The Response to my complaint From Social Care

Anonymised to protect individuals' identities

"The fact of the matter is that health care and social care services failed to provide safe care and treatment, exacerbated by staff incompetence. Services were repeatedly warned of dangers lurking. There is no incident in my view that couldn't have been prevented. It is reprehensible that HSC continually put her at significant risk of avoidable harm. We can only hope that this report falls into the correct hands and provides a much needed jolt to prioritise patient safety across both departments resulting in meaningful change.

To my mind, systemic failings caused or more than minimally contributed to these incidents and her injuries. Her situation and her suffering were contributed to by neglect and a gross failure to provide adequate basic care".

In September 2021 I submitted a detailed complaint to social care. I requested a summary investigation into to all incidents and injuries sustained, including the inadequate quality of care provision. I requested a copy of the ASP (safeguarding) report which has been promised on numerous occasions. I asked for a list of lessons to be learned and suggested outcomes.

In October 2021, I received an acknowledgement.

Later in October2021, I received a response from the Head of Service. Suddenly and conveniently mindful of HSC's statutory obligations to service users the letter claimed that social care was unable to provide the requested evidence of statutory records due to my "intention to publish this", although I stated no such intention. My intention was to encourage exposure of the fact that there is no evidence that all these statutory records exist because full investigations had not been held (if they had I would have been interviewed and copies of reports would have been held in the file kept at home – so that other workers could learn). Another reason given for denying this request was that there is no entitlement to this information once a person has died, as there is an ongoing duty of care to that person and they have to protect a person's right to confidentiality.

It's a sad state of affairs that social care is not equally mindful of their statutory obligations to a patient's safety and welfare while they remain alive. Perhaps then there would be far less incidents and perhaps we wouldn't be chasing records and encouraging reflection.

In response to my request for a summary investigation Social Care advised that this is not something they would do. They claimed they would look at these issues through the complaints procedure. They suggested these "appear" to be issues that have been looked into already further advising that I can contact the SPSO if I am not happy with their response. What is the SPSO to achieve if the answers remain within HSC?

I appealed this refusal to fully investigate the matters raised.

I received an email with a table listing earlier matters raised across 4 years. It was sparse and inaccurate. It served to support my view that record keeping is not HSC's strong point. The email also suggested that if I felt that there were matters that had not already been looked into I should provide more specific information.

This I did. As requested, I did provide more specific information. Whilst it was time intensive I created a very detailed, though user friendly spreadsheet covering the previous 4 years. I highlighted discrepancies in HSC's claims. I requested clarity over vague comments in a sparse table. I corrected erroneous entries. I listed the litany of matters which had not been investigated and were outstanding. I referred to emails providing supporting evidence. Specifically, a recurring question noted against most entries in the spreadsheet was "Where is the incident report and evidence of investigation?" Another key question was "There has never been any sign of documentation or evidence that the ASP was conducted as it should have been conducted according to the Adult Support and Protection Act. Where is the safeguarding report that should have been sent to the care inspectorate and why the resistance?"

HSC asked for more specific information and I provided it. A new response from Social Care stated that HSC had "reviewed the information provided" and hoped this provided the "necessary assurance" which, when you consider the amount of work that had been required, is a major insult.

I responded that it didn't. Originally, HSC refused to further investigate matters unless I could provide further information. Now faced with a ton of incontrovertible evidence, HSC's cursory response was to merely acknowledge my submission which was far from satisfactory.

In my view, this dismal response is not only woefully inadequate it is unconscionable if not a major procedural failing which serves to support my original assertion.

As stated, I escalated the matter to the Care Inspectorate, the independent regulator for care services in Scotland.

The Care Inspectorate conducted an investigation. My complaint was upheld. Social care appealed this decision and the investigation was reviewed. My complaint was upheld again although HSC has never explained what happened to the statutory ASP/safeguarding investigative report promised by her care manager and which has never materialised.

Ultimately a report from Social Care sent to my MP included a detailed action plan which was interesting and insightful.

Why was it necessary to escalate matters to the Care Inspectorate? What does this suggest about HSC's abilities to investigate itself?

When you consider the indignities, the injuries and the suffering my late mother endured, including the grotesque catalogue of failings, instead of pouring your energies into self-preservation HSC could have been a listening and learning organisation and prevented much of that suffering. This must surely be one key point of learning.

Social Care didn't contact me with its reflections or provide an apology for these pervasive institutional failings. The silver lining of this exercise is making inroads into a patient pathway littered with gaping craters. Hopefully this work helps to protect other service users from meeting a similar fate.
