A Whistleblowing Exercise

In my view, and it is a view widely acknowledged, numerous service users raise grievances about inadequate provision in the delivery of Health and Social Care services.

As this case demonstrates, service users with genuine grievances about service failures are unjustly treated like the problem.

The concerns of service users should not be dismissed because managers are more interested in suppressing trouble and protecting reputations, more than they are in delivering the safe, open culture that they are meant to have signed up to. This evasion serves only to intensify problems.

One key example is where I unwittingly repeated comments made by an ethical medic to a Senior Professional. I was told that "whatever happened, she didn't acquire those injuries through a guided fall". The professional I repeated these comments to looked alarmed. These comments contravened cultural practices. That person abruptly ended the conversation and ran to their office to address this revelation.

Policies guide services to listen to the concerns of patients, families and even staff, while following good governance procedures. But many of the policies to protect service users are just lip service in a lot of places. The statutory system needs to be a reality not just a tick-box exercise. Every department needs to make sure that the systems which should be in place are really in place.

It all provides an appalling reminder of a culture of denial, evasion and an engineered narrative which persists today in some parts of our Health and Social Care system.

Service users should feel confident that problems and incidents will be followed by ethical procedures and a prompt, honest response.

The need for Greater Public Scrutiny

Since this website and media articles were published, many comments have been received from people sympathising with the substandard care and injuries my late mother received. Numerous people have shared their own grievances.

I have explained to people that this website represents more than a narrative about one patient's journey. It is a case study carved from one patient's experience to reflect a litany of perceived inadequacies across our entire public services network.

This was a serious safeguarding issue. We were not listened to or taken seriously. The service was negligent in its service provision and in its handling of our complaints.

This exercise seeks to highlight the need for proper scrutiny arrangements when the service goes into an immediate state of denial and self-preservation. When service users are ignored and then conveniently portrayed as the problem members of the public need access to recourse.

There needs to be fundamental change in the culture and governance of health and social care institutions and it should start right now.

Due to this perceived culture of covering up failings the ultimate question has to be; who is independently regulating these public service organisations and what recourse do members of the public have when things go wrong?

Where there are problems delivering home care provided by the Council, members of the public have recourse via the Care Inspectorate which has the authority to independently inspect home care organisations.

But no similar independent scrutiny mechanism exists for the Council, Health Care and Social Work. While members of the public can escalate complaints to the Ombudsman, by contrast the Ombudsman's powers are limited (more on this later). As far as independent inspection is concerned, the Council, Health Care and Social Work effectively mark their own homework.

Executive Committees only generally see what these public organisations want it to see. What mechanism is independently investigating these public service organisations and drilling down to test the accuracy and veracity of that information?

Examples:

Dundee City Council

- There is the example of my extensive correspondence with Dundee City Council. I asked the Council to recognise my mother's injuries and disabilities. I requested access arrangements for emergency and disabled vehicles. Despite the rights conferred by the Equality Act, the same Government agency that caused her serious injuries is the same Government agency that refused to provide a solution in managing those injuries.

  In the face of such negligence, what recourse is available to members of the public?

Scottish Public Services Ombudsman (SPSO)

- There is the example of the matter being escalated to the SPSO. The Council argued their case robustly citing general traffic regulations and the finer feelings of neighbours. The SPSO replied that it did not have the authority to overturn a Council's decision. The SPSO said it could only consider the fairness of the complaints procedure. The SPSO supported the Council's position and concluded that the process and their response had been fair and reasonable. The SPSO closed the case. In my view this seemed like a perverse decision. It seemed incredible that, at the very least the SPSO wouldn't refer the Council to their policies and the Equality Act or, make recommendations about the how the matter might be resolved. Then again, the SPSO stated that the Council's original suggestion of obtaining planning permission and making major alterations while paying for this work privately was a reasonable proposal. It is also perplexing why the Council originally directed our complaint to the SPSO, if the SPSO did not have the power to adjudicate in this matter or overturn the council's decision. However, it has to be acknowledged that at the appeals stage the SPSO did share best practice guidance with the Council about complaints handling.

Scottish Public Services Ombudsman (SPSO) versus the Care Inspectorate

- Some public references are made referring to the SPSO as the regulatory body for public services in Scotland. However, this is incorrect. The SPSOs role is in part, to publish complaints handling procedures and monitor and support best practice in complaints handling. The SPSO states "Organisations do not have to comply with the SPSO's recommendations and are not bound by the law to do so". Given the SPSO's lack of teeth, if the Care Inspectorate is the scrutiny body for care services in Scotland, why is there no organisation with similar powers of inspection for the Council, the NHS and Social Work? After all, following the denial of an investigation by social care, what were the CI's findings? This would suggest that all public services need an inspection mechanism.

- There is the example whereby, following two years of correspondence about disabled access and after the Council had denied this request, the SPSO closed the case. We waited a year for the SPSO to tell us it had no authority to investigate our complaint or alter the outcome. So why had the Council referred us to the SPSO? It represented an exercise in futility and a complete waste of time and effort. Once my mother died, the Council installed a disabled parking bay. This u-turn clearly contradicts every objection made by Dundee City Council. It brings the Council's motivation and behaviour into question. It makes a mockery of the Council's argument, the SPSO's findings, and the entire public services complaints network. I alerted the SPSO to the Council's confounding u-turn and asked the SPSO to review the matter and demand an explanation. The SPSO refused to review the matter.

  Given the response received, how does the SPSO represent a legitimate form of recourse?

Social Work

- There is the example of my request for an investigation which was denied. I wrote to Dundee Health and Social Care Partnership requesting a summary investigation of her substandard care and injuries. Social Care refused to open an investigation and referred me to the SPSO. In their view they had already considered these matters. That wasn't my view. Social Care requested additional evidence to warrant an investigation. In my view they only wanted to find out what evidence I held. Nevertheless, I submitted this. Instead of opening an investigation the Council thanked me for my submission, said they had read it and they hoped this provided assurance. Social Care then ignored all future correspondence.

  The disabled parking example underlines the SPSO's stated inability to investigate Public Services. Therefore, if a Council unilaterally denies a request for investigation, why is there no alternative investigative mechanism?

Dundee Council Home Care

- Following their denial to conduct an investigation I contacted the Care Inspectorate (CI). The CI has a remit to investigate Home Care services but not Health Care or Social Work. The CI upheld my complaint. The Council appealed. The CI reviewed the matter and upheld my complaint again. Although originally denying an investigation, the Council subsequently developed an improvement plan. Social Work and Health Care however apparently remains immune to independent inspection and Social Care Response evaded exposure.

  When there are perceived attempts to bury a complaint, what does this example suggest about the benefits of providing the public with access to an independent investigative mechanism?

NHS Investigation

- There is the example of the NHS dragging its heels over the investigation conducted by Dundee Health and Social Care Partnership. After a month they suggested I could escalate the matter to the SPSO instead. Given they hadn't yet opened an investigation and given the SPSO has no powers to investigate; to what end exactly? In my view this was clearly another evasive tactic. Did DHSCP think perhaps that the SPSO would bury the complaint for them and save them the effort? More concerning is why, in the face of multiple serious injuries confining a patient to bed, they didn't feel duty bound to investigate and to learn from this negligence. Instead they apparently attempted to wriggle out of an investigation. More concerning is why our public services seem to have faith in the SPSO and why the SPSO in my view, seems to defer to public services organisations. As the SPSO stated that it does not have investigatory powers I declined. I replied that I wanted the NHS to investigate the matter and provide answers since the SPSO cannot. The NHS must surely be aware of this, so why is the Council and the NHS referring a complaint to an organisation without the remit to investigate a complaint? I am advised that the NHS investigation didn't start until six months after the original submission; evidently with no sense of urgency. DHSCP took a year to respond to the initial complaint. The majority of my complaint was cited as being out of timescales. The parts they were duty bound to respond to produced scant response full of inaccuracies, evasion and excuses. No answers or apology were provided. A nasty unconscionable business.

  Why do public service organisations seem to have faith in passing matters to the SPSO?

  Similar to the way in which the Care Inspectorate independently investigates care services, would it not make sense to establish a mechanism that independently investigates Council's, Health Services and social work?

Adult Support and Protection

- There is the example whereby, in their scant response, DHSCP referred to my assertion that an Adult Support and Protection referral was repeatedly ignored by Health Care and Social Care. They claimed they could find no record of my attempts to make this referral. Again it seems they wanted to know what evidence I held. I was asked to provide further details and told they would investigate this matter. I duly provided the requested evidence – referring to both written and telephone evidence. Once again, the service failed to respond which provides another example of their default position when faced with evidence of service failures; even when there is a legal obligation which seems to be a habit across the service.

- There is the example whereby we made multiple requests for a copy of the ASP report which social work were very tetchy about. While initially promised upon completion, ultimately we were told social work couldn't share this with us because the referral had been made by the Care Inspectorate. I am advised this statement was not accurate. The Care Inspectorate made the referral because health and social care ignored our repeated referrals. We were referred to the Care Inspectorate for a copy of the alleged report. But the Care Inspectorate received no such report. Many months later, when Social Care appealed the CI's findings a report suddenly reared its ugly head. I remain sceptical about many aspects of this report.

How can our public services disregard ASP referrals?

What recourse is available to people in the face of this perceived negligence?

How far does this situation go in explaining the series of safeguarding failures regularly reported?

Contrary to Public Partnership policies and statutory procedures for managing all these matters; why are public service organisations able to deny investigations, fail in their duty to investigate incident reports properly, without independent scrutiny?

How can these services unconscionably and brazenly disregard serious incidents by failing to meet with and inform family members of the results of an investigation without proper scrutiny and without detection?

Scottish Government

- All these behaviours would suggest adequate Governance, quality assurance and independent inspection arrangements do not exist as they should. As these examples provide they are badly required. It would all suggest a distinct credibility gap which is a high risk for any public service organisation.

- There is sadly a long history of similar examples. But these are not just local problems. These problems are widely acknowledged at a National level.

- Learning and improvement starts with proper independent examination.

- In this particular case, there was a perceived failure to act on warnings that could have prevented many incidents. Given the resistance to investigate all these incidents properly what mechanism exists to forensically examine the failings of the people and processes involved?

- Serious reforms are required. The nature of such reform should be a cultural shift that fiercely encourages and values the act of raising concerns. This should be one that deals harshly with executives and organisations that evade their responsibilities to service users. Only an independent inspectorate can achieve such necessary change.

- The Scottish Government has recently introduced joint inspections of Adult Support and Protection. These joint inspections are led by the Care Inspectorate in partnership with Healthcare Improvement Scotland and Her Majesty's Inspectorate of Constabulary in Scotland.

- It is suggested there is plenty evidence to suggest that similar joint inspections need to be applied more broadly across the NHS, the Council and Social Work.

- This case for a review of the independent scrutiny mechanisms inspecting our public services has been submitted to the Scottish Government for review.