GP and issue an apology for the incorrect information detailed in their earlier response. I also recommended that they consider reviewing their procedures for adhering to timescales for attendance at incidents, particularly with a view to ensuring that the correct information is provided to callers.

Clinical treatment, diagnosis

Tayside NHS Board (200501291)

The complainant, Ms C, complained about the care and treatment provided to her mother, Mrs A, in hospital when she was admitted to have a dialysis tube inserted. Following the procedure a complication arose and Mrs A died. I did not uphold the complaint that the incorrect procedure was used but I did find that there was a failure to diagnose a complication and so recommended that the Board apologise to Ms C for the distress caused to her and the rest of Mrs A's family by this failure. I also recommended that the Board ensure that staff on wards which receive patients who have undergone tunnelled line insertion are aware of the possibility of the known complication (perforation of a major blood vessel) and can recognise the symptoms.

Clinical treatment, diagnosis, complaint handling

Tayside NHS Board (200502264)

The complaint concerned the failure of hospital staff to diagnose and treat the complainant, Mrs C's, husband, Mr C, when he was admitted with heart failure. Mr C died within 24 hours of being admitted to hospital. Mrs C also raised concerns about a change in Mr C's medication shortly before his death. I did not uphold the aspect of her complaint relating to the change in medication but did find that there had been a failure to properly diagnose the seriousness of Mr

C's condition and provide appropriate treatment and that there had been communication failures in informing Mrs C of her husband's worsening condition.

While I welcome and acknowledge the apologies given by the Board to Mrs C for the delays in informing her of her husband's deterioration and for the manner in which the news of his death was broken to her, I concluded that this failure further supported the view that there was a lack of comprehension amongst staff of the serious and deteriorating nature of Mr C's condition. I also found fault with the Board's handling of Mrs C's complaint about this matter. I recommended that the Board:

- (i) undertake a review of the operation and knowledge of the two Chest Pain Protocols at the hospital and consider the adoption of a single unified protocol;
- (ii) review the events in this complaint at a Medical Assessment Unit multi-disciplinary meeting to ensure that lessons are learned;
- (iii) apologise to Mrs C for their failure to provide an adequate or timely response to her complaint and;
- (iv) ensure that their complaint handling process both acknowledges any errors identified and uses these to drive service improvement.

I did not uphold two other complaints in the health sector about the following issues and bodies:

Clinical treatment, delays

Tayside NHS Board (200602679)

Clinical treatment, diagnosis

Western Isles NHS Board (200503653)

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Scottish Executive and devolved administration

Policy/administration, complaint handling

Scottish Environmental Protection
Agency (SEPA) (200500641)

The complainant, Mr C, raised a number of concerns about questions he had put to SEPA about private discharge proposals in or near sewerage areas. I upheld the complaint that SEPA failed to answer a number of questions raised by Mr C and that they failed to abide by the terms and conditions of the Service Charter that was in operation at the time he made his complaint. I did not uphold three other aspects of the complaint. I recommended that SEPA apologise to Mr C for the failures identified in the report and review how they identify and address formal complaints that arise from ongoing correspondence.

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.



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

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