Scottish Parliament Region: Glasgow

Case 200602165: Greater Glasgow and Clyde NHS Board

Summary of Investigation

Category

Health: Communication, staff attitude, dignity, confidentiality

Overview

The complainant (Mrs C) complained about the Greater Glasgow and Clyde NHS Board (the Board)'s delay in dealing with her complaint concerning the circumstances pertaining when she required to view her son's body in the Royal Alexandra Hospital (the Hospital)'s mortuary.

Specific complaint and conclusion

The complaint which has been investigated is that the Board delayed in dealing with Mrs C's complaint concerning the circumstances pertaining when she required to view her son's body in the Hospital's mortuary (*upheld*).

Redress and recommendations

The Ombudsman recommends that the Board re-emphasise to staff the importance of following the stated complaints procedure and that, in the event of investigations over-running target dates, the complainant must be contacted on day 20 and fully advised. Further, that complainants' agreement to an extension should be sought and after 40 days, where they do not agree, complainants should be advised of their right to raise the matter with the Ombudsman.

The Board have accepted the recommendations and will act on them accordingly.

Main Investigation Report

Introduction

1. On 17 October 2006, the Ombudsman received a complaint from Mrs C about the Greater Glasgow and Clyde NHS Board (the Board)'s delay in dealing with her complaint concerning the circumstances pertaining when she required to view her son's body in the Royal Alexandra Hospital (the Hospital)'s mortuary. She was unhappy that it was not handled in accordance with the Board's stated procedures (particularly in relation to timescales) and that although she received an apology, she was not provided with an explanation.

2. The complaint from Mrs C which I have investigated is that the Board delayed in dealing with Mrs C's complaint concerning the circumstances pertaining when she required to view her son's body in the Hospital mortuary.

Investigation

3. The investigation of this complaint involved obtaining and reading all the relevant documentation, including correspondence between Ms C and the Board. I have also had sight of the NHS in Scotland's national complaints procedures. On 9 and 25 January 2007 I made written enquiries of the Board and responses were received dated 12 January and 23 February 2007.

4. While I have not included in this report every detail investigated, I am satisfied that no matter of significance has been overlooked. Mrs C and the Board were given an opportunity to comment on a draft of this report.

Complaint: The Board delayed in dealing with Mrs C's complaint concerning the circumstances pertaining when she required to view her son's body in the Hospital's mortuary

5. Mrs C said that in July 2006, she and her former husband had the distressing experience of having to attend the Hospital's mortuary to view the body of their son who had died in tragic circumstances. She said that their distress was compounded by the fact that the mortuary was hard to find, there was no parking, no one appeared to be expecting them although the visit had been arranged by the police, their son's body was not properly covered and that staff treated them with the bare minimum of courtesy. Mrs C said it had been an experience 'I would not wish on my worst enemy'. As she had found the experience so distressing, on 15 August 2006 she made a written complaint to the Hospital's Chief Executive.

6. On 23 August 2006, Mrs C received an acknowledgement to her complaint from the Board's Complaints Manager. The letter enclosed a leaflet explaining the complaints procedure and undertook to provide a response within 20 working days. By 21 September 2006, as Mrs C had not heard further, she wrote again (by email) and received a reply, the same day, apologising for the fact that the Board had been unable to respond within the specified time frame but that the investigation was 'now complete' and that it was hoped that a response would be with her within a few weeks. Mrs C was not happy with this and her immediate reply indicated that she wanted to hear from the Board with the minimum of delay. By 29 September 2006 as a reply had not been forthcoming she wrote again.

7. The Board's reply of 3 October 2006 apologised again but explained that the person dealing with the matter was on annual leave and that generally staffing levels were low due to unforeseen illness and annual leave. The writer noted what Mrs C had already been told about a reply (see paragraph 6) but said that she was not in a position to confirm exactly when a response would be sent. Mrs C's immediate response said that the reply was unacceptable as seven weeks had now passed. She wanted to know how to take the matter further.

8. On 6 November 2006 (12 weeks after making her complaint), the Director of Acute Services wrote to Mrs C responding to the terms of her complaint (see paragraph 6) but made no reference to the time taken to reply and, when Mrs C sent her acknowledgement on 13 November 2006, she advised that she had contacted the Ombudsman's office in that regard.

9. As it appeared that the Board had dealt, or were dealing, with matters that were at the centre of Mrs C's complaint and it was the handling of the complaint that remained outstanding; after Mrs C contacted the Ombudsman's office, I wrote to the Board on 9 January 2007 asking them for their definitive response to the complaint of delay bearing in mind Scottish NHS advice, as it did not appear to have been provided. The Head of Administration replied on 12 January 2007 saying that he did not agree with my assessment. He considered that emails sent to Mrs C on 21 September 2006 and 3 October 2007 (see paragraphs 7 and 8) had fully explained the situation. He agreed that the delay had been unacceptable but took the view that reasons for

this had been given. Mrs C, however, did not take the same view and requested that the Ombudsman's office consider matters further.

10. The Board were notified of the Ombudsman's office' intention to investigate on 25 January 2007 and asked to provide an explanation why Scottish NHS advice was not followed with regard to Mrs C's representations. Two paragraphs in particular from that advice were brought to the Board's attention which read:

> 'It is important that a timely and effective response is provided in order to resolve a complaint, and to avoid escalation. An investigation of a complaint should, therefore, be completed, wherever possible within 20 working days following receipt of the complaint. Where it appears that the 20 day target will not be met, the person making the complaint, and anyone named in the complaint, must be informed of the reason for the delay with an indication of when a response can be expected. The investigation should not, normally, be extended by more than a further 20 working days.
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> While it may be necessary to ask the person making the complaint to agree to the investigation being extended beyond 40 working days, for example because of the difficulties caused by eg staff illness, they should be given a full explanation in writing of the progress of the investigation, the reason for the requested further extension, and an indication of when a final response can be expected. The letter should also indicate that the Ombudsman may be willing to review the case at this stage if they do not accept the reasons for the requested extension'

11. The Board's formal comments on the complaint were received from the Head of Administration on 23 February 2007. He confirmed the correspondence that had been sent to Mrs C in response to her complaint (see paragraphs 6 to 9 above), however, he acknowledged that the Board had not met the initial 20 working day target (of 18 September 2006) but that after Mrs C had written querying a lack of reply she was sent an email of 21 September 2006 saying that a response would be with be with her in a few weeks. At that point no reason was given for the delay. This was provided on 3 October 2006 after a further enquiry from Mrs C. The Board also expressed their regret that it had not been possible to send her a reply but referred to staffing levels which had been affected by sickness and annual leave. The Head of Administration confirmed that the 40 day deadline of 16 October 2006

had also been missed but contended that the Board's correspondence to Mrs C had provided the reasons for this. He stated that the delay in Mrs C's case had been unsatisfactory and that the Board had apologised to Mrs C for this and for the fact that they had added to her distress but, that they should have intervened earlier. His letter went on to describe the action taken since the Board became aware of Mrs C's concerns about their complaints handling procedures. They had identified the backlog of cases, brought in a senior complaints manager from another part of the city to take over a number of cases and provide direct support to staff in reviewing their procedures, redirected some cases to line-managers, local managers had assisted with correspondence and a retired senior member of nursing staff began working with complaints staff to provide further support and to work through a number of cases.

Conclusion

12. The Board missed the first target date of 18 September 2006 to reply to Mrs C but she was not told why. She was not told after 40 days that if she did not agree to an extension she could refer her complaint to the Ombudsman. The 40 day target (16 October 2006) then passed and a reply was not sent until some 59 days after the complaint was received. While I accept that the Board expressed their apologies to Mrs C in their email of 3 October and letter of 6 November 2006 and that she was told about the staffing situation, there was an unacceptable delay and the Board did not follow the procedure set out in paragraph 11 above. This was maladministration and I uphold the complaint.

Recommendation

13. The Ombudsman recommends that the Board re-emphasise to staff the importance of following the stated complaints procedure and that in the event of investigations over-running target dates, the complainant must be contacted on day 20 and fully advised. Further, that complainants' agreement to an extension should be sought and after 40 days, where they do not agree, complainants should be advised of their right to raise the matter with the Ombudsman.

14. The Board have accepted the recommendations and will act on them accordingly.

18 July 2007

Annex 1

Explanation of abbreviations used

Mrs C	The complainant
The Board	Greater Glasgow and Clyde NHS Board
The Hospital	Royal Alexandra Hospital