I laid seventeen reports before the Scottish Parliament today. Eleven relate to the local government sector, four to health, one to the Scottish Executive and devolved administration and one to further and higher education.

Ombudsman’s overview
The reports that I laid today relate to four sectors and cover seventeen very different issues. They demonstrate once again the range and complexity of services that are delivered to the public. It is worth repeating a point that I often make – that the vast majority of the millions of transactions that take place every day between individuals and public bodies go smoothly, and my office sees only those rare instances when a member of the public believes that something has gone wrong and has not been able to resolve the issue with the body concerned.

When something does go wrong, we try to provide not only justice for the individual but also to share the learning from the complaint. Even in cases where I do not uphold a complaint, I may make recommendations to the public body. This may be because the investigation has brought to light areas where improvements should be made. In feeding back this wider learning, my office can contribute to improving the delivery of public services. In this month’s compendium, I make recommendations in two such cases (Aberdeen City Council and Queen Margaret University College).

Many bodies have good complaints processes in place and in one of the investigation reports laid this month I commend Forth Valley NHS Board both for the high standard of care offered to the patient and for their thorough and fair complaint handling.

Local government
Of the eleven reports about local government, one was upheld in full, five were partially upheld and five were not upheld.

Failure to respond to a formal complaint in respect of a child’s education
Argyll and Bute Council
My investigation found that the Council had gone to great lengths to try to resolve the complainants’ concerns about problems their son was having at his secondary school. However, I found that there was a procedural error in respect of the Council’s failure to complete the complaints procedure and, accordingly, I upheld the complaint. I recommended that staff be reminded of the importance of following their formal complaints procedure.

Failure to provide adequate information when making an offer of housing; breaking a tenancy agreement; failure to fit an additional electricity meter
The City of Edinburgh Council
The complainant (Mr C) raised a complaint that his client (Ms D) had accepted the offer of a Council house based on inaccurate information provided by the Council in respect of the central heating system. The Council had advised that the house was fitted with gas central heating when in actual fact only electric storage heaters were fitted. These storage heaters did not have the appropriate meter installed to allow for use of the cheap overnight electricity tariff. As such, Ms D’s electricity costs were significantly higher than they would otherwise have been.

I upheld Mr C’s complaint that the Council had provided inaccurate information when making their offer of housing, partially upheld his complaint that the Council had broken the tenancy agreement by failing to provide appropriate affordable heating and upheld his complaint that the Council had failed to fit an additional meter to allow for cheap night time electricity.

I recommended that the Council apologise for the delay in resolving the complaint. The Council has agreed to pay for the additional cost of heating resulting from the lack of a meter for cheap overnight electricity and I commended them for agreeing to make the offer prior to the production of my report.
Poor handling of planning application
Perth and Kinross Council

The complaint concerned the Council’s actions in relation to planning matters affecting the site of a hotel situated in wooded grounds. Of the specific complaints brought to me I upheld the following, namely that the Council had:

- failed to take prompt and effective action to implement a Tree Preservation Order;
- failed to address all relevant policies in the Local Plan in a report on a planning application;
- failed to investigate within a reasonable time the existence of a claimed right of way and to secure the unlocking of a gate; and
- responded to the complaint in a selective, brief and inaccurate fashion.

I did not uphold two other aspects of the complaint.

I recommended that the Council:

- apologise to Mr C;
- review the way that their own policies are referred to in reports; and
- take action to finalise their investigations on the claimed right of way at an early date and inform my office of the outcome.

Misleading information; poor complaint handling
Falkirk Council

The complaint concerned the way in which the Council handled a lease between themselves and the complainant. I partially upheld the complaint that misleading information had been given; did not uphold the complaint that there had been delay before issuing a rent and rates bill; and upheld the complaint that the complaint to the Council had not been properly investigated.

I recommended that the Council:

- apologise for the confusion caused about the rateable value; and
- apologise for their failure to investigate properly the formal complaint.

Failure to protect tenant’s interests
Shetland Islands Council

The complaint related to the sale of land owned by the Council. The complainants, Mr and Mrs C, said that access to their home (which they rented from the Council) was restricted as a result of the sale. Mr and Mrs C decided to move into another council house but were unhappy that this move affected their discount entitlement and their right to buy the new property. My investigation partly upheld the complaint that the Council had failed as landlord to protect Mr C’s interests as their tenant but I did not uphold two other aspects of the complaint. I recommended that the Council apologise for their contribution to the deterioration in relations between Mr and Mrs C and their former neighbour.

Planning – handling of an application
Highland Council

This complaint concerned advice given by the Council about the listing status of a property and the work carried out on the property. I partially upheld Ms C’s complaint that the Council had given erroneous advice and delayed in installing replacement windows and carrying out remedial work. I did not uphold her complaints that the Council had acted inconsistently in another matter and had misinformed her about consent. I made no finding on the complaint that the Council had provided inconsistent information on a contractual position.

I recommended that the Council:

- meet the legal costs incurred in relation to the abortive sale of one property and the abortive purchase of another; and
- apologise to Ms C for the delay caused due to their communication failure.

Other complaints investigated and not upheld or on which there was no finding related to the following issues:

- Care services (Stirling Council)
- Social Work (custody hearings) (Dundee City Council)
- Neighbour notification (South Lanarkshire Council)
- Changes to refuse and recycling procedures (Aberdeenshire Council)
- Failure to adequately address findings of a report into alleged racism and discrimination within an organisation receiving preferential, unrestricted and discounted access to a public funded sports facility (Aberdeen City Council). Although I did not uphold this complaint, I recommended that the Council agree a firm timescale for implementation of a system to check and review that clubs using their facilities are compliant with legal requirements and Council values.
Health
I upheld or partially upheld two complaints and did not uphold two other complaints in the health sector this month. I made a number of recommendations, which relate to record-keeping; procedures in respect of post-mortem examinations; and reviews of training for staff dealing with dementia sufferers.

Poor record-keeping and communication; inadequate post-mortem examinations procedures; poor complaint handling
Greater Glasgow and Clyde NHS Board
The complainant (Mrs C) said that the Board had failed to provide a satisfactory explanation into why, after an operation to remove part of his lung, her husband’s condition rapidly and unexpectedly deteriorated, leading to his death. Additionally, she was concerned that a post-mortem had not been carried out and that the Death Certificate did not appear to be correctly completed. Mrs C pursued her complaint through the NHS complaints system. When she received the final response to her complaint she remained dissatisfied with the outcome and further aggrieved at the time taken to investigate her complaint. I upheld Mrs C’s complaint in full and recommended that the Board:
• carry out a review of their record-keeping in respect of clinical treatment and of how clinicians communicate with patients and their relatives;
• carry out a review of their procedures in respect of requesting post-mortem examinations and the completion of Death Certificates and consider training requirements to ensure staff are aware of their responsibilities in this area; and
• provide a full written apology to Mrs C and her family for the failures identified.

Poor care and treatment of a dementia sufferer
Greater Glasgow and Clyde NHS Board (former Argyll & Clyde Board)
The complainant, Mrs C, said that the Board had failed to provide an acceptable level of care for her father (Mr D) who suffered from dementia. In addition, it was alleged that staff in the hospital failed to provide appropriate observation to Mr D which led to him suffering a fall. After the fall, Mrs C claims that they restrained Mr D inappropriately. The specific complaints which were investigated were that:
• the level of care provided by the hospital was not of an acceptable standard;
• the level of observation provided to Mr D was not satisfactory; and
• hospital staff did not properly deal with Mr D’s dementia related problems and used unnecessary physical restraint.
I did not uphold the first two aspects of the complaint. I did uphold the last and I recommended that the Board:
• review training for staff dealing with dementia sufferers;
• review training on the production of care plans; and
• review training on communication with dementia patients’ families.
In particular, I recommended that the Board review staff training in light of the current guidance provided by the Mental Welfare Commission for Scotland on problems associated with patients with dementia. These publications include: Safe to Wander? and Rights, Risks and Limits of Freedom.

Other health complaints investigated and not upheld related to the following issues:
• inadequate care for the elderly (Greater Glasgow NHS Board – Acute Services Division)
• withdrawal of prescription (Forth Valley NHS)

Scottish Executive and devolved administration
Handling of investigation into alleged tree felling
Forestry Commission Scotland
The complaint concerned the way in which Forestry Commission Scotland (FCS) dealt with an investigation into alleged illegal tree felling. I did not uphold the complaints that the FCS had unreasonably taken the view that trees had been felled illegally and begun an investigation, and that the FCS had acted beyond their remit. I partially upheld the complaint that the FCS had failed to consider representations made and to keep the complainant updated. I recommended that the FCS:
• apologise for their oversight in not keeping the complainant properly advised about their investigation procedures; and
• ensure that their investigation procedures reflect this and the need for regular updates.
Further and Higher Education

Inadequate supervision
Queen Margaret University College

The student complained that supervision arrangements for his MSc dissertation were inadequate. I did not uphold the complaint, but I did recommend that the University College reinforce to staff the importance of following their policy that, on completion of supervision, copies of the completed forms relating to the supervision are kept in the student’s central file.

Compliance and Follow-up

All the organisations complained about have accepted my recommendations. In line with SPSO statutory responsibilities and practice, my office will follow up with the organisations to ensure that they implement the actions to which they have agreed.

Alice Brown. 29.08.2006

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

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