Scottish Parliament Region: Lothian

Case 200603203: Lothian NHS Board

Summary of Investigation

Category

Health: Hospital; General medical; Complaint handling

Overview

The complainant (Mr C) raised a number of concerns regarding the arrangements put in place for the management of his care and behaviour by Lothian NHS Board (the Board). Mr C complained that those arrangements were inadequate, unfair and deprived him of his right to dignity and privacy. Mr C also had concerns regarding the Board's relationship with the media, which he claimed caused him and his family unnecessary distress.

Specific complaints and conclusions

The complaints which have been investigated are that:

(a) measures put in place by the Board unfairly denied Mr C his right to dignity and privacy (*not upheld*);

(b) the arrangements in place for Mr C's care were not adequate (*not upheld*);

(c) the Board's application of their complaints procedure unfairly prevented Mr C from receiving responses to his complaints (*upheld*); and

(d) the Board's relationship with the media in relation to Mr C's case was inappropriate (*not upheld*).

General Conclusions

This investigation has raised some difficult issues. For the Board, my investigation has coincided with a long and ongoing process of trying to manage Mr C's behaviour by informal negotiation, formal contracts and legal proceedings. The Board and their staff were concerned that an investigation by the Ombudsman's office would result in heightened risk to staff and consequently further stress and anxiety. I am also aware that the Board and Mr C will continue to have an ongoing relationship (which may well continue to be affected by many of the issues that have been covered in this report) and that the Board are anxious about the impact my investigation might have on that relationship.

However, the Ombudsman has a duty to consider all complaints and any decision not to pursue a complaint must be fully justified. In this case, while the Board's strong feelings about the potential impact of an investigation on the health and safety of their staff were taken seriously, there were, in my view, no reasons strong enough to prevent an investigation being launched. I must also emphasise that the Ombudsman does not pass judgement on those who complain to her office and all complaints are considered on their merits, regardless of the background of the complainant.

Notwithstanding the routine procedural considerations that must be gone through when deciding to launch an investigation, I feel that it is in the public interest to report on this difficult and sensitive case. As the report below shows, the Board's actions, with the exception of the procedural failings identified in relation to their complaint handling, show that they dealt well with a patient presenting a complex mix of problems and difficulties in a way that protected the interests of their staff, without denying Mr C his right to be treated with fairness, consideration and dignity. The Board's example, and my recommendations where failings have been identified, may provide useful guidance for other bodies under my jurisdiction in dealing with complex situations involving conflicting rights and responsibilities.

The issue of violence against frontline public service staff is one that has rightly gained the attention of the media and politicians. There have been initiatives to ensure that any inappropriate behaviour is dealt with strongly and according to a 'zero tolerance' model. I would be surprised if any public body providing a frontline service did not now have a zero tolerance policy in place. Similarly, the unacceptable actions of some complainants in pursuing complaints and in accessing services generally have been a matter of public comment recently and many bodies, including the Ombudsman's office, have adopted policies to deal with such behaviour.

In order for such policies to be effective and for staff providing key services to be able to carry out their duties without fear of abuse or assault it is vital that public bodies show leadership and strength in implementing them and supporting their staff. However, it is also extremely important that bodies ensure the rights of an individual accused of inappropriate behaviour are respected and that any action is proportionate, reasonable, taken at an appropriate level and only after careful and full consideration. It is also vital that

bodies pay close attention to the requirements of their own policies and ensure that those requirements are fulfilled.

With regard to the points which have been investigated here, while needing to rethink their approach to handling Mr C's complaints, the Board showed regard to ensuring that Mr C's rights were taken into account while at the same time taking tough action to protect the rights of their staff. In conclusion, the Board's handling of the issues which have been investigated has been commendable and (again with the exception of their complaint handling) the processes they have put in place and actions they have taken to manage a sensitive and potentially volatile situation were sound.

As a final point, I return to the issue of the Board and Mr C's ongoing relationship. Given that this relationship is likely to continue for the foreseeable future in light of the life-saving treatment that Mr C requires, any measure that might improve that relationship and which might prove beneficial to it should be considered. I have, therefore, suggested to the Board and to Mr C that they consider entering into a process of mediation to try to construct a positive relationship, draw a line under the historical issues dealt with in this report and find a way to move forward with Mr C's care and management in a mutually acceptable way. I have advised Mr C and the Board that, should they wish to engage in such a process, the Ombudsman's office would be happy to help find a suitable mediator. In addition to this suggestion, I have the following formal recommendations:

Redress and recommendations

The Ombudsman recommends that the Board:

(i) make staff who treat and guard Mr C aware of the issue regarding him being stared at and ask them to be alert to any instances where any person, without good reason in terms of security or clinical need, is seen looking into the room Mr C uses for dialysis (haemodialysis – a procedure using a machine to clean or filter the blood when the kidneys are failing);

(ii) consider whether a blind or curtain could be fitted to the outside of the window of the room in which Mr C dialyses to deter any passers-by from looking in at him and to ensure that only relevant security and clinical staff look into the room, in order to increase Mr C's feeling of privacy;

(iii) consider my comments at paragraph 75 and, in particular, my suggestion in the last sentence of that paragraph which may help modify Mr C's

behaviour and distract him from other recognised problems he suffers from, such as his fear of needles;

(iv) consider whether it would be appropriate to measure regularly the temperature of the room in which Mr C dialyses in order to monitor any problems and ensure that objective information is collected to inform their responses to any future complaints that might arise about the heat in the room;

(v) review their decision to classify Mr C as an unreasonably demanding or persistent complainant and ensure that, if they decide that he should retain that classification, the decision is properly taken and justified in accordance with the criteria listed in Appendix 2 of the Policy and that the impact of that classification is properly explained to Mr C. In particular, the Board must make clear that the classification of a person as unreasonably demanding or persistent, will not prevent that person from receiving responses to complaints about new issues and incidents not previously dealt with under the NHS Complaints Procedure; and

(vi) should amend the Policy to include a process, including clear timescales, for reviewing the classification of a person as unreasonably demanding or persistent in line with the advice contained in the Guidance.

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

Main Investigation Report

Introduction

1. On 18 January 2007, the Ombudsman received a complaint from a man, referred to in this report as Mr C, regarding the arrangements put in place for the management of his care and behaviour by Lothian NHS Board (the Board). Mr C complained that those arrangements were inadequate, unfair and deprived him of his right to dignity and privacy. Mr C also had concerns regarding the Board's relationship with the media, which he claimed caused him and his family unnecessary distress.

Background

2. More detail is provided later in this report, but the background to Mr C's situation must be briefly set out here in order that his complaint to the Ombudsman's office is fully understood.

3. Since July 2003 Mr C, a 39 year old man, has been provided with life-saving haemodialysis (dialysis) treatment by the Board. Between July 2003 and October 2003 he was treated in the dialysis satellite unit of the Western General Hospital. Between October 2003 and April 2006 he was treated on the outpatient ward of the Royal Infirmary of Edinburgh (the Hospital). Since April 2006, Mr C has been receiving his treatment in a single room, where he is treated in isolation, at the Hospital.

4. Currently, to stay alive, Mr C must receive three dialysis sessions a week lasting approximately five hours each (although Mr C told me that it could occasionally last up to seven hours). He will require this treatment as long as he lives. Mr C's condition is complicated by the fact that he has a recognised needle phobia and fear of medical procedures, which means that he is anxious in a hospital setting.

5. Mr C has been diagnosed with a severe paranoid personality disorder, although this diagnosis confirms that he is considered to be responsible for his actions. The traits associated with Mr C's disorder are that he is: solitary; over-sensitive to the point of paranoia; poorly aware of the give and take of ordinary social relationships and of the need to consider other people's point of view; and inconsiderate of the effect he can have on other people, though possibly at times enjoying it. Since he started receiving dialysis treatment, evidence shows

that he has displayed inappropriate behaviour towards the Board's staff and patients at various times, and this has been carefully documented by the Board.

6. That Mr C's behaviour has been a cause for concern and required to be managed has been fully evidenced by the Board and the violent and inappropriate behaviour Mr C has, on occasions, exhibited has been a matter of public record. Since he has been receiving treatment from the Board, he has been convicted of: a breach of the peace for an incident in December 2004 (relating to an outburst on the ward); a racist incident in October 2005 (for racially abusing a security guard); and an assault in April 2006 (for attacking a nurse).

Mr C's complaint

7. I met with Mr C on 20 March 2007, at which time he had the opportunity to explain his concerns regarding the Board's actions and to confirm the basis of his complaint. Paragraphs 8 to 22 below summarise the points Mr C made during the meeting.

8. Mr C told me he accepted that he had 'done some bad things' while receiving his dialysis treatment and he said he regretted doing them. I note that Mr C also expressed regret when asked for a comment as part of a television programme about violence against NHS staff. Mr C told me that he considered he had already been punished for what he had done. He said that the way he was now treated by the Board was unfair and upsetting.

9. Mr C said the Board's actions and the way they had treated him showed they took no account of his illness and did not give him enough support. Mr C said that the public generally did not have a good understanding of dialysis and the impact the treatment had on patients. Mr C said, for example, that he often had headaches because he had to restrict his fluid intake and felt sick and weak after dialysis sessions.

10. Mr C said that while he was generally happy with the staff who looked after him, there were a few members of staff who he felt treated him differently because of his history of past convictions. Mr C said he had stopped making complaints for a while because he felt that no-one, even his family, would believe him. He said that he had had things to complain about during the latter half of 2006, but he had refrained from making complaints because the Board

had told him that they would not answer them. Mr C felt that he should have rights in that regard, but that they were being denied him.

11. Mr C said several incidents had happened since he started his dialysis treatment with the Board, which led him to believe that staff were treating him differently and were prejudiced against him. For example, Mr C highlighted an occasion when a member of staff allegedly made a derogatory remark of a sexual nature to him in earshot of another member of staff. Mr C said that when he raised the issue with the members of staff they denied anything had been said. Mr C said he often had complaints such as those, where it was his word against that of members of staff and that no-one believed him. He said this made him feel very angry, as there was nothing he could do about the situation he was in.

12. Mr C highlighted other occasions where he felt he was being singled out and abused by members of staff who knew his past history. For example, he had heard people walking past him say the word 'beast' within earshot of him. He also told me he had been assaulted by a nurse in the summer of 2004 and that he had made a civil claim as a result.

13. Mr C explained that, when he was released from prison after serving a sentence for racial abuse and assault, he started being met by security guards at the front of the Hospital. He said the route he was escorted by to reach the room he used for dialysis went through the busiest parts of the Hospital and that he had previously been met and escorted via a more low key route. Mr C felt that having a security escort which drew attention to him in such a public way was an embarrassing and inhumane way to treat him.

14. Mr C said his security escort waited outside the room in which he received his treatment and that this also attracted attention to him. He said the main ward was very busy and that people were continually staring in at him. He said that the window looking into the room was partially reflective which meant that while he could only see vague shapes outside looking in at him, others could see clearly into the room.

15. Mr C said that the stress he felt at constantly being stared at on his way into hospital and while he received his treatment had led him to end his treatment early on several occasions, which could have a significant impact on his health and well being. He said that he was distressed due to a combination

of degrading and humiliating treatment, the heat in the room in which he dialysed and the fact that the lights were very bright.

16. Mr C said he was unhappy that there was no television in the room in which he dialysed and he told me that he had one previously when dialysing in the outpatient ward and it had made his treatment more bearable.

17. Mr C said there had been several occasions when he felt things had happened during his treatment that should not have. For example, he referred to the fact that on one recent occasion there had been a complication with his dialysis needles and a bag of blood had been required, but no-one had explained to him why. Mr C said he was aware that he might be being paranoid but he considered that the fact that lots of small mistakes in his treatment had happened meant his paranoia was justified.

18. Mr C said he was unhappy about arrangements in place for him to go to the toilet while he was receiving his dialysis treatment. He said that this involved him having to go to the toilet under a blanket in full view of the window. He said that other patients would normally be given a proper screen.

19. Mr C said he was unhappy that he was not allowed to have visitors and that when he had asked a member of staff about this he had been told it was for security reasons. He said that when he asked another member of staff about it he had been told they would check to see whether visitors could be allowed and get back to him, but that he had heard nothing back.

20. Mr C raised concerns about the Board's relationship with the media in relation to his case and referred to 'a friendship type thing' going on between the Board and the media. He said that he felt a recent article in a Sunday tabloid newspaper, which he said claimed that he had been trying to obtain the addresses of members of the Board's staff, was misleading. He also said that he was concerned about statements made by the Board on a television programme, about violence against NHS staff, in which his case was featured. He denied the allegations made by the Board that he had threatened to kill a nurse and had followed nurses to their cars. He said the notion that he would do anything like that given his past history was ridiculous and he said he wanted his past to stay there and would not do anything to jeopardise that.

21. Mr C said that the overall impact of his dialysis treatment along with the way he felt he was being treated by the Board meant he felt tired, weak and harassed.

22. I asked Mr C what he hoped to achieve from his complaint to the Ombudsman. He told me he wanted to be treated like a normal patient.

23. In commenting on a draft of this report, during a meeting with me on 3 December 2007, Mr C disputed much of the evidence provided by the Board and put forward his opinion on various matters, although he was not able to provide any evidence in support of his statements. I did not consider that the comments he made related directly to the factual accuracy of the report. Generally, however, he told me that he believed the Board and this report had misrepresented him and that there were a vast number of events and incidents that he could mention that showed the Board had behaved badly towards him. Mr C went through some of these examples, although they neither related to the factual accuracy of the report nor, in my view, did they provide any evidence of wrongdoing on the Board's part. Some of the points raised by Mr C in fact provided further evidence that he had not always behaved appropriately in his interaction with the Board's staff. Nevertheless, Mr C wanted it recorded that he stood by his complaints and that, prior to starting treatment at the Hospital, he had not been in any trouble for ten years.

24. The complaints from Mr C which I have investigated, and which were agreed with Mr C at our meeting of 20 March 2007, are that:

(a) measures put in place by the Board unfairly denied Mr C his right to dignity and privacy;
(b) the arrangements in place for Mr C's care were not adequate;
(c) the Board's application of their complaints procedure unfairly prevented Mr C from receiving responses to his complaints; and
(d) the Board's relationship with the media in relation to Mr C's case was inappropriate.

Investigation

25. As part of the investigation, three meetings were held with the Board and I made two substantive written enquiries of them. I spent a day at the Board's offices examining their files and their response to my formal enquiries, after which I held a short interview with a member of the Board's staff. I carried out a site visit during which I saw the route by which Mr C was escorted to the room

in which he dialyses, the room itself and the outpatient dialysis unit. I also met with Mr C prior to the investigation commencing to give him the opportunity to put his complaint to me and confirm a basis of complaint for the investigation (see paragraphs 8 to 22 above). I met with Mr C on two further occasions to present my findings to him and to receive his comments on the factual accuracy of the report. I also arranged a telephone interview with Mr C to receive his comments on the factual accuracy of the report. Finally, I sought the advice of one of the Ombudsman's medical advisers, although I do not include his advice in this report as it was not, ultimately, relevant to my findings.

26. During the course of my enquiries, I obtained copies of:

- Mr C's clinical notes;
- 28 complaints files relating to Mr C's complaints to the Board from October 2003 to April 2007;
- a complaints file relating to a complaint made by another patient about Mr C's behaviour;
- a log book recording staff's comments and observations regarding Mr C's behaviour during treatment;
- a security log book recording security guards' comments and observations regarding Mr C's behaviour during treatment;
- media call logs recording the contact between the Board and the media in relation to Mr C;
- notes of several meetings held between Mr C and members of the Board's staff;
- minutes of quarterly security and management review meetings at which Mr C's behaviour and the arrangements in place to manage Mr C were monitored;
- Mr C's patient contract with the Board;
- a legal opinion commissioned by the Board regarding their duties in terms of the Human Rights Act 1998 with regard to the continuing treatment of Mr C, which assessed Mr C's human rights and the rights of the Board's staff;
- a report produced by the State Hospital recommending arrangements to manage Mr C's treatment and behaviour;
- a report, commissioned by the Sheriff Court in relation to Mr C's court case, produced by a forensic psychiatrist, which assessed the risks posed by Mr C;
- a summary application lodged by The City of Edinburgh Council in pursuit of an Anti-Social Behaviour Order against Mr C;

- papers relating to an interim interdict which was granted by the Court of Session against Mr C following a petition by the Board.
- a letter from Mr C's solicitor intimating a civil claim against the Board in relation to an allegation that Mr C had been assaulted by a nurse.
- an information leaflet entitled 'Going to Hospital'.
- Scottish Executive guidance on the NHS Complaints Procedure entitled 'Can I help you?';
- the Board's complaints policy;
- the Board's Zero Tolerance Policy;
- the Board's Management of Violent/Abusive Patients & Visitors/Members of the Public (Age 16 & Over) Procedure;
- the Board's Management of Violence and Aggression Policy;
- the NHS Code of Practice on Protecting Patient Confidentiality;
- the Board's Protocol for Camera Teams Filming on NHS Lothian Property;
- the Board's Protocol for the Use of CCTV Footage by the Media;
- the Board's Protocol for Media Handling;
- the Board's Protocol for Media Handling Issues at the Hospital; and
- a recording of a television programme.

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

(a) Measures put in place by the Board unfairly denied Mr C his right to dignity and privacy

28. Mr C told me that several of the measures the Board had put in place to manage his care denied him his right to dignity and privacy. He told me that the window in the room in which he dialysed allowed people to stare at him while he was on the dialysis machine and while he was eating his lunch, which made him feel like an animal. Mr C told me that he was met outside the Hospital by security guards and escorted to the ward, which he believed was inhumane and brutal treatment as he passed through busy areas of the Hospital and felt everyone was staring at him. He told me there were no arrangements in place to ensure his privacy if he needed to urinate during his dialysis treatment. He also told me that, on one unspecified occasion, two security guards were present while he had an operation on his chest.

The Board's policies relating to inappropriate behaviour

29. The Board told me that the action they had taken against Mr C and the measures they had put in place to manage his continuing care were in line with the requirements of their Policy on Violence and Aggression (the Violence Policy) and their Zero Tolerance Policy. The Zero Tolerance Policy states:

> '3. Definition of violence and aggression
>
> The Division defines an incident of violence and aggression as:
>
> 'any incident in which any individual, whilst receiving or providing the services of the organisation is verbally abused, threatened or physically assaulted'.
>
> 4. Policy aims
>
> This policy aims to:
>
> - create a zero tolerance culture of violence and aggression
> - create a safe environment for all individuals who provide or receive services of this organisation
>
> 5. Objectives
>
> - … To ensure that the risk of violence and aggression is managed in a systematic and ongoing way, and that safe systems and methods of work are put in place.
> - To establish a mandatory training programme for all relevant staff in all areas, that equips them to recognise risk and provides practical advice on preventing and managing violence and aggression.
> - To encourage full reporting and recording of all incidents of violence and aggression, pursue each to a conclusion and where relevant learn from the experience.'

30. The Violence Policy states:

> '1. Introduction
>
> - There has been a steady increase in recent years in the level of violence and abuse faced by staff, visitors and patients within this institution. Incidents have included significant injury to staff, damage to vital equipment and extreme verbal abuse and threats.
> - Sadly, some perpetrators of violence and abuse are well known to staff and have persisted with this unacceptable behaviour during repeated visits to our hospitals. There is a widespread recognition among staff and management of a need to tackle such behaviour effectively and a

belief that fear of violence is seriously affecting morale and our ability to retain and recruit staff.

- [the Board] University Hospitals Division has a duty to provide a safe and secure environment for its patients, staff and visitors/members of the public. Violent or abusive behaviour will not be tolerated and decisive action will be taken to protect staff, patients and visitors and members of the public, in line with our Zero Tolerance approach to unacceptable behaviour.
- Those patients who, in the expert judgement of the relevant clinician are not competent to take responsibility for their actions will not be subject to this procedure e.g. an individual who becomes abusive as a result of delirium (Adults with Incapacity Act 2002).
- This procedure has been introduced in the context of an UK-wide initiative against violence in the NHS and it must be applied effectively in all situations …

4. Unacceptable Standards of Behaviour

The following are examples of behaviours that are not acceptable on [the Board's] premises:

- Violence.
- Threats or threatening behaviour.
- Threatening or abusive language involving excessive swearing or offensive remarks.
- Derogatory racial or sexual remarks …
- Abusive or threatening phone calls.
- Excessive noise, e.g. loud or intrusive conversation or shouting …

5. Sanctions to be Applied to Adult Patients (Age 16 & over) Displaying Unacceptable Behaviour

- The staff member in charge of the area will explain to the patient that their behaviour is unacceptable and the expected standards that must be observed.
- In the event of further unacceptable behaviour, the situation will be brought to the attention of the responsible manager or clinician who will give an informal warning about the possible consequences of any further repetition.
- If the patient's unacceptable behaviour persists this will, following careful review by the patient's clinical team (or the on call team out of

hours), result in hospital staff initiating a 'Contract of Care for Violent/ Abusive Patient'. This contract involves the patient being made aware of the standards of behaviour expected from them while on [the Board]'s premises and sets in motion a series of actions to record and communicate the incident(s) …

7. Responsibilities of Staff Authorised to Initiate the Contract of Care

- … Ask the patient to sign this contract. If the patient refuses to sign, their refusal should be noted and the patient made aware that the procedure will be valid with or without their agreement. Treatment may be limited to emergency or other medical care only and this being provided under the supervision of security staff where available …
- If the patient fails to comply with the Contract of Care, the relevant Directorate/Operations Manager and the Clinical Director (or their nominated deputies) may request security staff (depending on their availability) to attend during episodes of treatment on hospital premises.'

Mr C's recorded behaviour

31. The Board told me that the measures they had put in place to manage Mr C's care were a consequence of Mr C's well documented behaviour towards members of their staff. The Board's nursing communications log, security log and Mr C's clinical records provide extensive records of inappropriate behaviour by Mr C; these documents were submitted to me as evidence. In addition, the Board have referred to Mr C being arrested for a breach of the peace while on the ward which occurred on 31 March 2004 and for which he was sentenced to a year's probation in September 2004. The Board said that Mr C was arrested in December 2004 after he allegedly threatened to kill a nurse, but explained that the court case was abandoned after a key witness failed to appear. The Board told me that Mr C was arrested for racially abusing a member of security staff in September 2005 and again in April 2006 for assaulting a nurse. Mr C was sentenced to nine months in prison for these offences in June 2006.

The Board's response to Mr C's behaviour

32. The Board said they had tried to deal with what they saw as Mr C's problematic behaviour in a number of ways. Initially, they tried to resolve issues of concern informally by meeting with Mr C to discuss his concerns and those of staff (see paragraph 92 below). A more formal approach was then taken, where Mr C was provided with a memorandum (the Memorandum - see Annex 3)

outlining the Board's expectations regarding his behaviour and eventually a formal agreement (the Agreement - see Annex 4) was signed and has been in place ever since. The Board explained that Mr C had had a chance to provide his input prior to signing the Agreement and that he was accompanied to a meeting to discuss it by his probation officer. The Board told me that Mr C was given time to take the Agreement away and consider it before signing it and that they had accepted the changes that Mr C had made to the Agreement.

33. The Board told me that, in addition to the Agreement, in order to ensure the safety of their staff, they had put legal measures in place so that action could be taken against Mr C if he displayed inappropriate behaviour. They said, for example, that an interim interdict was sought and granted by the Court of Session in November 2005. This interdict sought to prevent Mr C from 'molesting [the Board]'s staff, patients and visitors by abusing them verbally, threatening them, placing them in a state of fear and alarm or distress or using violence towards them'. The Board told me that The City of Edinburgh Council had additionally applied for an Anti-Social Behaviour Order (ASBO) against Mr C, but that this application was unsuccessful as the interim interdict was already in place.

34. The Board said that they had dealt with, monitored and reviewed Mr C's behaviour at a senior level and had sought and obtained input from a variety of external agencies such as the Central Legal Office, the Scottish Executive Health Department, other Health Boards, the Police, Social Work Services and the State Hospital. The Board provided evidence of this in the minutes of security and management meetings which were at various times attended by senior staff and members of external organisations. The Board said that the measures put in place to treat Mr C in a single room and for him to be escorted to that room by security had been recommended by the State Hospital (see paragraph 59 below).

35. The Board provided me with a copy of a report produced by a court-appointed forensic psychiatrist in June 2006, which included a risk assessment of the threat Mr C posed to members of the Board's staff. That report concluded that 'there is an ongoing risk of verbal and minor physical aggression towards staff dealing with [Mr C] in hospital'. Other sections of the report highlighted by the Board included the comments that '[Mr C] is clearly able to think through a plan involving physical violence … in an attempt to solve the problem he is facing' and 'verbal aggression may well be reactive to a particular

situation and occur immediately, whereas physical aggression may be used more deliberately to dysfunctionally achieve a goal'. The Board's position was, therefore, that in light of the recorded instances of violent and inappropriate behaviour Mr C exhibited and the expert risk-assessment of the court appointed psychiatrist (which supported the Board's own view regarding the threat posed by Mr C), they had to put measures in place to ensure that their staff were protected from violence and abuse.

36. The Board have emphasised that their key consideration in dealing with this case was the health and safety of their staff. As well as taking the actions already described above, the Board obtained a legal opinion (the Opinion) from a Queen's Counsel regarding the Board's responsibilities in continuing to care for Mr C. This document outlined Mr C's right to treatment and also considered the rights of staff to work free from abuse in terms of the Human Rights Act 1998.

37. The Board said that they had also sought advice from the Central Legal Office throughout their management of the case. They stated that they were satisfied that due consideration had been given to the balance of rights between Mr C and the Board's staff. They also said that the approach they had adopted had been supported by the former Scottish Health Minister and they submitted a letter from him to a trade union (representing members of the Board's staff) dated 8 May 2006, in which he endorsed the action that had been taken to manage Mr C.

38. The Board stated that Mr C was fortunate that the Hospital continued to provide him with treatment.

The Board's response to Mr C's specific complaints

39. The Board said, with reference to Mr C being treated in isolation, that he had himself indicated a preference for this in order to avoid having to dialyse in a room with patients who, following media coverage, had become aware of his past convictions. The Board said that, on 12 April 2006, Mr C was recorded as stating that he was happier with the option of dialysing in isolation rather than being treated in the main outpatient unit. They said that Mr C had also told them on 25 October 2006 that he did not think going back onto the outpatient ward would be a good idea.

40. In relation to Mr C's security escort, the Board stated that Mr C used to be brought to hospital by the Scottish Ambulance Service, until they refused to take him due to verbal aggression towards their staff. After this, Mr C was brought to hospital using contract taxis, which dropped him off at the rear of the Hospital. This was also where Mr C was dropped off when he was serving his prison sentence. From that entrance there was a route, via a lift, which took Mr C to the room in which he was treated. However, the Board told me that Mr C no longer used the contract taxi service as he did not want anyone to know his address and, therefore, he came by bus, which dropped him off at the front of the Hospital where he was met by security staff.

41. During my site visit to the Hospital on 12 June 2007, I noted that in order to get to the room where he received his treatment Mr C was escorted from the front entrance down a long and wide central corridor, known as the 'Mall', which is a busy area featuring shops and places to eat and drink. I asked a member of the Board's staff whether any consideration had been given to changing Mr C's route to a more private one, for example, using the 'back route' that had been employed when Mr C was under prison guard while in custody. I was told there would not be a great difference in terms of privacy by using this 'back route' as it was an area where smokers congregated. I was also told that to enter through that route Mr C would need to go all the way round the Hospital, which would negate the intended effect of the security escort in that he would be in the grounds of the Hospital without an escort. I was told that, as Mr C now organised his own transport, the main entrance would be more convenient for him. In addition, it was pointed out that the Hospital was normally relatively quiet at the time when Mr C came in for his dialysis, although it was acknowledged that it was busier when Mr C left after treatment. Mr C, during a telephone call on 4 October 2007, told me that he was now being taken by a different, more private, route and that he was much happier with this.

42. During the same site visit, I saw the room in which Mr C received his dialysis. The window into the room had a special mirrored finish which was partially reflective and opaque, but which allowed for people to both look in and look out of the room.

43. Referring to Mr C's complaint about passing urine, the Board told me that, generally, patients on dialysis who wished to urinate either used a bottle or a commode whilst still connected to the dialysis machine. The Board explained that allowing a patient to go to the toilet during dialysis posed two separate and

significant risks. The first was the risk of a needle dislodgement resulting in a major bleed leading possibly to death. There was also a separate risk regarding infection control issues. The Board said that, because the procedure of disconnecting from the dialysis machine safely could take up to twenty minutes, most dialysis patients would prefer to be offered a bedpan or bottle to prevent having a break in their dialysis session.

44. The Board told me that the arrangements put in place for Mr C were that a security guard would stand outside the window to make sure no-one could look in while Mr C used a bottle under a blanket.

45. Regarding the allegation that security guards were present during an operation on Mr C's chest, the Board told me they were unaware of the alleged incident. I asked Mr C to provide further details regarding this point, such as the date or approximate time period in which it was alleged to have occurred, but Mr C was not able to provide me with that information.

Evidence relating to Mr C's complaint

46. My investigation of this complaint not only involved considering particular pieces of evidence brought to my attention by the Board, but a full review of Mr C's files (see paragraph 26 above for the evidence considered). In going through the vast amount of information in the files, I noted two instances where there was some evidence to support statements Mr C had made in the course of pursuing his complaints. The first related to Mr C's impression that he was being picked on by staff. Three entries, each recorded by a different member of staff, in the nursing communications log dated 25 January 2006, recorded:

> 'Security men in presence had a foam stress ball at the nurses' station with 'throw me at [Mr C]' written on it.
>
> Approx at [10:30] I came back from my break and noticed a … ball with … tape on it saying Throw me at [Mr C] when I said look at that? Who did that the security man for today said it was me. I showed it to [nurse] and [nurse] then I told [nurse].
>
> [Manager] contacted re below problem, she in turn contacted the head of security.'

The second relates to Mr C's belief that he is often stared at while on dialysis. An entry in the security logs dated 29 May 2006 stated:

'It has been observed that the subject [Mr C] has become an attraction for domestic staff, patients and visitors. This may be due to his light being on and gossip.'

(a) Conclusion

47. I note that Mr C is escorted to and from his dialysis treatment by security guards as a consequence of his inappropriate, violent and aggressive behaviour towards the Board's staff. That behaviour is not a matter of speculation or based on the subjective opinion of the Board, but is a matter of public record as seen in Mr C's several convictions for offences committed on the ward. The risk assessment, produced by the court-appointed psychiatrist and, therefore, providing an independent view of the threat Mr C poses, clearly concludes that Mr C poses an ongoing threat to staff. In the circumstances, having sought involvement from a number of appropriate agencies such as the Police and the State Hospital, it was entirely appropriate for the Board to put measures in place to ensure that the risk to their staff was minimised. I consider that the use of security staff to protect employees from harm, particularly when this was recommended in a report produced by the State Hospital, is appropriate. I also note that this action is line with advice contained in the Board's Violence Procedure (see paragraph 30 above).

48. I note Mr C's view that people stare at him because he is being escorted by security guards through public areas but, given his record of inappropriate behaviour, it is clear that the Board need to continue providing him with a security escort to ensure his behaviour on the Hospital's grounds is acceptable. I also note that the Board have recently changed the route taken by the security escort and that Mr C is happier with that route.

49. While I note that isolation and privacy are not synonymous terms and that it would not necessarily follow that someone treated in isolation would also be treated in privacy, I consider that, in this case, Mr C's privacy has been respected. Indeed, I consider that his privacy is likely to be greater than the vast majority of dialysis patients receiving NHS treatment. I note that he receives his treatment in a private room with a semi-opaque window, which at least partially obscures sight into the room. Most dialysis patients would receive their treatment on an open ward with several other patients. Mr C is concerned that people stare in at him through the semi-opaque window, yet I consider that he would be more visible on an open ward with other patients. In any event, it

is clear that staff need to be able to see into the room for safety reasons and that a window is, therefore, required.

50. I am aware that Mr C feels that people are continuously staring at him through the window and I have noted at paragraph 46 above an entry in the security logs referring to Mr C having become an 'attraction'. It is impossible, however, to extrapolate from a single entry in the security logs, which occurred at the time Mr C's case was generating the most publicity and public comment, that Mr C's general and ongoing complaints about being stared at are justified. Consequently, I have no criticism to make of the Board in that regard although I am recommending that the Board consider whether a blind or curtain could be fitted to the outside of the window in order to deter any passers-by from looking in at him and to ensure that only relevant security and clinical staff look into the room, in order to increase Mr C's feeling of privacy.

51. In addition, because I consider that the security log entry provides some limited corroboration for Mr C's complaint, I suggest that the Board should make staff who treat and guard Mr C aware of his concerns and ask them to be alert to any instances where any person, without good reason in terms of security or clinical need, is seen looking into the room in which Mr C dialyses. Despite the fact that Mr C himself initially courted public attention, he is entitled to his privacy and I suggest that the comment, albeit apparently isolated, that he has become an attraction requires to be addressed by the Board.

52. That the nursing and security records have provided some limited evidence to support some of Mr C's concerns demonstrates, in my view, that the records have been kept objectively and have not sought to cover-up problems or to ignore issues that might reflect badly on members of staff. Mr C should take comfort from the fact that where a specific instance of inappropriate behaviour has been highlighted (as with the stress ball) the incident was reported to appropriate senior staff to be dealt with.

53. I consider that the arrangements in place to allow Mr C to urinate while on dialysis are practical and reasonable. Had he been a patient on the main ward a screen might have been provided to shield him from other patients, but I do not consider that Mr C's privacy is compromised as things stand given that he is in a room on his own, the window into the room is semi-opaque and a security guard is stood outside the window. Again, in the circumstances, it is difficult to see what Mr C would like to see happen instead.

54. With regard to the alleged incident relating to security guards being present while an operation was carried out on his chest, I cannot make any comment as Mr C has not provided basic information regarding when and where it allegedly occurred.

55. Having considered all the evidence, I am satisfied that the Board gave full and careful consideration to Mr C's dignity and privacy in putting measures in place for his care. They have demonstrated that appropriate legal advice was sought at every stage of their consideration of Mr C's case and that expert legal advice was sought regarding Mr C's human rights and how those related to the rights of the Board's staff to work free from abuse. They have demonstrated that, as well as considering Mr C's case at a senior level within the Board, they sought appropriate expert and independent advice to help them deal with the unique difficulties presented by Mr C. Indeed, the Board have shown that in managing Mr C's care and in continuing to provide him with care despite his repeated violent and aggressive behaviour, they have adopted a reasonable and considered approach.

56. In light of my comments above, I do not uphold this complaint, but I do make some recommendations below.

(a) Recommendation

57. The Ombudsman recommends that the Board:

(i) make staff who treat and guard Mr C aware of the issue regarding him being stared at and ask them to be alert to any instances where any person, without good reason in terms of security or clinical need, is seen looking into the room Mr C uses for dialysis; and

(ii) consider whether a blind or curtain could be fitted to the outside of the window of the room in which Mr C dialyses to deter any passers-by from looking in at him and to ensure that only relevant security and clinical staff look into the room, in order to increase Mr C's feeling of privacy.

(b) The arrangements in place for Mr C's care were not adequate

58. Mr C told me that the room in which he received his dialysis was inadequate because it had no television, whereas most dialysis patients had access to a television. Mr C also complained that the room was too hot and the lights were too bright, which made his headaches worse and made his

treatment much more stressful. He also told me that he was not being allowed visitors and had not been told why.

59. The Board told me that the room in which Mr C dialysed was primarily used for him and the decision that he should, exceptionally, receive his treatment in isolation had resulted from a recommendation by the State Hospital, from whom they sought expert independent opinion regarding Mr C. This recommendation was contained in a report from the State Hospital dated 20 October 2005, which stated:

> 'Create a suitable single room accommodation to which the patient is escorted by the security staff member by a planned route.'

The Board said they had decided to seek advice from the State Hospital in response to Mr C's behaviour on the ward (see paragraph 31 above for examples of that behaviour).

60. The Board told me, contrary to statements made on a television programme, that the room was not solely for Mr C's use and that it was used for other patients in unforeseen circumstances. The Board confirmed that other patients had used the room and that no formal or informal complaints had been received about it from them.

61. The Board stated that whether a patient had access to a television depended on where he or she was receiving treatment. They said that in the main dialysis unit of the Hospital television access could be purchased from Patientline; at the Western General Hospital Satellite Unit there was shared access to televisions; there was no access to television on Ward 115 of the Hospital for patients on renal replacement therapy; and there was no access to television in the Hospital's Outpatient Department Area Annex.

62. The Board stated that the room in which Mr C dialysed was smaller than other rooms in the ward area and that, at times, it was undoubtedly hotter that on the main ward. The Board pointed out, during my site visit on 12 June 2007, that there had been some general problems with the heat at the Hospital and that other patients, not just Mr C, might have encountered issues with the heat. I am also aware that problems with the heat at the Hospital were the subject of reports in the media in 2003 and 2006 and that a trade union representing members of staff issued a press release relating to problems with heat at the Hospital in 2006.

63. However, the Board stated that the heat in the room had been monitored and complied with standards. I asked the Board to provide me with evidence that the heat had been monitored and asked what standards had been complied with. The Board told me that the issue of heat in the room in which Mr C dialysed was raised with the Hospital's building management and that an engineer changed the setting to frost control; an email from the building management contractors confirmed this. This email stated that the room had mechanical ventilation and that, as there was no cooling in the room and no window, it was likely that the room could get hot and stuffy. No evidence of monitoring was provided nor any explanation regarding what standards the Board claimed were being met.

64. The Board told me that Mr C had been offered a fan on several occasions and they pointed out that Mr C had turned down efforts of staff to ease the problem with the heat. The Board submitted evidence showing that on three occasions Mr C had asked for a fan to be turned off, despite complaining of the heat.

65. During my consideration of the nursing communications log, I noted that on several other occasions when Mr C complained regarding the heat, some action had been taken by staff to address Mr C's concerns. For example: 31 May 2006 – fan provided and door left ajar; 14 August 2006 – fan provided, door left ajar and cold drink provided; 29 September 2006 – cold drink provided.

66. During a visit to the site on 12 June 2007, I was informed by the Board that the temperature of the renal ward was higher than in other parts of the Hospital due to its situation and the amount of sunlight it received. They told me that the Hospital did not have air conditioning but that some measures had been taken to correct the temperature, such as putting special surfaces on the windows to deflect the heat.

67. The Board provided evidence showing that the issue of lighting had been discussed with Mr C and it had been explained to him that the lights could not be turned off as it would represent a safety issue for him. They explained that staff would need to be able to see into the room and ensure that his dialysis was proceeding smoothly.

68. The Board said they had no formal visiting policy but that they did operate designated visiting times on their various wards. They told me that dialysis patients would not normally have visitors as they were outpatients and they were only in hospital for a limited duration (three to five hours three times a week). The Board stated that, although it was not normal practice in an outpatient area, a specific offer was made to Mr C (when he used to dialyse in the outpatient dialysis area) to bring a relative or friend to help him on dialysis. The Board told me that Mr C had refused this offer. I asked Mr C whether this was the case and he told me that it was and that the person who might have accompanied him to dialysis, his mother, was unable to, as she was a carer for her brother and did not have time to attend.

69. The Board explained that the ward on which Mr C was dialysing was an inpatient ward, with strict visiting times. The Board told me that Mr C's dialysis times were outwith the ward's visiting hours, which were in place to ensure minimal disruption in respect of patient safety and, therefore, he could have no visitors.

70. The Board provided evidence showing that Mr C was given an explanation on two occasions about the fact that he could not have visitors in the room in which he dialysed.

71. During a site visit carried out on 12 June 2007, I noted no discernible difference between the temperature in the dialysis room and that on the ward. However, the room was not in use and the dialysis machine had not been in use that morning and it is possible that the room was cooler than normal during my visit. Nonetheless, in my assessment (which involved no scientific measurement) the temperature did not appear excessive.

72. Similarly, I noticed no discernible difference in the brightness of the lights in the room compared to the brightness on the ward or in other parts of the Hospital I visited. I did note, however, that the nursing communications log (for the period when Mr C was being treated in the outpatient area of the Hospital) showed that Mr C frequently requested that the lights above his bed be turned off and this appeared to have been his preference.

73. I was told by the Board during my site visit that the room was too small for a television to be fitted and that, in any event, television equipment was provided by Patientline as a commercial operation. I noted, when visiting the

outpatient dialysis ward (where Mr C received his treatment before he was moved to the room he now uses) that patients had personal flat screen televisions which were fixed to the wall by a substantially-sized crane-like device which overhung the bed and allowed the screen to be adjusted so that patients could see it while receiving dialysis. I do not know, based on my observations during this visit, whether there would be enough space for such a 'crane' and television to be fitted in the room in which Mr C dialysed.

(b) Conclusion

74. I note that not all patients receiving dialysis have access to a television. The arrangements the Board have put in place for Mr C have (as already commented on under complaint (a) above) been made to ensure his own safety and the safety of staff, following careful consideration and receipt of expert independent advice. In my view, the Board have put significant resources into ensuring that Mr C can continue to receive life-saving dialysis treatment while at the same time ensuring their staff are protected, as far as possible, from the risk Mr C poses to them and which has been recognised by independent psychiatric and other expert assessments. That Mr C has no television may be unusual for a dialysis outpatient, but I consider that the circumstances which led to Mr C being treated in isolation are also unusual. The fact that Mr C does not have access to a television springs from the appropriate and legitimate measures the Board have taken to protect their staff from abuse, rather than springing from any prejudicial desire to treat Mr C differently from other patients or to deprive him of facilities which some other dialysis patients enjoy. In effect, a consequence of Mr C's inappropriate behaviour and the Board's need to take action to reduce its impact on staff has been that Mr C does not have the access to a television he might have had if he continued to be treated with other dialysis outpatients. However, I do not consider that this consequence unfairly discriminated against him or that it deprived him of any fundamental right.

75. While I consider the Board's response and actions regarding the issue of the television to be entirely reasonable, I note that the decision to place a television in the room would ultimately be down to Patientline who, I understand, install and operate phone and television systems in the Hospital. Should the installation of a television in the room be logistically practical, continue to allow sufficient room for the provision of safe treatment to Mr C, and should Patientline consider such an installation to be commercially viable, I do not consider that it would be inappropriate to ask Patientline to consider such an installation. Indeed, the provision of a television (or even a small radio) may

well, by providing a distraction, help to modify Mr C's behaviour and distract him from other recognised problems he suffers from, such as his fear of needles.

76. With regard to the heat in the room, I am satisfied that the evidence provided by the Board shows they were responsive to Mr C's concerns and took some action to remedy them. I note that Mr C is not the only patient at the Hospital who might have concerns about the heat and that the problem appears, from what has been reported in the press, to affect others. I note that staff offered Mr C a fan or a cold drink when he complained about heat in the room and also that the door was left ajar on occasions. The issue regarding the heat was also reported to the Hospital's building management and fans were put on in the room before Mr C came to receive his treatment.

77. I have, therefore, seen no evidence to suggest that the heat in the room Mr C uses for dialysis is excessive and evidence has been provided to show that the Board have tried to reduce any problems with heat. In the circumstances, I have no criticism to make regarding the Board's actions in this regard.

78. However, in their response to my investigation, the Board mentioned that the heat in the room had been monitored but I have been given no evidence to support this. Given Mr C's repeated complaints about the heat, I suggest that the Board may wish to consider whether, in future, regular monitoring of the heat in the room should take place. This would ensure that the Board, as well as their subjective assessments of the temperature in the room, will have an objective measure against which to judge whether any action needs to be taken if further concerns are raised by Mr C.

79. With regard to the lighting in the room, I have noted at paragraph 72 above that I considered it was consistent with the lighting on the main ward. I have also noted that evidence shows that Mr C, when on the outpatient ward, had a preference for the lights above his bed to be turned off. However, that is clearly not possible in the room in which he currently dialyses, as having the lights off in that room would effectively mean him dialysing in the dark. The Board have stated that this would represent a safety concern and I agree. It is unfortunate that Mr C's preferences cannot be accommodated in the room in which he dialyses, but as I have noted above, this has resulted from the unusual and unfortunate circumstances of the case and from Mr C's own behaviour during dialysis.

80. With regard to Mr C receiving visitors, evidence shows that it has been explained to him that he cannot have visitors as his dialysis time is outwith the visiting times of the ward he is on. I consider this to be a perfectly reasonable explanation, particularly when most outpatients would not normally receive visitors given that they can see friends and family whenever they like and are only in hospital for between nine and 15 hours a week.

81. To conclude, I consider that rather than being inadequate, as Mr C has alleged, the arrangements put in place for his care are appropriate. Mr C is being provided treatment in a private room, which although smaller than other rooms in the ward, is spacious enough for him to receive his treatment safely and privately. I have seen no evidence that the room is too hot nor that the lights are any brighter than elsewhere in the Hospital and the fact that he is not allowed visitors is in line with the designated visiting times for the ward. I also have no criticism of the fact that Mr C does not have access to a television. In light of my comments above, I do not uphold this complaint.

(b) Recommendation

82. The Ombudsman recommends that the Board:

(i) consider my comments at paragraph 75 and, in particular, my suggestion in the last sentence of that paragraph which may help modify Mr C's behaviour and distract him from other recognised problems he suffers from, such as his fear of needles; and

(ii) consider whether it would be appropriate to measure regularly the temperature in the room in which Mr C dialyses in order to monitor any problems and ensure that objective information is collected to inform their responses to any future complaints that might arise about the heat in the room.

(c) The Board's application of their complaints procedure unfairly prevented Mr C from receiving responses to his complaints

83. Mr C told me that, since 27 March 2006, the Board were refusing to respond to his complaints and that by doing so they were attempting to cover up problems he was raising.

Policy background

84. Paragraphs 85 to 87 below set out the requirements of the policies relevant to the Board's actions regarding this point of complaint.

85. The Board's Complaints Policy (the Policy) sets out certain exceptional circumstances in which it is appropriate to classify a person as an unreasonably demanding or persistent complainant. Classifying a person as 'unreasonably demanding or persistent' allows the Board not to respond to correspondence from that person, but only in certain circumstances. The Policy is closely based on the advice and directions provided by a Scottish Executive guidance document entitled 'Can I Help You? Learning from Comments, Concerns and Complaints' (the Guidance).

86. The Guidance states:

'18.1 NHS staff should be trained to respond with patience and empathy to the needs of people who make a complaint, but there will be times when there is nothing further which can reasonably be done to assist them or to rectify a real or perceived problem. Where this is the case and further communications would place inappropriate demands on NHS staff and resources, consideration may need to be given to classifying the person making a complaint as an unreasonably demanding or persistent complainant …

18.3 Classifying a person making a complaint as unreasonably demanding or persistent should only occur in exceptional circumstances when it can be shown that:

- the complaints procedure has been correctly implemented
- all reasonable measures have been taken to resolve the complaint
- no material element of the complaint has been overlooked or inadequately addressed and a full written case has been submitted to and approved by the Chief Executive and Chair of the NHS Board.

18.4 Before agreeing to classify a correspondent as unreasonably demanding or persistent, consideration should be given to dealing with future correspondence in one or more of the following ways:

- by drawing up a signed 'agreement' with the correspondent (and if appropriate involving any relevant practitioner in a 2-way agreement) which sets out a code of behaviour for the parties involved if the complaint is to continue being processed. If these terms are contravened, consideration would then be given to implementing other action as indicated in this section.

- declining contact with the correspondent either in person, by telephone, by fax, by letter or any combination of these, provided that one form of contact is maintained.
- temporarily suspending all contact with the correspondent or investigation of a complaint whilst seeking legal advice or guidance from other relevant agencies.

18.5 Where a decision is taken to classify a correspondent as an unreasonably demanding or persistent complainant, the Chief Executive must notify the person in writing of the reasons why they have been so classified and the action which will be taken with future correspondence or calls. The letter should provide a summary of the organisation's position on their complaint, indicating that:

- they have responded fully to the points raised and, as there is nothing more to add, continuing contact on the matter will serve no useful purpose
- that further correspondence will simply be acknowledged unless it raises a new matter of substance …

Reviewing or Withdrawing Unreasonably Demanding or Persistent Status

18.7 The local procedure should also set out arrangements for reviewing or removing the designation of 'unreasonably demanding or persistent complainant' from an individual at a later date if, for example, they subsequently demonstrate a more reasonable approach. Staff who previously have used their judgement in recommending 'vexatious or habitual' status should similarly be prepared to use it in recommending that this status be withdrawn where appropriate. Once again, the Chief Executive and Chairman should make any such decision. Subject to their approval, the normal contact arrangements under the NHS complaints procedure should then be resumed. This change of status should be copied to anyone who previously was informed of the decision to classify the correspondent as unreasonably demanding or persistent.'

87. The Board's Policy repeats much of the Guidance word for word, but additionally provides definitions, based on previous guidance provided by the Scottish Executive in 1999, relating to unreasonably demanding or persistent behaviour. Appendix 2 of the Policy states:

'The Guidance issued by the Scottish Executive in May 1999 ['Guidance for NHS Complaints: Hospital and Community Health Services', Annex 5A] outlined that complainants (or anyone acting on their behalf) may be deemed to be unreasonably demanding or persistent complainants where previous or current contact with them shows that they meet TWO OR MORE of the following criteria.

Where complainants –

- Persist in pursuing a complaint where the NHS Complaints Procedure has been fully and properly implemented and exhausted.
- Change the substance of a complaint or continually raise new issues or seek to prolong contact by continually raising further concerns or questions upon receipt of a response whilst the complaint is being addressed. Care must be taken not to discard new issues that are significantly different from the original complaint. These might need to be addressed as separate complaints.
- Are unwilling to accept documented evidence of treatment given as factual, e.g. drug records, nursing and medical records. Deny receipt of an adequate response in spite of correspondence specifically answering questions or do not accept that facts can sometimes be difficult to verify when a long period of time has elapsed.
- Do not clearly identify the precise issues that they wish to be investigated, despite reasonable efforts of [the Board]'s staff to help them identify their concerns, and/or where their concerns are outwith the remit of the Board to investigate.
- Focus on a trivial matter to an extent that is out of proportion to its significance and continue to focus on this point. It should be recognised that determining what is a 'trivial' matter can be subjective and careful judgement must be used in applying this criterion.
- Have threatened or used actual physical violence towards staff at any time. – This will in itself cause personal contact with the complainant and/or their representatives to be discontinued and the complaint will thereafter only be pursued through written communication. All such instances should be documented.
- Have in the course of addressing a registered complaint had an excessive number of contacts with the Health Board, placing unreasonable demands on staff. This contact may be in person, by telephone, letter, fax or email. Discretion must be used in determining

the precise number of 'excessive contacts' using judgement based on the specific circumstances of each individual case.

- Have harassed or been personally abusive or verbally aggressive on more than one occasion towards staff dealing with their complaint. Staff should however recognise that complainants may sometimes act out of character at times of stress, anxiety or distress and make reasonable allowances for this. All incidents of harassment should be documented.'

Record of complaints

88. Evidence I have seen shows that there were 54 instances of informal complaining from Mr C in the period between February 2004 and April 2006 (when the Board took their decision to classify Mr C as an unreasonably demanding and persistent complainant). The evidence shows that a further 36 instances of informal complaining were recorded between April 2006 and July 2007.

89. Annex 5 provides a summary of all the formal complaints Mr C has made and the Board's responses since October 2003. It shows that 22 formal complaints were made to the Board in the period between October 2003 and April 2006. Only one formal complaint was raised in 2003 and only one complaint was raised in 2004, so that the bulk of the formal complaints were made in 2005 and up to April 2006. Following the Board's decision to classify Mr C as an unreasonably demanding and persistent complainant, no complaints were received until January 2007, around the same time that Mr C complained to the Ombudsman. Between January 2007 and May 2007, there were five instances of formal complaining to the Board. In commenting on a draft of this report, the Board said that during the period between April 2006 and January 2007 Mr C had made a number of complaints to the prison authorities and that he had, therefore, redirected rather than ceased his repeated complaining.

90. It should be noted that the instances of complaining relevant to my investigation are those that occurred before April 2006 and the Board's decision to classify Mr C as an unreasonably demanding and persistent complainant. That is because, in considering whether the Board took their decision to classify Mr C as an unreasonably demanding and persistent complainant fairly and in line with the Policy and Guidance described at paragraphs 85 to 87 above, my analysis must be based on the information available to and used by the Board at the time.

The Board's response

91. Paragraphs 92 to 105 below summarise the Board's response to my enquiries regarding this complaint.

92. The Board told me they had taken the decision to classify Mr C as an unreasonably demanding and persistent complainant after a long process of trying to resolve the multiple issues he raised about the Board's staff. They said they had concerns about his behaviour since he started dialysis in July 2003 but that by early 2004 the Board felt that he was becoming more intimidating towards staff. They said they had held a number of meetings with Mr C to discuss both his concerns and those of staff and provided me with evidence showing that was the case.

93. On 23 February 2004, the Board issued Mr C with the Memorandum, a copy of which is at Annex 3, listing five points relating to his behaviour on the ward and summarising the Board's expectations regarding Mr C's behaviour. The Memorandum also contained a clause regarding the use of log books for Mr C, which the Board intended to be used as a way to deal with any concerns raised both by Mr C and members of the Board's staff:

> 'You will be given a book to log your concerns in. The nursing staff will also have a log book where events on each dialysis session are recorded. This will help us to address any situations arising from the above points.'

The Board stated that Mr C chose not to make use of the log book and Mr C has confirmed to me that the Board's statement is correct. Mr C told me that he thought the log book was pointless and, therefore, had not used it.

94. On 6 December 2004, the Board met with Mr C to discuss how to progress with his care. Mr C was given a draft copy of the Agreement, a copy of which is at Annex 4, which listed what was expected of him and what he could expect from the Board. The clause of the Agreement that relates to complaints stated:

> '10. I agree that if I have a complaint about my treatment I will follow the official Lothian University Hospitals Division procedure, which is to write to the Patient Liaison Officer. Should I contact the Unit or any other member of staff I acknowledge I will be referred to the procedure and required to write to the Patient Liaison Officer.'

95. The Board stated that the log book entries throughout 2004 and 2005 showed that Mr C was using the threat of complaints to intimidate members of staff. They provided evidence which they said supported their assertion.

96. The Board said it was following much internal discussion regarding Mr C's complaining that they had decided that the Board's Chief Executive should be asked to consider classifying Mr C as an unreasonably persistent and demanding complainant. They said they hoped this would afford the management team some control over what they believed were unreasonable demands on staff time spent responding to Mr C's complaints and because of the considerable emotional impact that Mr C's intimidating behaviour engendered. The Board said that their overriding concern in taking this drastic measure was to attempt to protect members of staff from the impact that Mr C's behaviour had on their well-being.

97. The Board said that Mr C's complaining fitted four of the criteria listed in Appendix 2 of the Policy (see paragraph 87 above). They said that he continually raised new issues of complaint and that this was shown in the 22 formal complaints that had been made up to April 2006. They said that Mr C had threatened physical violence towards staff to the extent that members of staff had to make their telephone numbers ex-directory, move offices and get escorts to their cars. They said that Mr C had made an excessive number of trivial complaints and that this placed unreasonable demands on members of staff. They said that Mr C had continued to pursue a complaint where the complaints procedure had been fully and properly implemented and exhausted.

98. The Board said they had followed the Policy. They said that a recommendation and report outlining the reasons for classifying Mr C as unreasonably persistent and demanding had been sent to the appropriate officer at the Board and that the letter notifying Mr C had been sent from the Board's Chief Executive, in line with the Policy. The Board said they had negotiated a contract of care and behaviour with Mr C in December 2004 and that was in line with the Policy's requirement that other options, such as drawing up an agreement, should be considered before classifying a person as unreasonably demanding or persistent. They said that a letter sent to Mr C from the Chief Operating Officer on 23 March 2006 and a letter from the Board's Chief Executive on 27 March 2006 offered a route of communication, explained what would happen to his complaints and explained that the decision could be reviewed if Mr C demonstrated a more reasonable approach in future.

99. The Board's letter to Mr C dated 23 March 2006 stated:
'I am writing to you about the many complaints you have made about your care in the Dialysis Unit at [the Hospital].

All of these complaints have been fully investigated and responded to but you have continued to make what I consider to be unreasonable demands on the staff in the Unit and I am aware that, on occasions, you have threatened staff.

I am therefore writing to inform you that I consider your complaints to be both persistent and unreasonably demanding; this means your complaints, in future, are unlikely to be responded to, as they have been in the past.

A letter outlining this matter in more detail will shortly be sent to you from the Chief Executive of [the Board]. The NHS Complaints Procedure requires that the Chief Executive of the Health Board provides the formal letter to you about the points I have raised above.'

100. The Board's letter to Mr C dated 27 March 2006 stated:
'[Chief Operating Officer] assures me that on each occasion you have made a complaint the issues you have raised have been fully investigated and a response given to you under the NHS Complaints Procedure. I am advised however that you have continued to use the NHS Complaints Process to make unreasonable demands on the staff within the Dialysis Unit and indeed, I am advised by [Chief Operating Officer] that on occasion you have used the NHS Complaints Procedure as a threat against the staff in the Unit.

We recognise that there may be occasions where a patient, or their relatives, may be unhappy with the care they have received and it is important that we have a complaints procedure that allows them to bring their concerns to our attention in order that actions can be taken to address these concerns.

It is not acceptable however for this procedure to be used as a means to make demands on the staff or the Service. Under the NHS Complaints Procedure the Scottish Executive allows us to classify a complainant as

unreasonably demanding and therefore no longer respond to the communications made by that complainant.

This is not a step that is taken lightly but given the circumstances that have been reported to me by [Chief Operating Officer], I am writing to inform you that your complaints are now classed by the Division as both unreasonable and demanding. The Division will therefore no longer enter into any communication with you about these complaints.

Under the NHS Complaints Procedure any new correspondence will simply be reviewed by the complaints staff and acknowledged.

It is regrettable that such action has to be taken but it is also unacceptable for the staff to be threatened in this way. The decision will be reviewed once you have shown that you are prepared to act in a more reasonable manner towards the staff who look after you in the Dialysis Unit.'

101. Another letter dated 7 April 2006, not mentioned by the Board in their response, but also referring to the decision to classify Mr C as an unreasonably demanding or persistent complainant stated:

'Following investigation I have found no evidence to support your allegation and I would remind you that the staff within the Unit work extremely hard in delivering quality of care to their patients. As you will be aware, [the Board] has considered you an unreasonably persistent complainer and therefore this Division is no longer required in law to respond to your comments.'

102. The Board explained that classifying Mr C as an unreasonably demanding or persistent complainant allowed them to continue to receive complaints and investigate them but not necessarily respond to them if there was no basis to them. They said this allowed them to protect staff from the continuous negative impact of complaints and Mr C's use of his formal complaints as a threat to members of staff. They said Mr C's complaints were reviewed by a member of their staff with extensive experience in acute care and experience of caring for patients on dialysis. They said any complaints were forwarded to the Board's Clinical Treatment and Management Team to ensure that emerging issues, patterns of behaviour or staff being specifically targeted by complaints were monitored. The Board said this review of Mr C's complaints showed that full consideration had been given to his human rights. They also said the decision

to classify Mr C as an unreasonably demanding or persistent complainant was discussed with the Central Legal Office and was considered to comply with the legislation.

103. The Board said that quarterly reviews of Mr C's care and management were undertaken. I have seen minutes of review meetings dated 25 January 2005, 24 May 2005, 13 September 2005, 24 January 2006, 28 April 2006, 12 May 2006, 13 October 2006 and 10 January 2007. The Board said that Mr C had yet to act in a more reasonable manner towards staff and that, while his behaviour was regularly reviewed, they felt there had been no need to change the measures in place to manage Mr C's complaints. They accepted that discussion of their classification of Mr C as unreasonably demanding and persistent was not specifically minuted, but said that in future this would be a repeating formal agenda item.

104. During the several meetings I held with the Board, they put great emphasis on the fact that, while they were satisfied that the Policy and Guidance were followed properly, there should also be recognition of the unique circumstances and difficulties which Mr C presented. They said that his formal complaints should be put into the context of his frequent informal complaining on the ward and should be seen in the light of other inappropriate behaviour that Mr C was recorded as exhibiting. The Board said that Mr C's use of the complaints procedure was considered to be part of a wider attempt to intimidate and threaten staff who were caring for him. They considered that Mr C's complaints were intended to attack and undermine staff and that his use of the complaints procedure was part of his wider pattern of bad behaviour.

105. The Board emphasised that classifying someone as an unreasonably demanding and persistent complainant was extremely rare. They said it was an action they had taken only once before. In reviewing whether someone should continue to have that classification, the Board would assess each complainant as an individual. The Board said that Mr C's recurrent behaviour and personality disorder would require a different review process to another patient.

(c) Conclusion

106. There is no doubt that, in dealing with Mr C's management, the Board were facing a difficult, highly complex and unique situation. In that context, and in a pressurised environment where staff members felt they needed protection and the Board wanted to ensure the continuing provision of safe care to Mr C

along with a safe working environment for their staff, it is clear that the Board felt that action was required on a number of levels. I recognise the complexity of the situation and the challenges it presented in management terms. That said, I have several concerns about the way the Board have implemented the Policy and the Guidance in relation to Mr C's case. These concerns relate to six main areas: the action taken prior to deciding to classify Mr C as an unreasonably demanding or persistent complainant; the grounds upon which the decision was taken; the way the decision was communicated to Mr C; the fact that there is no evidence to show that Mr C was informed of his right to complain to the Ombudsman; the measures put in place by the Board to consider new complaints from Mr C; and the lack of a review mechanism in the Policy.

The action taken by the Board prior to deciding to classify Mr C as an unreasonably demanding or persistent complainant

107. The Policy requires that the Board give consideration to dealing with complaints in a number of ways before making a decision to classify a person as unreasonably demanding or persistent. The first of these is the drawing up of an agreement setting out the behaviour expected if a complaint is to continue being processed. If the terms of such an agreement are then contravened, consideration could be given to: declining contact in a number of ways, so long as one avenue remains open and temporarily suspending contact while legal advice or guidance was sought.

108. The Board have argued that they fulfilled the requirements of the Policy in this regard through the Agreement. However, I note that the clause in the Agreement which referred to complaints simply stated that complaints should be sent to the Patient Liaison Office and did not set out specific terms under which complaints would continue to be considered. I also note that, while the Board have referred on a number of occasions to the volume of formal complaints Mr C has generated, it is significant that prior to the Agreement being in place and the requirement that Mr C raise all complaints formally with the Patient Liaison Office, only two formal complaints were made by Mr C (see paragraph 89 above). It can, therefore, be seen that Mr C's increased use of the formal complaints procedure after that time showed Mr C adhering to the terms of the Agreement as they related to complaining. There appears to have been no recognition of this by the Board either directly to Mr C or at meetings where his case was reviewed.

109. The Board, in taking their decision to classify Mr C as an unreasonably demanding and persistent complainant, referred to Mr C using the complaints procedure as a threat and as a means to make unreasonable demands on staff. However, the Agreement did not include any clauses to try to lesson the impact of those issues or to engender a change in Mr C's behaviour in relation to complaints.

110. Consequently, while the Board may have felt that they had given proper consideration to this part of the Policy, I consider that the Agreement they put in place did not fulfil the requirements of the Policy, because although it referred to his behaviour on the ward it did not set a code of behaviour in particular relation to Mr C's complaints. Given that the Board clearly found Mr C's behaviour in pursuing complaints objectionable, the drawing up of a more detailed agreement would have been beneficial.

111. On the other hand, I do note that the Board did try to use other methods to resolve Mr C's concerns and ensure that his complaints could be heard. For example, the idea of using a log book was a positive measure, but one which Mr C unfortunately refused to make use of. Similarly, the meetings the Board had with Mr C show a genuine desire to resolve Mr C's concerns and to try to avoid having to take more formal action. I commend the Board for making these efforts, even though my criticism regarding the lack of detail relating to complaints in the Agreement still stands.

The grounds of the Board's decision to classify Mr C as unreasonably persistent or demanding

112. The Board, in response to my investigation, said that Mr C fitted four of the criteria listed in Appendix 2 of the Policy (see paragraph 86 above) which complainants had to meet in order to be classified as unreasonably demanding or persistent. The Board's statement requires some close attention and I consider each of the four criteria at paragraphs 113 to 114 below.

113. The Board claim that Mr C continually raises new issues of complaint and that this is shown in the number of formal complaints Mr C has made. It is certainly true that Mr C has made a significant number of complaints; however, the Policy refers to continually raising new issues of complaint 'whilst the complaint is being addressed' and, therefore, refers to new issues being raised in the course of a complaint being processed rather than new, different complaints being raised once a complaint has been through the complaints

procedure. Indeed, that part of the Policy specifically draws the Board's attention to the fact that 'Care must be taken not to discard new issues that are significantly different from the original complaint. These might need to be addressed as separate complaints'. In my view, under the Policy, the fact that Mr C has made a number of separate complaints is not a valid criterion for classifying him as an unreasonably demanding or persistent complainant. The Policy only allows for repeated complaining to become a criterion if the new issues are raised in the course of pursuing a single complaint.

114. The Board claim that Mr C has had an unreasonable number of trivial contacts with the complaints procedure and that this has placed unreasonable demands on staff. I have seen no evidence that Mr C has had an unreasonable amount of contacts with the Board in addressing 'a registered complaint', which is the circumstance in which the Policy envisages a complainant's actions being deemed unacceptable. The evidence I have seen indicates that Mr C has simply complained and received a response to that complaint. In my view, the complaint files do not show excessive contact in the pursuit of individual, registered complaints.

115. The Board claim that Mr C has continued to pursue a complaint where the complaints procedure has been fully and properly exhausted, but again I have seen no evidence that this is the case. The complaints files do not show that, after a response has been received to a complaint, Mr C has continually challenged a decision or sought to persistently pursue the complaint in question. It is true that Mr C has raised new complaints after other complaints were dealt with, but those are new complaints and nothing in the Policy indicates that it is unreasonable for a complainant to wish to raise new and separate issues of complaint once another complaint has been decided.

116. The Board state that Mr C has been physically violent towards their staff and I accept that this is the case and that it forms a valid criterion for classifying Mr C as an unreasonably demanding or persistent complainant. However, in my view, this shows that only one criterion has been met and I am, therefore, unconvinced that there were adequate grounds for Mr C to be classified as an unreasonably demanding or persistent complainant in terms of the Policy.

117. As a general remark, I note that the Policy and the Guidance consistently refer to unacceptable behaviour being exhibited during the course of a single complaint (see paragraphs 86 and 87 above, where reference is made to 'a

complaint', 'the complaint', 'their complaint', 'a registered complaint', etc). In my view, the Policy and Guidance, therefore, offer a tool for the Board to restrict a complainant's access to their complaints procedure in situations where the complainant's behaviour in pursuing an individual complaint has been such that unreasonable demands have been placed on staff. However, I consider that neither the Guidance nor the Policy offer a facility to not respond to substantially new complaints on the basis of the number of previous complaints that have been made by an individual. Indeed, the Guidance is very clear in stating that, while matters which relate to a complaint already dealt with will simply be acknowledged, that is only the case 'unless [correspondence] raises a new matter of substance'.

118. As a further remark regarding the basis of the Board's decision, I note that the Guidance states that classifying a person making a complaint as an unreasonably demanding or persistent complainant should only occur when the complaints procedure has been 'correctly implemented'. I note that the Policy states that 'complainants who are dissatisfied with the outcome of local resolution will be advised of their right to approach the Scottish Public Services Ombudsman'. I comment on this further below at paragraph 122 below, but I have concluded that there is no evidence that Mr C was properly advised of his rights in this regard, which is another factor which puts in doubt the reasonableness of the Board's decision (given that, before a complainant can be classified as unreasonably demanding and persistent the Board must be satisfied that the Policy has been correctly implemented). The Board, in commenting on a draft of this report, presented further information in relation to this point and I discuss this at paragraph 124 below.

Communication

119. Formal notification of the Board's decision to classify Mr C as an unreasonably demanding or persistent complainant was contained in the Board's letter at paragraph 100 above and other letters, at paragraphs 99 and 101, also made reference to the decision.

120. In my view, these letters are confusing and do not properly advise Mr C of the reasons for the decision to classify him as an unreasonably demanding and persistent complainant. They do not adequately explain what would happen to his future complaints, what arrangements the Board had in place to deal with these or what mechanisms were in place to review his status as an unreasonably demanding or persistent complainant.

121. The first letter, at paragraph 99 above, advises Mr C that 'your complaints, in future, are unlikely to be responded to, as they have in the past'. The second letter, at paragraph 100 above, states 'Under the NHS Complaints Procedure any new correspondence will simply be reviewed by the complaints staff and acknowledged'. The third letter, at paragraph 101 above, states that the Board 'has considered you an unreasonably persistent complainer and therefore this Division is no longer required in law to respond to your comments'. The comment in the first letter comes closest to fulfilling the advice in the Policy that complainants should be written to with an indication that 'further correspondence will simply be acknowledged *unless it raises a new matter of substance*' (my emphasis). The second letter (which represented the formal notification and, therefore, the key letter under the Policy) neglected to mention that new issues of substance would be considered and that the classification of a complainant as unreasonably persistent or demanding did not mean a 'blanket ban' on all future complaints. The third letter is even less accurate and fails to provide an accurate picture of the consequences for Mr C of his classification as an unreasonably demanding or persistent complainant. Overall, Mr C was given a confusing picture of the way his future complaints might be affected by the Board's decision and letters from the Board omitted advice that was indicated in the Policy.

Right of appeal to the Ombudsman

122. The complaint correspondence provides no evidence to show that, until Mr C made his complaint to the Ombudsman's office, he was informed by the Board of his right to complain to the Ombudsman. As stated at paragraph 118 above, providing this information to complainants is a requirement of the Policy. Not only that, but the Board had a legal duty under the Scottish Public Services Ombudsman Act 2002 (the SPSO Act) to publicise the right of complainants to complain to the Ombudsman. Section 22 of the SPSO Act states:

> '22 Information about right to make complaint
>
> (1) A listed authority must take reasonable steps to publicise the application and effect of this Act in relation to the authority including, in particular, providing information about—
>
> (a) the right conferred by this Act to make a complaint,
>
> (b) the time limit for doing so, and
>
> (c) how to contact the Ombudsman.
>
> (2) Information about the matters specified in subsection (1)(a) to (c) must be included in or provided with—

(a) any document published by the listed authority and containing information about services provided by the authority to members of the public or about the procedures of the authority for dealing with complaints,
(b) any document issued by the listed authority responding to a complaint made to it by any person who might be entitled to make a complaint to the Ombudsman.'

123. In commenting on a draft of this report, the Board said that prior to the introduction of the new NHS Complaints Procedure in April 2005, their normal practice had been to send all complainants a copy of the Health Rights Information Scotland booklet entitled 'Making a complaint about the NHS'. They said this booklet contained information about the right to complain to the Ombudsman. The Board said that after April 2005, they developed a new information pack for complainants which included the booklet and a copy of a leaflet produced by this office entitled 'How to Make a Formal Complaint to a Public Authority'. The Board said Mr C would have therefore received information about his right to complain to the Ombudsman 22 times prior to him being classified as an unreasonably demanding and persistent complainant.

124. I note the points made by the Board and, while their normal practice was clearly to enclose information about the right to complain to the Ombudsman in complaint correspondence, it was unfortunate that none of the letters sent to Mr C prior to the decision to classify him as an unreasonably demanding and persistent complainant referred to the fact that a booklet or an information pack were enclosed. Doing so would have represented good administrative practice and would have allowed me to determine whether the Policy and the requirements of the Act had been followed. Given the duty placed on the Board by the SPSO Act, I consider that the Board should have been able to demonstrate compliance with that duty. They could not do that in this case.

125. I am pleased to note that the Board have since amended their practice so that a paragraph about a complainant's right to complain to the Ombudsman is included in their letters responding to complaints.

The measures put in place by the Board to deal with Mr C's complaints following his classification as an unreasonably demanding and persistent complainant

126. The Board explained that, after the decision was taken to classify Mr C as an unreasonably demanding or persistent complainant, the process in place to deal with new complaints involved a member of staff with extensive clinical

experience reviewing the complaints and forwarding them to the management team. The Board explained that this allowed them to investigate complaints but not necessarily respond if there was no basis to them.

127. I do not consider that these arrangements were satisfactory and I consider that they show a misunderstanding of the Policy's requirements in terms of classifying a person as an unreasonably demanding or persistent complainant. Indeed, nowhere in the Policy does it state that a complaint will not necessarily be responded to if it was found not be justified. The Policy is clear in stating that new issues of substance (which I take to mean new complaints about new and different issues or incidents not substantially the same as complaints previously considered) should receive a response. Simply sending out an acknowledgement will only be appropriate where the issue raised in the complaint had previously been fully considered under the complaints procedure.

128. In addition, simply 'reviewing' rather than investigating new complaints is not, in my view, a robust enough mechanism to ensure that new issues of complaint are given an appropriate hearing and response. It is also a concern that having a new complaint only 'reviewed' restricts Mr C's ability to make a complaint to the Ombudsman's office, given that he would have no information from the Board regarding their decision and no information on which to base a complaint to this office. Mr C, like all members of the public in terms of the SPSO Act, has a right to have his complaints considered by the Ombudsman. I, therefore, have concerns about the Board's actions in this regard.

Review mechanisms

129. The Board told me that they had reviewed their decision to classify Mr C as an unreasonably demanding and persistent complainant at their quarterly management and security meetings. I am concerned that this review was not specifically minuted, although I am pleased to note that in future the review of Mr C's classification as an unreasonably demanding or persistent complainant will be a repeating agenda item.

130. I have noted, however, that the Guidance requires that local procedures should set out a process for review of the classification of a complainant as unreasonably persistent or demanding. The Policy does not set out such a process but merely repeats the advice in the Guidance that a process should be put in place. I suggest that the Board should now amend their policy to ensure that a process exists in their local procedure for reviewing the classification of

persons as unreasonably demanding and persistent complainants and that the process, and timescale, is communicated to complainants who are so classified.

131. In conclusion, therefore, I have found that the Board failed to follow the Policy and Guidance in that:

- the Board's Agreement did not adequately fulfil the advice contained in the Policy regarding action that should be taken before deciding to classify a complainant as unreasonably persistent or demanding;
- the grounds on which the Board made their decision did not meet two or more of the criteria listed in Appendix 2 of the Policy;
- the way the Board communicated their decision to Mr C was confusing and omitted advice which the Policy required to be set out in the formal letter to the complainant;
- the Board failed to provide evidence that Mr C was informed of his right to complain to the Ombudsman (which represented a failure in the duties imposed under the SPSO Act);
- the Board's mechanisms for considering new complaints from Mr C were inadequate and showed a misunderstanding of the Policy's requirements; and
- the Board did not follow the Guidance by setting out a process for reviewing a person's classification as unreasonably demanding or persistent in their Policy.

In light of these failing, I consider that the Board failed to implement their Policy correctly. Consequently, I uphold this complaint.

132. While I uphold this complaint and while, in my view, there were significant failings in the way the Board implemented their Policy I recognise that the Board viewed classifying Mr C in this way as only one of a package of measures they had put in place to try to reduce the effects they felt his behaviour had on their staff. I am aware of the particular challenges presented by Mr C and the resulting difficulty in managing his care and behaviour. In the circumstances, it is perhaps not surprising that there was some scope for administrative failings on the Board's part. While this does not excuse those failings, I consider that it is important they be seen in their proper context.

(c) Recommendations

133. I recommend that the Board:

(i) review their decision to classify Mr C as an unreasonably demanding or persistent complainant and ensure that, if they decide that he should retain that classification, the decision is properly taken and justified in accordance with the criteria listed in Appendix 2 of the Policy and that the impact of that classification is properly explained to Mr C. In particular, the Board must make clear that the classification of a person as unreasonably demanding or persistent will not prevent that person from receiving responses to complaints about new issues and incidents not previously dealt with under the NHS Complaints Procedure; and

(ii) should amend the Policy to include a process, including clear timescales, for reviewing the classification of a person as unreasonably demanding or persistent in line with the advice contained in the Guidance.

(d) The Board's relationship with the media in relation to Mr C's case was inappropriate

134. Mr C told me that the Board had invited film crews into the room in which he dialyses to film for a television programme, although he confirmed that the filming did not take place while he was receiving his treatment. He told me that he felt it was embarrassing for him to see the room in which he received treatment on television. Mr C told me he objected to a statement the Board were reported to have made to a national newspaper which allegedly supported claims that Mr C had been trying to obtain the contact details of members of the Board's staff. Mr C told me he believed the Board and the media had a friendship which was inappropriate and caused him concern. Mr C expressed particular concern about being harassed by journalists on his way out of the Hospital after his treatment had finished.

135. The Board stated that it was Mr C who originally went to the media regarding his case and provided evidence showing that Mr C had acknowledged this. The story reported in the press, and which set the tone for much of the subsequent coverage of the case, gave details of Mr C's previous convictions.

136. The Board said that in situations where patients themselves actively recruited the media, the Board had a duty to counter inaccuracies in response. They provided copies of five responses they had given to media enquiries. They said that given the substantial local, national and international interest in the case it was significant that the Board had only issued five responses about the case in total.

137. The Board told me they had supported a television programme about violence against NHS staff which featured a number of cases including Mr C's. The Board stressed that they did not invite the programme makers to film the room. Rather, they received a request which they agreed to. The Board pointed out that the room in which Mr C dialysed was not for his sole use and not his private room. They, therefore, felt it was acceptable for it to be filmed. However, they pointed out that filming was not done while Mr C was on dialysis in order to protect his privacy. They said that strict criteria were also set to ensure the location of the room within the Hospital could not be identified.

138. With regard to Mr C's concern that the Board had made a statement in the press supporting allegations made by a national newspaper, the Board pointed out that their response to the enquiry from the newspaper in question stated: 'If this is true I am shocked …'.

139. With regard to Mr C's concerns about allegedly misleading statements made by the Board on a television programme that Mr C threatened to kill a nurse and followed nurses back to their cars, I have seen evidence in the Board's files which provide some support for those statements. There were records relating to three specific incidents which provided some factual support for the statement made on the programme.

140. The Board said that the only occasion when they were aware of Mr C having been seen by the media while at the Hospital was when the film makers were at the Hospital's Accident and Emergency Department filming interviews with members of the Board's staff. The Board said that pure chance brought the film makers and Mr C together. They said they had been at pains to keep Mr C's visits to the Hospital confidential despite the three days a week he attended becoming public during a court case against him.

141. The Board said there had been no collusion between their communications team and the media. They said this was evidenced by the lack of media contact Mr C had had at the Hospital despite the number of times he attended for treatment. The Board said that, after Mr C contacted the media in April 2006, journalists had tried to approach clinical staff directly for comment. The Board said that no comment was given and that journalists were referred, in line with the relevant procedure, to the communications team. The Board

submitted a copy of an email which had been sent to members of their staff stating that no comments should be made to the press.

142. The Board provided me with a copy of their Media Handling Protocol which states that all calls from journalists should be logged on their system along with any response given. I asked the Board to provide me with copies of all contact between the Board and journalists regarding Mr C's case. This was provided in the form of a table charting calls received from journalists and responses issued and showed no evidence of inappropriate information having been given out and no evidence of collusion.

(d) Conclusion

143. I have seen no evidence of an inappropriate relationship between the Board and the media in relation to Mr C's case.

144. The Board received and accepted a request to film the room Mr C used for dialysis and ensured that the filming was done when Mr C was not present and that the location of the room could not be identified from the footage.

145. The Board's response to a media enquiry, which Mr C believes supported allegations made against him, does not provide support for the allegations but rather states very clearly that the Board's comments are conditional on the story being accurate.

146. I have seen no evidence that Mr C has been hounded by the press when he leaves the Hospital. The only instance the Board are aware of was when programme makers were making their film on violence against NHS staff. There is no evidence that the Board deliberately engineered an encounter between Mr C and the film crew. The only other instance where I can confirm Mr C was approached by the press directly comes from a photograph that appeared in the local press and on a website which shows Mr C walking down a road by a bus stop. The same photograph has been used in the media since the story broke in April 2006 to March 2007 when the latest story appeared. The photograph does not appear to have been taken on the Board's property. That the same photograph has been used over and over again suggests and provides some evidence to support the view that Mr C has not been regularly 'door-stepped' or hounded by the press.

147. In any event, there is very little that the Board could do, or should be expected to do, to stop journalists approaching Mr C on his way out of the Hospital. The Hospital itself is a public building and, while there are protocols in place to ensure that journalists with an interest in the Board's patients approach the communications team, it is clear that the Board would be unable to restrict access to journalists who could show up unannounced at any time while Mr C is receiving his dialysis. The Board cannot be held responsible for the actions of the press and, if Mr C believes that the press have acted inappropriately towards him, I have told him to seek advice from the Press Complaints Commission.

148. In light of my comments above, I do not uphold this complaint.

General Conclusions

149. This investigation has raised some difficult issues. For the Board, my investigation has coincided with a long and ongoing process of trying to manage Mr C's behaviour by informal negotiation, formal contracts and legal proceedings. The Board and their staff were concerned that an investigation by the Ombudsman's office would result in heightened risk to staff and consequently further stress and anxiety. I am also aware that the Board and Mr C will continue to have an ongoing relationship (which may well continue to be affected by many of the issues that have been covered in this report) and that the Board are anxious about the impact my investigation might have on that relationship.

150. However, the Ombudsman has a duty to consider all complaints and any decision not to pursue a complaint must be fully justified. In this case, while the Board's strong feelings about the potential impact of an investigation on the health and safety of their staff were noted, there were, in my view, no reasons strong enough to prevent an investigation being launched. I must also emphasise that the Ombudsman does not pass judgement on those who complain to her office and all complaints are considered on their merits, regardless of the background of the complainant.

151. Notwithstanding the routine procedural considerations that must be gone through when deciding to launch an investigation, I feel that it is in the public interest to report on this difficult and sensitive case. As the report above has shown, the Board's actions, with the exception of the procedural failings identified in relation to their complaint handling, show that they dealt well with a

patient presenting a complex mix of problems and difficulties in a way that protected the interests of their staff, without denying Mr C his right to be treated with fairness, consideration and dignity. The Board's example, and my recommendations where failings have been identified, may provide useful guidance for other bodies under my jurisdiction in dealing with complex situations involving conflicting rights and responsibilities.

152. The issue of violence against frontline public service staff is one that has rightly gained the attention of the media and politicians. There have been initiatives to ensure that any inappropriate behaviour is dealt with strongly and according to a 'zero tolerance' model. I would be surprised if any public body providing a frontline service did not now have a zero tolerance policy in place. Similarly, the unacceptable actions of some complainants in pursuing complaints and in accessing services generally have been a matter of public comment recently and many bodies, including the Ombudsman's office, have adopted policies to deal with such behaviour.

153. In order for such policies to be effective and for staff providing key services to be able to carry out their duties without fear of abuse or assault it is vital that public bodies show leadership and strength in implementing them and supporting their staff. However, it is also extremely important that bodies ensure the rights of an individual accused of inappropriate behaviour are respected and that any action is proportionate, reasonable, taken at an appropriate level and only after careful and full consideration. It is also vital that bodies pay close attention to the requirements of their own policies and ensure that those requirements are fulfilled.

154. With regard to the points which have been investigated here, while needing to rethink their approach to handling Mr C's complaints, the Board showed regard to ensuring that Mr C's rights were taken into account while at the same time taking tough action to protect the rights of the Board's staff. In conclusion, the Board's handling of the issues in this investigation has been commendable and (again with the exception of their complaint handling) the processes they have put in place and actions they have taken to manage a sensitive and potentially volatile situation were sound.

155. As a final point, I return to the issue of the Board and Mr C's ongoing relationship. Given that this relationship is likely to continue for the foreseeable future in light of the life-saving treatment that Mr C requires, any measures that

might improve that relationship and which might prove beneficial to it should be considered. I have, therefore, suggested to the Board and to Mr C that they consider entering into a process of mediation to try to construct a positive relationship, draw a line under the historical issues dealt with in this report and find a way to move forward with Mr C's care and management in a mutually acceptable way. I have advised Mr C and the Board that, should they wish to engage in a such a process, the Ombudsman's office would be happy to help find a suitable mediator.

156. The Board have accepted the recommendations in this report and will act on them accordingly. The Ombudsman asks that the Board notify her when the recommendations have been implemented.

19 December 2007

Annex 1

Explanation of abbreviations used

Mr C	The complainant
The Board	Lothian NHS Board
The Hospital	Royal Infirmary of Edinburgh
The Violence Policy	The Board's Policy on Violence and Aggression
The Memorandum	A memorandum issued to Mr C by the Board relating to his behaviour on the ward
The Agreement	An agreement signed by Mr C and the Board which outlines the behaviour expected from him
The Opinion	A Queen's Counsel's opinion regarding the Board's duties in providing continuing care to Mr C
The Policy	The Board's complaints policy
The Guidance	The Scottish Executive's Guidance on the NHS Complaints Procedure
The SPSO Act	The Scottish Public Services Ombudsman Act 2002

Annex 2

List of legislation and policies considered

Human Rights Act 1998

NHS Code of Practice on Protecting Patient Confidentiality

NHS Lothian's Complaints Policy

NHS Lothian's Management of Violent/Abusive Patients & Visitors/Members of the Public (Age 16 & Over) Procedure

NHS Lothian's Management of Violence and Aggression Policy

NHS Lothian's Protocol for Camera Teams Filming on NHS Lothian Property

NHS Lothian's Protocol for Media Handling

NHS Lothian's Protocol for Media Handling Issues at Royal Infirmary of Edinburgh

NHS Lothian's Protocol for the Use of CCTV Footage by the Media

NHS Lothian's Zero Tolerance Policy

Scottish Public Services Ombudsman Act 2002

Scottish Executive Guidance on the NHS Complaints Procedure entitled 'Can I help you?'

Annex 3

Memorandum issued to Mr C on 23 February 2004

1. Time of attendance for dialysis

1a. Transport

You have [time] dialysis slot. This finishes at [time]. The space is then needed for another patient. It is your responsibility to turn up for … dialysis.
Delays instigated by you will not be allowed to compromise the care of another patient.

If you arrive by hospital transport, you will receive your full dialysis.

If you travel independently, either because you turn the ambulance away, the ambulance is late or there are delays in the journey, you will receive only the hours of dialysis we can fit in before [time]. If you wish to come by bus, you must leave in time to be here at [time].
Currently, even if late, ambulance transport gets you here before your independent travel does.

We will ask ambulance control to keep a record of your transport to which we will have access. Your time and mode of arrival at the Unit will be noted at each attendance.

1b. After Arrival

Once you have arrived, if you delay going onto dialysis for more than the 15 minutes it takes for your GTN patch to work, you will receive only the hours of dialysis we can fit in before [time].

If you wish to see someone before going onto dialysis, you will arrange this appointment in advance and get yourself there in time to see them before the start of … dialysis. You will appreciate that staff have other commitments and cannot always see you when you wish.

You are aware of the need for dialysis. If you decline to go onto dialysis, that is your choice.

2. Behaviour on dialysis

This hospital has a zero tolerance policy to verbal & physical aggression.

Your current behaviour on the dialysis Unit is unacceptable.
You will be aware of the fact that other people besides yourself dialyse and that your behaviour on the unit affects them.

If you wish to attract the attention of the nursing staff, you will use the call button.
Only use this when you actually need it. Do not call out. This is very disruptive to the working pattern of the staff and disturbs the other patients.

You will not make personal comments to other patients or nursing staff.

If you become verbally abusive to nursing staff, they have been instructed to call Security to be present for the remainder of your dialysis.

Any physical abuse will result in the police being called and a charge of assault being made.

3. Medication
The aim of the tablets given to you on dialysis is to help reduce the anxiety you feel in respect of needles, blood and dialysis and to help you cope with being in hospital, which, we appreciate is a place of high anxiety for you. The dose is limited so that you are not overly sedated and can leave the unit able to continue with your normal life.

4. [Psychiatrist]
[Mr C's psychiatrist] is happy to offer you weekly contact to help you learn to cope with being in hospital, as this is an unavoidable event in your life now …

5. Log books
You will be given a book to log your concerns in. The nursing staff will also have a log book where events on each dialysis session are recorded. This will help us to address any situations arising from the above points. Both books will be reviewed by you and [Mr C's psychiatrist] at your weekly meeting. Do not ask to discuss them at other times. They will not be.

A copy of this memorandum will be kept in the dialysis unit, and a copy given to [Mr C's psychiatrist] and sent to your GP

Annex 4

The agreement between Mr C and the Board

NHS LOTHIAN
LOTHIAN UNIVERSITY HOSPITAL DIVISION

RENAL SERVICES

AGREEMENT BETWEEN

NAME: [MR C] Date: 06.12.04

ADDRESS: […]

AND LOTHIAN UNIVERSITY HOSPITALS

I [Mr C] solemnly agree to abide by the following obligations:

1. I will never verbally abuse or use intimidating/threatening behaviour or actual violence towards staff, fellow patients or other external service providers e.g. taxi drivers, ambulance staff. I will not shout or raise my voice. [Mr C circled the words 'raise my voice' and his handwritten notes state 'Can't promise phobia of needles but will definitely try'.]
2. I agree to use the call bell system if I require staff attention during a treatment session. [Mr C circled the words 'I agree to use the call bell system' and his handwritten notes said 'nobody else does but ok'.]
3. I agree not to loiter within the dialysis unit or surrounding area outwith my treatment times.
4. I agree my treatment times are […] and that Lothian University Hospitals Division has no obligation to provide elective treatment outwith these times. I understand that there may be times when unforeseen delays within the dialysis unit may result in my start time being delayed, however I accept that my treatment will commence as soon as possible. I also acknowledge that I will attend the dialysis unit for […] pm. I agree that I must apply my GTN patch to my fistula as advised prior to arriving in the unit in order that my fistula is ready for immediate use. I understand that, in refusing to attend at these times

specified I am refusing dialysis. I know that in doing so I am endangering my health. If, as a consequence, of non-compliance with the treatment arranged, I will require emergency dialysis and this will be provided as an in-patient.

5. If I require to attend the Royal Infirmary of Edinburgh outwith my dialysis times I will notify […] Head of Security (or deputy) via the hospital switchboard before arriving.
6. I agree that it is not my decision who cannulates my fistula or who delivers the treatment each session.
7. I agree that, if I require to discuss my care with a member of staff I will make an appointment. I will not telephone or demand to see them without reasonable prior notice. I will indicate the particular aspects of the care I wish to discuss. I am aware that appointments can be made via the ward clerk in the dialysis unit when I attend for dialysis. I agree that if I require medical attention outwith my dialysis times I will contact my General Practitioner.
8. I understand that I am responsible for managing my diet and fluid intake in line with advice given by dieticians. I acknowledge I have received this advice and that failure to adhere to this will affect my health.
9. I understand I need to see [Mr C's psychiatrist] on a regular basis …
10. I agree that if I have a complaint about my treatment I will follow the official Lothian University Hospitals Division procedure, which is to write to the Patient Liaison Officer. Should I contact the Unit or any other member of staff I acknowledge I will be referred to the procedure and require to write to the Patient Liaison Officer.

Signature:

Witness:

Date: 08.12.04

LUHD will:

1. Offer dialysis treatment 3 times per week commencing at […]pm or as near to this time as possible subject to any unforeseeable delays.
2. Respond to the call bell system as with other patients in priority order.

3. Provide appropriately qualified staff to meet the clinical dialysis needs of [Mr C]. This will be determined by the Charge Nurse or Deputy as appropriate.
4. Offer appointment time within 7 days of a request to discuss care being requested provided notification to the issues to be discussed are provided at the time of the request for a meeting and are deemed appropriate to the person with whom the appointment is requested.
5. Communicate with [Mr C's] General Practitioner regarding his renal care when appropriate.
6. Treat [Mr C] in a professional and courteous manner.
7. Follow the standards in the Lothian University Hospitals Division Complaints Procedure.

Signature:

Witness:

Date: 06.12.04

Annex 5

Summary of Mr C's formal complaint to the board

1. 02.10.03

Mr C's Complaint	Mr C complained that a nurse waved tubes with blood dripping out of them in front of him, saying 'look lots and lots of blood', when she knew he had a needle phobia and did not like the sight of blood. The nurse allegedly did this repeatedly, smiling as she did so. This made Mr C's phobia worse and raised his blood pressure. Mr C was convinced that the nurse was 'sick' and he was concerned for her state of mind. The letter was copied to a solicitor and a newspaper.
The Board's Response	Not upheld. The Board responded that the nurse told Mr C to look away when removing treatment lines from another patient's machine and did not make inflammatory remarks as Mr C suggested. The Board's account was supported by staff and another patient on the ward.

2. 17.08.04

Mr C's Complaint	Mr C complained that a nurse allegedly shouted at him for loitering when he had stopped for six seconds to put a patch on. On a different day the same nurse allegedly told Mr C that dialysis machines could be tampered with to give people heart attacks, which scared Mr C who stated that he started shaking every time he saw the nurse. Mr C alleged that the same nurse was always giving cigarettes to patients and he believed that the nurse should understand that they are bad for patients' health. Mr C alleged that the nurse was always swearing and was out of control.
The Board's Response	Not upheld.

	The Board responded that statements taken from individuals present on the ward showed no evidence to support Mr C's allegations. The Board were satisfied that members of staff act appropriately and professionally.
3. 13.01.05 4. 01.02.05 Mr C's Complaint	Mr C complained that a nurse said 'you're away with the fairies' to him when removing needles from his arm. Mr C stated that the nurse was constantly trying to upset him. Mr C said he was concerned that the Patient Liaison Office was covering up for staff. He stated that he was taking professional advice about that. Mr C stated that the nurse had been taking too many chances and risks and 'freely' getting away with it. Mr C stated that the nurse constantly shakes, which could cause an accident on dialysis. He suggested that she should be moved before she hurt a patient. Mr C said that he complained of chest pains and the nurse said 'oh well' and walked away. He alleged that when she took Mr C off dialysis she removed the needle, which was covered in blood, and put it very close to Mr C's face on his chest. Mr C was very depressed and upset as a result of the incident and couldn't sleep that night. Mr C believed the nurse was 'sick' and required professional help.
The Board's Response	Not upheld. The Board responded that Mr C's complaint of chest pain was looked into and observations were taken, which were within normal limits. This was discussed with a doctor who decided Mr C was fine and fit to go home. The Board stated that none of the witness statements they had taken supported Mr C's allegation that a needle was placed on his chest. The Board

	stated that staff acted appropriately and that their investigation did not support Mr C's allegations.
5. 15.03.05	
Mr C's Complaint	Mr C complained that he told a security guard that, on advice of his lawyer, he would not be speaking to him. Mr C alleged that the security guard was very aggressive and pointed his finger at Mr C's face saying 'don't you speak to me'. Mr C said he was very shaken by the security officer's behaviour.
The Board's Response	Not upheld. The Board responded setting out the statement from the security guard, which contradicted Mr C's complaint. The Board said they considered that the member of staff complained about had acted appropriately and professionally.
6. 11.05.05	
Mr C's Complaint	Mr C complained that a support worker said the words of the Burns poem, 'Wee, sleekit, cow'rin, tim'rous beastie', to Mr C and then stared at him and smiled at him. Mr C said that minutes later another support worker told him to hang himself. Mr C said this happened all the time from these two workers who said words like 'beast' and 'pervert' to him. Mr C said he was being picked on and that being allowed to tape record his dialysis sessions would prove it.
The Board's Response	Not upheld. The Board responded that statements taken from the two support workers categorically denied Mr C's allegations. The Board said they considered that the members of staff complained about acted appropriately and professionally.

7. 23.05.05

Mr C's Complaint	Mr C complained about a support worker who allegedly woke Mr C up to offer him a sandwich. Mr C said he really needed his sleep and, given that it was so hard to sleep on dialysis, he felt it was not right that the support worker persisted in waking him up. Mr C believed that the support worker had 'got it in' for him, which was stupid because the support worker had so much more to lose. Mr C said that the support worker kept on taking chances which he didn't have to take. Mr C asked that the support worker be told to stop trying to impress female members of staff as it was pathetic.
The Board's Response	Not upheld. The Board responded that the support worker had offered him a sandwich in good faith. They said the support worker had observed another support worker offering Mr C a fan a few moments earlier, and he did not realise that Mr C had fallen asleep in the meantime. The Board said they were satisfied that the support worker had acted appropriately and professionally.

8. 01.07.05

Mr C's Complaint	Mr C complained about a security guard, who started a conversation with Mr C. Mr C stated that conversations were always about rape and rapists, which was very upsetting for him.
The Board's Response	Not upheld. The Board responded that the security guard denied that a conversation took place and, as there were no other witnesses, they were unable to take the matter further. They said they had advised the security guard not to engage in any general conversation in future.

9. 11.07.05

Mr C's Complaint	Mr C complained that he had asked a nurse, after giving blood back following dialysis, why it took only ten seconds rather than the usual two minutes. He said the nurse also took Mr C off dialysis 12 minutes earlier that he was supposed to come off. Mr C stated that another nurse told him he should have got his blood back slower because it could damage veins. Mr C then asked to speak with the police, as he became very suspicious of the nurse, but instead spoke to the manager who then spoke with the nurse. Mr C alleged that the nurse returned to the unit laughing and smiling and putting on loud music. Mr C said the nurse always played loud music. Mr C said he was afraid that he was slowly being murdered and that management were turning a blind eye.
The Board's Response	Not upheld. The Board responded that it was documented that Mr C received full dialysis. They said that it was not technically possible to give blood back in ten seconds and that a well established procedure was used to give Mr C his blood back. The Board said that CD players were there for patients, and staff had been told to ensure that volume is kept at a minimal acceptable level. The Board apologised if the volume was disturbing Mr C. The Board concluded that they were satisfied that staff acted appropriately and that management were not turning a 'blind eye'. The Board stated they took all complaints seriously and that if Mr C had any evidence that they had not considered he should provide it.

10. 08.08.05

Mr C's Complaint	Mr C complained that a nurse gave Mr C his blood back at a pump speed of 250. Mr C heard another nurse telling her that there was a problem with Mr C's drugs and that he had been given the wrong dose. Mr C said

	he was scared that every time that nurse was on dialysis something did not seem right.
The Board's Response	Not upheld. The Board responded that staff acted appropriately and that their investigation had shown that no mistreatment of Mr C occurred in relation to his dialysis care. The Board stated that the nurse in question was one of the most experienced in the dialysis unit and that Mr C's blood results testify to the fact that he was receiving excellent dialysis.
11. 17.08.05 Mr C's Complaint	Mr C complained that a nurse used a tourniquet on Mr C's arm and then went away for her break. Mr C said that when she returned she said it had not been very tight but Mr C disagreed and believed that it was extremely careless of the nurse. He said he wanted a written apology.
The Board's Response	Partially upheld. The Board responded that both the nurse that put the tourniquet on Mr C and the nurse who removed the tourniquet said it was in situ but slack. They said that one nurse went away when Mr C requested oral medication. They said that the nurse had been reminded to remove tourniquets following cannulation and the Board apologised for any distress caused.
12. 07.09.05 Mr C's Complaint	Mr C complained that a nurse left a tray full of needles right next to Mr C, even though she was aware of his needle phobia. Mr C said that he wanted action to be taken against the nurse.

The Board's Response	Not upheld. The Board responded that a nurse was called away due to an urgent request and the nurse was unable to discard needles she had used to commence dialysis. The Board said that the incident was regrettable given Mr C's documented phobia of needles but unavoidable given the clinical commitments of the nurse.
13. 16.09.05 Mr C's Complaint	Mr C complained about the nurse giving dialysis with a pump speed of 295. Mr C said that was the speed for a single needle but that he had two. Mr C said the nurse changed the pump speed to 220 but by then the blood had already been given back. Mr C felt he had to let the public know about what was happening in the hospital as it was disgraceful. Mr C said he would be taking legal action.
The Board's Response	Not upheld. The Board responded that Mr C was given the appropriate prescribed treatment by a trained nurse and clinical support worker.
14. 16.09.05 Mr C's Complaint	Mr C complained that he gave a nurse four pounds to buy him a TV card, but she told him the machine was broken. Mr C was subsequently informed by Patientline that the machine was not broken. Mr C said he was upset that he kept on being treated differently to other patients.
The Board's Response	Not upheld. The Board responded that the nurse was busy with clinical duties and did not have time to get Mr C a TV card. They pointed out that Mr C had been told to buy

	TV cards before dialysis and reminded him that the Patientline machine was situated at the entrance to dialysis.
15. 26.09.05	
Mr C's Complaint	Mr C complained that blue needles rather than green needles were used for dialysis. Mr C believed that was a careless mistake.
The Board's Response	Not upheld. The Board responded that the colour of the dialysis needles made no difference to Mr C's prescribed treatment.
16. 02.12.05	
Mr C's Complaint	Mr C complained that a manager aggressively shouted at him saying that he should take his hat off until he got outside. Mr C said the manager was constantly harassing Mr C when on dialysis and made mistakes and covered up important things. Mr C believed that the manager had done her best to destroy Mr C's life. Mr C said she wanted revenge. Mr C wanted an investigation into all the manager's affairs and decisions.
The Board's Response	Not upheld. The Board responded that the incident referred to, was when Mr C was being served with an Interim Interdict witnessed by four people, the manager, the messenger at arms and two security officers. They said Mr C was asked to remove his hat for identification purposes. The Board said that the messenger at arms confirmed that was part of the procedure of serving an interim interdict.
17. 13.12.05	
Mr C's Complaint	Mr C complained that when he dropped his pillow on the floor and asked a support worker if he could have it

	back, the support worker did not change the pillow case. This upset Mr C due to risk of infections in hospitals. Mr C said that the support worker also hung a teddy bear close to Mr C on the wall and used the word 'hang' three times. Mr C said that the support worker was constantly, when walking past Mr C, saying the words 'not long now'. Mr C said he was not comfortable with this 'sick' behaviour.
The Board's Response	Not upheld. The Board responded by stating that the teddy bear alleged to be being hanged was in fact a soft toy in the form of a reindeer which kept falling off the Christmas tree. They said the support worker was trying to hang it back on the Christmas Tree. The Board said that the support worker did say 'not long now', in the context of Christmas approaching. The Board said that their Infection control policies were adhered to strictly.
18. 18.01.06 Mr C's Complaint	Mr C complained that the nurse put a needle box next to him and, when he asked what was in it, she told Mr C it was lots of bloody needles. Mr C said that freaked him out. Mr C complained to someone else and the box was removed. The nurse then called Mr C a troublemaker and 'jokingly' threatened to hit him over the head with a kidney tube from the machine. Mr C believed that behaviour was not acceptable.
The Board's Response	Not upheld. The Board responded that members of staff identified acted in an appropriate manner. They said there were numerous sharps boxes within the unit to ensure safe practice. They said that when Mr C asked the box had been taken away. The Board said this was all documented in Mr C's dialysis file.

19. 18.01.06

Mr C's Complaint	Mr C complained that a security guard was using patients' toilets. Mr C said there was only one toilet and it should be for patients. Mr C suggested that the security guard use a toilet 20 seconds away from the dialysis unit.
The Board's Response	Not upheld. The Board responded that the security guard was entitled to use the toilet facilities within the unit when he was working there to protect patients and staff. The Board said that the security guard did not inconvenience anyone.

20. 10.02.06

Mr C's Complaint	Mr C complained that someone who was 'supposed to be' a nurse stood next to him and shouted 'I've nothing to hide'. Mr C believed that the nurse was causing trouble and hoping that he would retaliate.
The Board's Response	Not upheld. The Board responded that the nurse acted professionally and their investigation did not support allegation.

21. 22.02.06

Mr C's Complaint	Mr C complained that a patient with MRSA came to speak with him while on dialysis.
The Board's Response	Not upheld. The Board responded that an MRSA patient did speak with Mr C, but this did not endanger his health.

22. 23.03.06

Mr C's Complaint	Mr C complained that another patient collapsed and a

	support worker did not do anything. Mr C ended the complaint stating that the unit should be closed before 'these people kill someone'.
The Board's Response	Not upheld. The Board responded that their investigation found no evidence to support Mr C's allegation and reminded him that staff worked very hard to deliver care to their patients. The Board concluded that they now considered Mr C an unreasonably persistent complainer and, therefore, they were no longer required in law to respond to his comments.
23. 05.01.07	
Mr C's Complaint	Mr C complained about his security escort and the route taken, where he said everyone could stare at him. Mr C said that people said things like 'there's that beast' and 'pervert' when he passed them. Mr C believed that management were doing it on purpose to get a reaction out of him.
The Board's Response	The Board responded that Mr C's use of the complaints procedure had been deemed unacceptable. They acknowledged his complaint and that its contents had been reviewed.
24. 21.03.07	
Mr C's Complaint	Mr C complained about the wrong needles being used for his dialysis and problems with his potassium levels. This complaint was first sent to the SPSO and subsequently forwarded to the Board.
The Board's Response	Not upheld. The Board responded that his complaint had been fully

	investigated, but not upheld. They reminded Mr C that his complaints continued to be classed as unreasonable and demanding, which meant that the Board were no longer required to respond to communications made by Mr C. The Board said that any new correspondence would simply be reviewed by the Patient Liaison Adviser and acknowledged.
25. 03.04.07	
Mr C's Complaint	Mr C complained that a nurse tried to intimidate him by staring at him nine times in the space of ten minutes. Mr C said that everyone was always staring at him when he was there and that a normal hospital would not allow that. Mr C believed that the nurse was trying to get Mr C to lose his temper. Mr C believed he was being psychologically affected by being put in a small, hot room facing a window through which many people could stare. Mr C said he had nightmares about people staring at him.
The Board's Response	The Board responded that they considered Mr C's use of the complaints procedure to be unacceptable. They acknowledged the complaint and that it had been reviewed.
26. 25.04.07	
Mr C's Complaint	Mr C complained that a nurse put the wrong coloured needles in his fistula and that another nurse forgot to take Mr C's bloods. Mr C said that a security guard took Mr C's phone out his pocket while on dialysis, which he had no right to do. Mr C said he had to wait 12 minutes after pressing his alarm bell and complaining of chest pains.
The Board's Response	The Board responded that they considered Mr C's use of the complaints procedure to be unacceptable. They acknowledged the complaint and that it had been reviewed.

27. 09.05.07

Mr C's Complaint	Mr C complained that a security guard stared at him for four hours. Mr C said he was affected psychologically by this and angered more than he could possibly contemplate. Mr C asked someone to do something and for the message 'leave me alone' to be passed on to those concerned, if not 'let this be on your head'.
The Board's Response	The Board responded that they considered Mr C's use of the complaints procedure to be unacceptable. They acknowledged the complaint and that it had been reviewed.