Legal Claims Annual Report 2020-2021

NHS
East London
NHS Foundation Trust

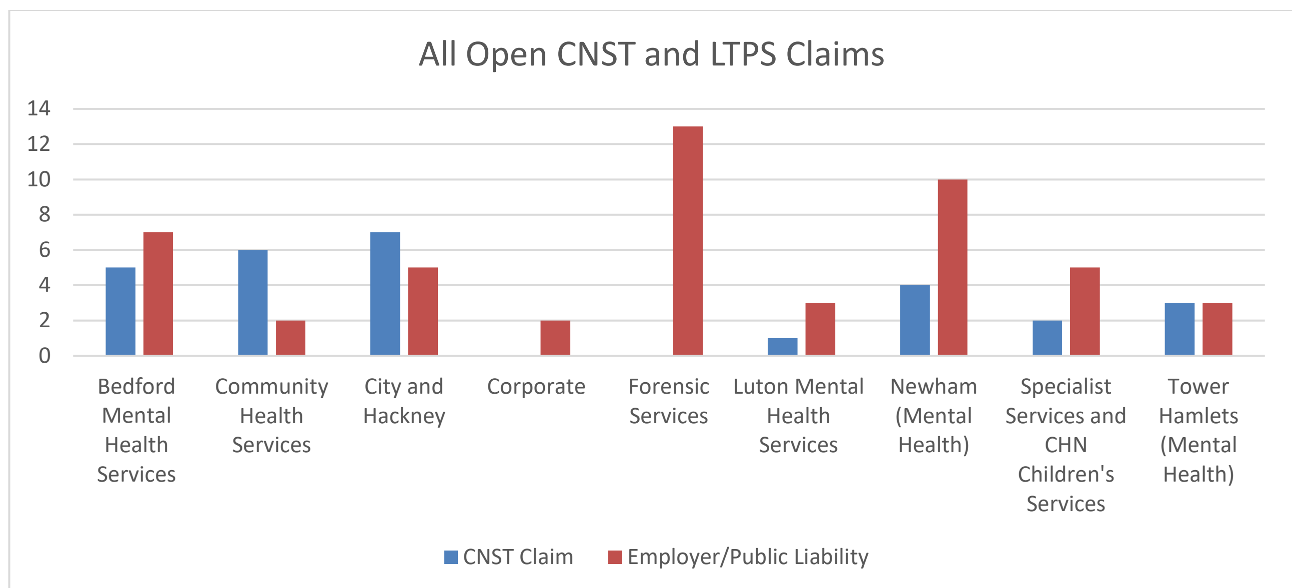
1.0 BACKGROUND

1.1 This report will focus on the claims activity under the Clinical Negligence (CNST) and Liability to Third Party (LTPS) schemes between 1st April 2020 and 31st March 2021.

2.0 CLAIMS OVERVIEW

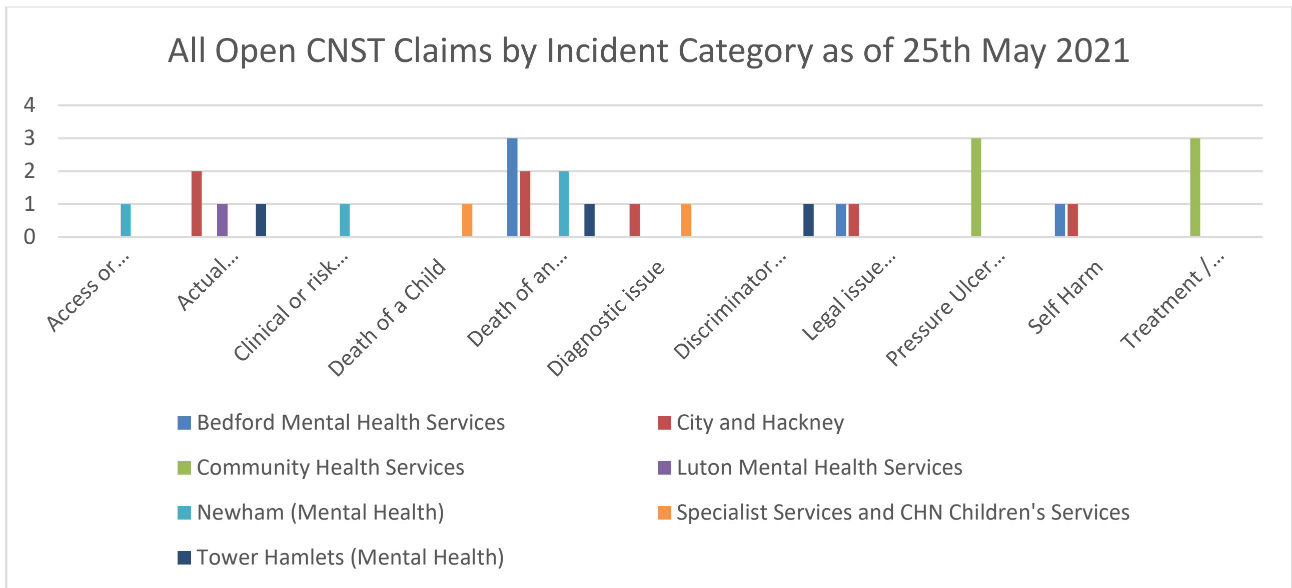
2.1 As noted above, this report focuses on claims activity between 1st April 2020 and 31st March 2021. However, to provide context this section will provide an overview on the number of claims currently open. There are currently 78 open claims across both schemes which divide into 28 CNST and 50 LTPS claims. This compares with 32 CNST claims and 39 LTPS claims in the previous 12 months.

2.2 The graph below shows the number of currently open claims, both clinical negligence and liability to third parties, split by Directorate.

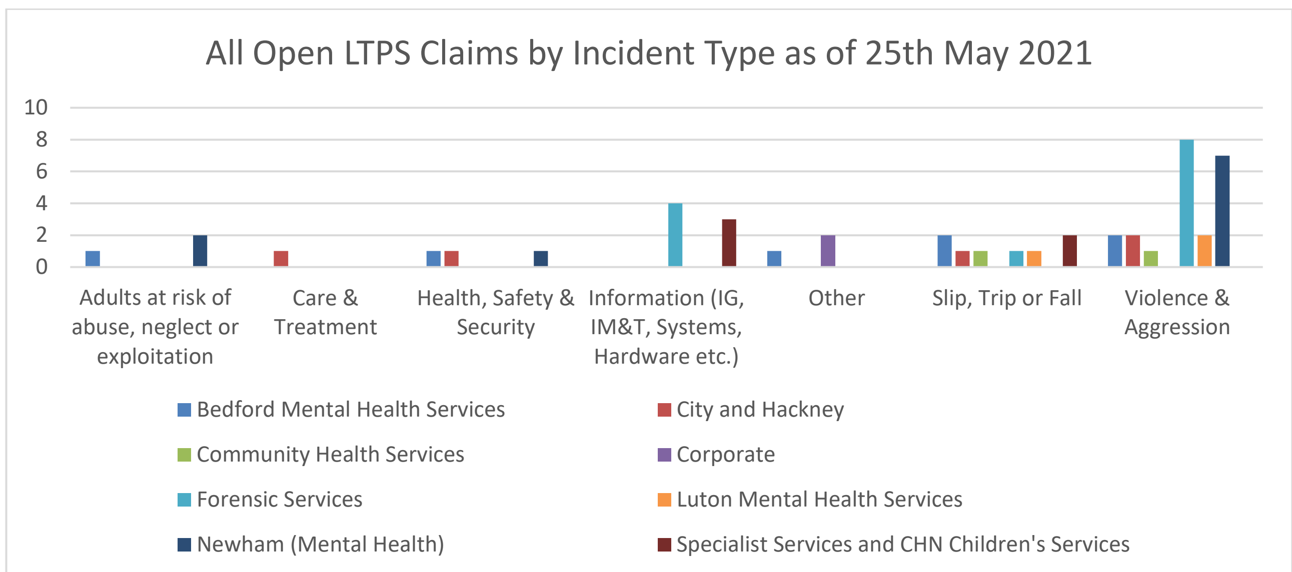


2.3 All claims are categorised on receipt based on the categorisation used in the recording of incidents

2.4 The graph below shows the number of all open CNST Claims as of 25th May 2021



2.5 The graph below shows the number of all open LTPS Claims as of 25th May 2021.

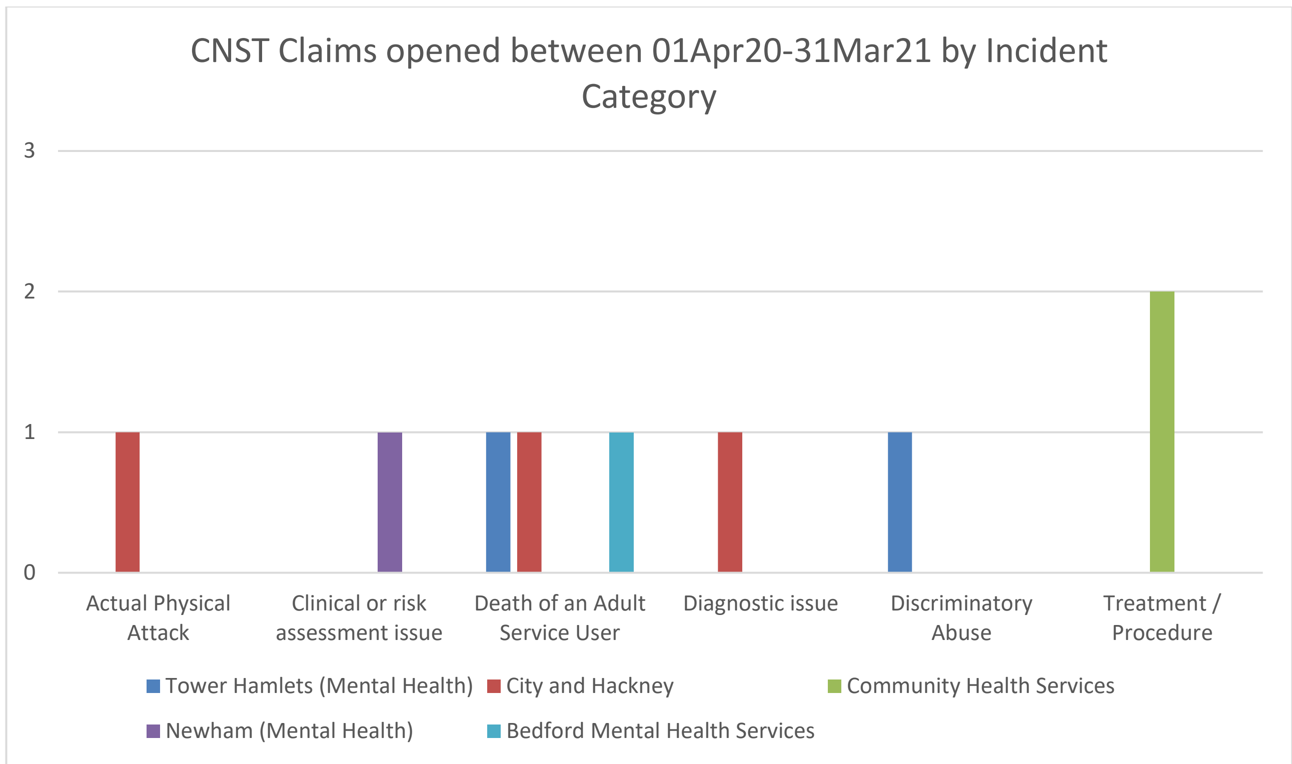


3.0 CLINICAL NEGLIGENCE (CNST)

3.1 CNST Claims received between 1st April 2020 and 31st March 2021

3.2 Between 1st April 2020 and 31st March 2021, 9 new CNST claims were received.

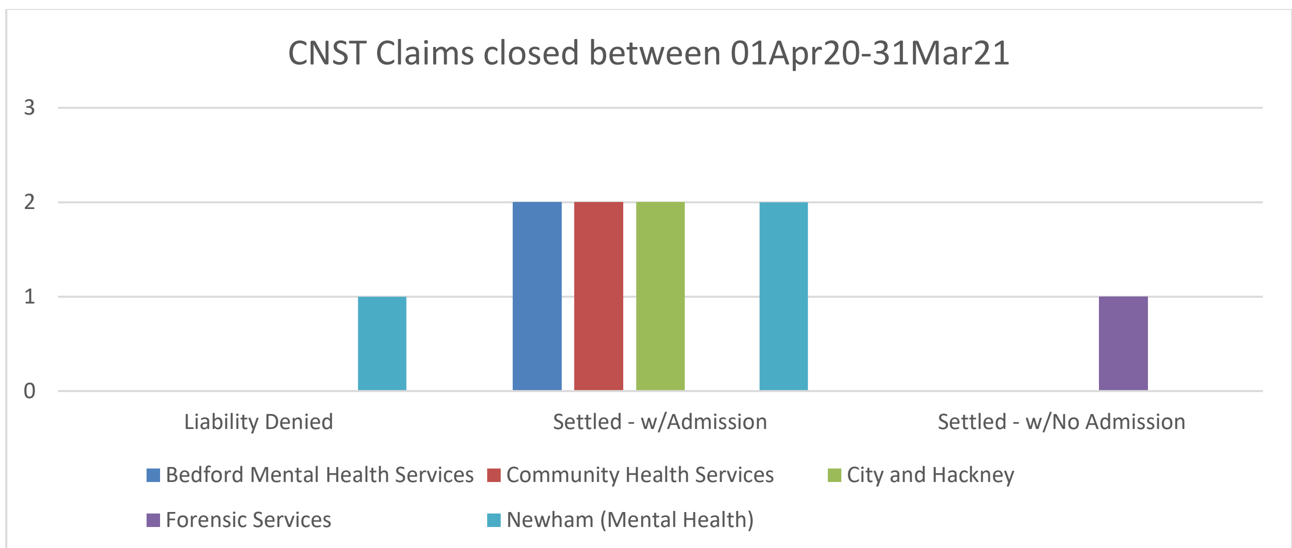
3.3 The graph below shows the number of claims received during this period broken down by incident category and Directorate.



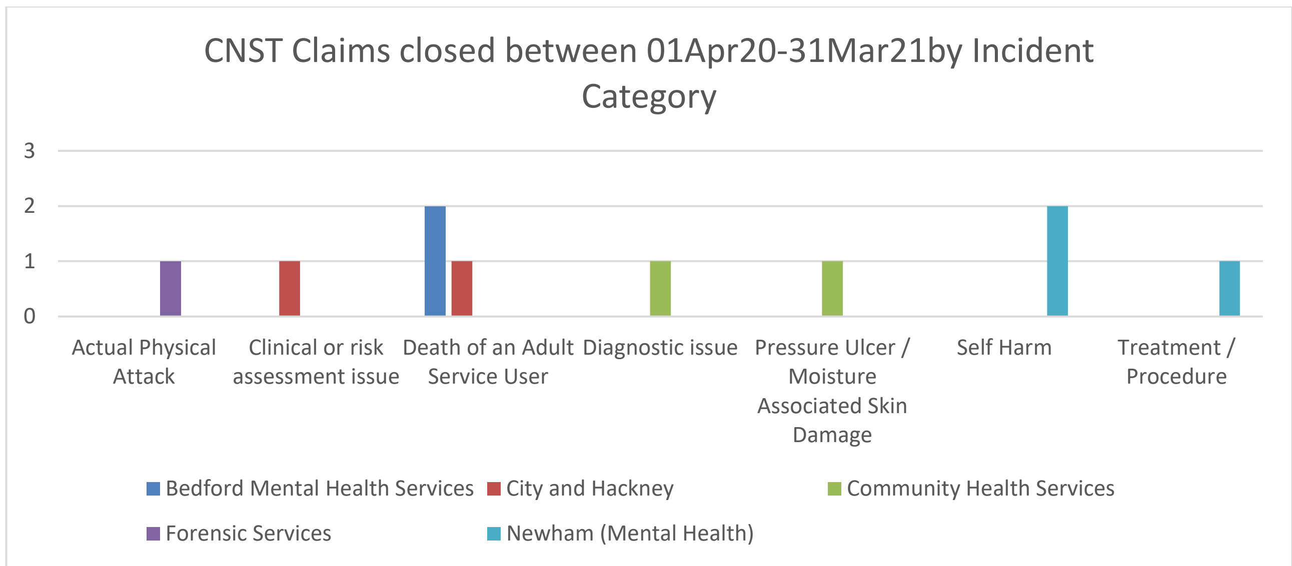
3.4 Outcome of CNST Claims closed between 1st April 2020 and 31st March 2021

3.5 Between 1st April 2020 and 31st March 2021, 10 claims were closed under the CNST scheme.

3.6 The graph below shows number of claims closed during this period broken down by outcome and Directorate.



3.7 The graph below shows the number of claims closed during this period broken down by incident category and Directorate.



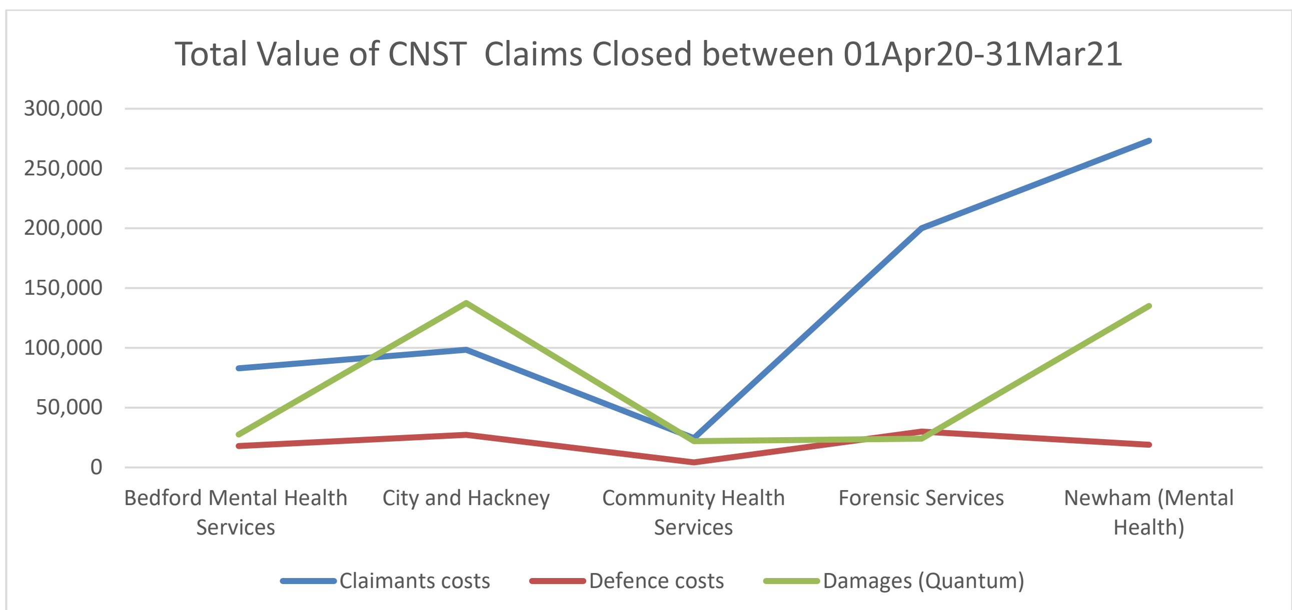
3.8 Of the eight claims that were settled with admission during this period, three related to death and the remaining five to care and treatment provided within the inpatient setting and in the community. The claim that was settled without admission relates to a service user attacking another service user. The Trust had intended to deny liability in this matter however the breach of duty risk and the potential risk that a Court will be persuaded by the Claimant that causation follows breach led to this matter being settled on best possible terms.

3.9 Total value of CNST claims closed between 1st April 2020 and 31st March 2021

3.10 All CNST claims have a nil excess.

3.11 The number and value of claims each year has an impact on the Trust's contribution to NHSR's CNST scheme the following year. The NHSR site states that *"individual member contribution levels are influenced by a range of factors, including the type of trust, the specialties it provides and the number of "whole time equivalent" clinical staff it employs. Claims history is also taken into account meaning that members with fewer, less costly claims pay less in contributions."*[1]

3.12 The graph below shows the total value of claims closed between 1st April 2020 and 31st March 2021.



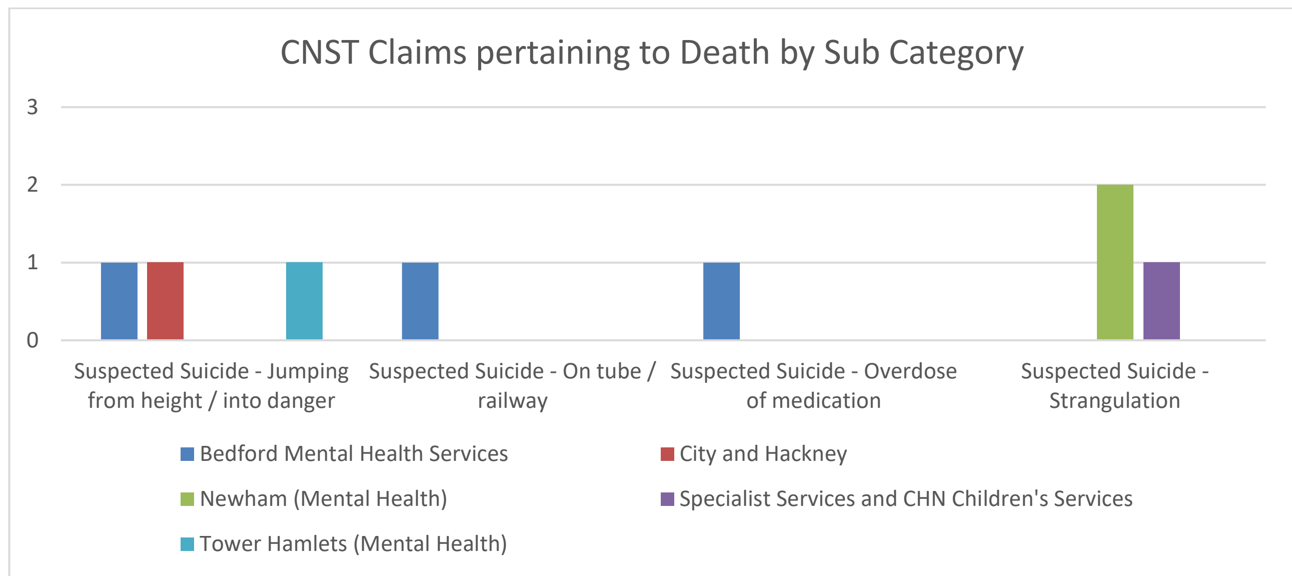
[1] https://resolution.nhs.uk/services/claims-management/clinical-schemes/clinical-negligence-scheme-for-trusts/

3.13 Qualitative information regarding CNST claims

3.14 For the purposes of this section the top categories have been taken from all open claims. This includes new claims received in 20/21. The top three sub categories of claims are: deaths, actual physical attacks and pressure ulcers. These categories are the same as of last year. More details are set out below.

3.15 Deaths

3.16 The graph below shows the number of claims relating to the death of a service user by sub category.



3.17 Of the 8 claims, we have admitted liability in three; denying liability in one case; and four are under investigation. All the deaths in these claims have been the subject of an inquest.

3.18 The first two cases concern deaths relating to inpatient admissions. The first concerns a 49 year' old lady who was admitted to Ruby Triage Ward at Newham Centre for Mental Health on 17.12.14 following an overdose of Diazapam. Whilst in triage she attempted an overdose with Citalopram; she was initially admitted informally, then detained. On 19.12.14, Ms W was found hanging in the shower (using her bra strap) at approximately 23.30 hours (she was under 15 minute observations), resuscitation was commenced/crash call. Paramedics attended approximately 23.45 hours and she was taken to Newham Hospital but was pronounced dead. The jury Inquest conclusion was: *"Hanging using ligature of bathroom suite on Friday 19 December. The time for this is between 23hours-23.30 hours and is imprecise due to lack of clarity and observation checks to which a failure in medical treatment contributed".* Our SI noted that there was lack of clarity in medical records regarding the Citalopram overdose and uncertainty as to whether or not all of the tablets were taken from Ms W when admitted. Whilst the medical records state that the Citalopram was handed into the nursing office following the overdose, Ms W's family state that the police informed them they found tablets on her person following death. The SI also states that a property list was not completed upon admission.

3.19 The second case relates to treatment provided on Newham Ruby Triage Ward in 2014. Two days before Mr X's death, he left the ward stating that he would be back in an hour. He never returned and was found hanging at his home following a welfare check. At inquest, the Coroner delivered a narrative conclusion. She stated that *"Mr X died from hanging. On*

13th August 2014 whilst an inpatient at the NCfMH he went AWOL and no adequate action was taken to ascertain his whereabouts. He was discharged in his absence. On 15th August 20214 he was found hanging at his home address. It is not possible to state when he died or whether a welfare check on 13th or 14th could have prevented his death." The omissions in this case included: the patient did not return to the ward from leave and he was not circulated as missing and no welfare check was completed; the patient was discharged in his absence having not been assessed by the early intervention team for support post discharge (having initially been recommended for intervention by the Home treatment team which was refused); and he did not have his prescribed medication. We have admitted liability in this case and the claimant has accepted our offer of £200k.

3.20 The next two claims centre on an alleged underestimation of patient risk to self. The first case concerned a 40 year' old man who died on 18.04.2020 after a fall from his fourth-floor bedroom, potentially linked to a first emergence of psychotic symptoms in the preceding 24 hours. Mr Y had no known history of mental health issues and his only contact with ELFT services was through crisis services on 17.04.20. On 17.04.20 at about 18.30 a GP family friend and Mr Y's flatmate contacted the Crisis line saying he was acting out of character; he had been using more cannabis than usual and earlier that day, he had been in a heightened agitated state, shouting and taken his clothes off. The Coroner in the inquest into Mr Y's death delivered a very long narrative conclusion, noting that Mr Y's injuries were too severe to allow his life to be saved. Our internal review concluded that the staff member's risk assessment identified that Mr Y was mentally unwell and needed to be urgently assessed, but underestimated the extent and immediacy of his potential risk in that she did not consider Mr Y needed to be seen within the most urgent timescale of 4 hours. Our review concluded that this the risk assessment was inappropriate because his presentation was very unusual for him, he had no known history, he had psychotic symptoms and at the time of the call was mute and uncommunicative. The very absence of known risks and his unpredictability made him high risk. We are likely to admit liability in this case; Mr Y was an established musician with a child and estimated damages are currently 150k damages.

3.21 The second case concerns a man in his 40s who attended the Emergency Department of the Royal London Hospital on the 26th August 2019 at 15:29hrs. He was seen by a band 7 Psychiatric Liaison Nurse (in the ED at the RLH and discussed with but not seen by an ST6 in psychiatry). The nurse's impression was that Mr Z was suffering from: 'anxiety; panic attacks with some depressive symptoms and morbid jealousy. No psychotic symptoms elicited or reported.' The nurse and the ST6 made a plan to refer Mr Z to the psychiatric home treatment team but Mr Z declined this intervention. Instead, Mr Y was given PRN Lorazepam; he was also given a prescription for Risperidone and if in crisis, to call the Crisis Line. Mr Z died a few weeks after his presentation to A&E after he jumped onto a train track. At inquest the Coroner concluded that Mr Z's death as a suicide. Our internal review noted in particular that the (possibly fluctuating) psychotic nature of this presentation was not necessarily fully appreciated by our team at the time he presented to ED. The strong belief that his wife was unfaithful, the idea that his wife was monitoring him with hidden cameras at home, the family history of schizophrenia and the anxiety/sleeplessness are all features picked up in the nurse's detailed entry that in the opinion of the reviewer most likely suggested psychosis. This claim is currently under investigation. We are currently denying liability on the basis of our expert's report which concludes that psychosis was considered and that the treatment plan was appropriate for his symptoms including those of morbid jealousy or psychosis grounds. However, if our position changes or we lose this case, the damages are likely to be substantial because My Z was a senior and

successful lawyer with a wife and two young children. (The maximum potential damages in this claim has been estimated at £2,000.000).

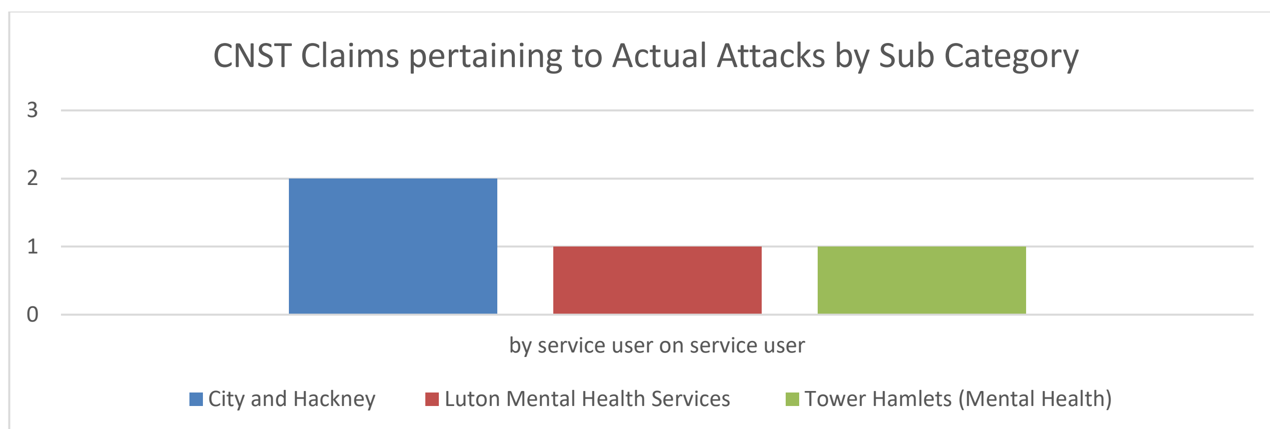
3.22 Non death CNST High Value Claim

3.23 While the claims above are specifically linked to deaths, we need to bring to your attention a further potential high value claim. This concerns a claimant who was born with Mosaic Down Syndrome, a complex variant of Down syndrome. The claim is that there was a delay in treating PTSD following a sexual assault at school by a fellow school boy in April 2009 allegedly causing life-long additional behavioural problems and the need for additional care. We have admitted liability insofar as there being a delay in diagnosing his PTSD, but the issue of lifelong behavioural problems is still being investigation by several experts. The maximum potential cost of this claim has been estimated at 2,740,000.

3.24 In all these cases, internal investigations have been completed with recommendations and action plans so learning can be identified and disseminated.

3.25 Actual Physical Attacks

3.26 The graph below shows the number of claims pertaining to actual physical attacks by sub category

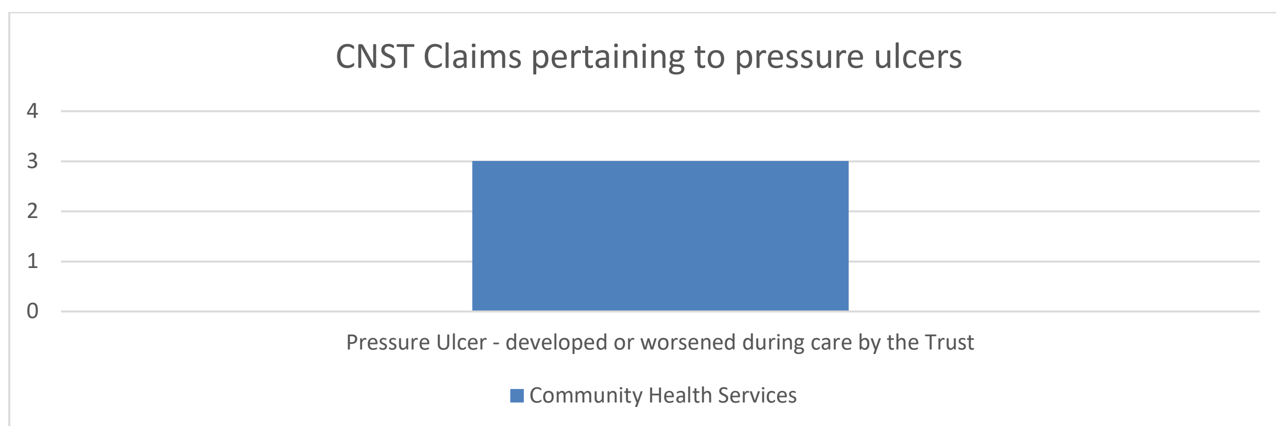


3.27 These claims concern service user attacks on other service users. We have admitted liability in all four claims. Failings identified include: not holding a patient in low level restraints or cutting off his means of escape (following his attack on one service user) which meant he was able to break away and seriously injure a different service user; and there being no evidence of service user's/perpetrator's care plan and risk assessment being updated on return to the Ward after him going AWOL for 3 weeks. In one of these cases, an inpatient (in Tower Hamlets) was grievously injured by another service user and passed

away with his injuries in hospital. We have established that the Trust would fail to defend this matter if this went to trial due to the following breaches: failure to conduct any or adequate risk assessment of service user who injured deceased (service user X) when he became unwell in April 2010 and admitted; failure to put proper care plan in place for service user X once admitted; service user X being placed on general observations was a significant failure; staff failed to make significant attempts to investigate and manage service user's X intimidation of the deceased; failure of staff to take any action when service user X attacked the deceased 2 days before the serious incident that led to his death or to make any change in care plan for service user X/ no incident form completed. The maximum damages in this claim has been estimated at £275,000 (exclusive of costs).

3.28 Pressure Ulcers

3.29 The graph below shows the number of claims pertaining to pressure ulcers by sub category.



3.30 The first case concerns nursing care following a surgical procedure for broken a broken femur. The patient in question was transferred from an Acute Hospital to East Ham Care Centre for aftercare with a post-surgical sock between January and February 2018. It is reported that the patient left the Acute Hospital with no pressure ulcers. It has been established that Grade 4 pressure ulcer developed on the patient's heel whilst on Fothergill ward. In particular, there was inadequate skin assessment as stockings were not removed for 10 days despite the family asking staff to remove them. We have agreed that, but for, the above breach of duty the patient would have avoided the Grade 4 pressure ulcer to his left heel and approximately 6 months' recovery. The maximum damages have been estimated at £92,000.

3.31 In the second case, we have found that the nursing care provided to the patient in respect of his sacral pressure ulcer in February 2014 fell sufficiently below the standard to be reasonably expected so as to constitute a breach of duty. In respect of causation, the patient had significant pre-existing co-morbidities which increased the risk of developing pressure sores in any event. However, notwithstanding this, we have accepted that the admitted breach of duty led to a worsening of the pressure sores. In particular, we found: incomplete patient's notes; failure to adequately monitor ulcer and document findings; insufficient assessment and care planning; assessment form not, SSKIN Bundle pressure ulcer prevention and wound care plan was not completed; roles and responsibilities not clearly defined as staff made assumptions that the assessment forms and care plans would be completed by somebody else; and no referral to TVN was made despite the fact that the pressure ulcer deteriorated to grade 3. The maximum damages have been estimated at £43,000.

3.32 The final claim concerns an alleged failure to adequately treat the deceased's left heel pressure ulcer between 22 September 2016 and 19 April 2017. We have identified no failings in care and we have therefore denied liability.

3.33 Qualitative information regarding closed CNST claims brought against the Trust

3.34 We have closed 10 cases. We have admitted liability or settled without admission in 9 of these cases. The total cost of these claims range from approximately £5,000 to £400,000 (with the latter relating to a long standing claim about a service user with a history of absconding from the ward and during his last absconding from the ward, he purchased a pair of scissors from a local shop and had cut off his penis. He had also attempted to cut off his testicles).

3.35 With regards to the claims relating to mental health, issues arising included: communication difficulties between Ward and care-co-ordinator (with the latter not able to effectively contribute to ward rounds); lack of documentation of conversation with family in records; family were not consulted about discharge plan; the discharge plan should have included CRHTT monitoring his medication; risk assessment by CRHTT after discharge by CRHTT (nil risk) not consistent with presentation on Ward; a service user going AWOL from the ward 3 days after his admission, escaping through the airlock and jumping to his death; no physical examination completed on admission, blood tests and ECG were requested but not undertaken, and seclusion physical monitoring reviews were not undertaken.

3.36 With regards to the claims relating to community nursing care/physical health, issues arising included: failure to undertake an x-ray of a triplane fracture; failure in care provided by district nursing teams of sacral pressure sores in particular, failure to: provide or to implement a robust preventative pressure ulcer care plan in a timely manner; consider the co-morbidities of the patient and the risk of the patient and the increased risk of developing pressure ulcer; to provide, and/or instruct on regular repositioning for the patient in a timely manner; or to check all pressure areas regularly and consistently.

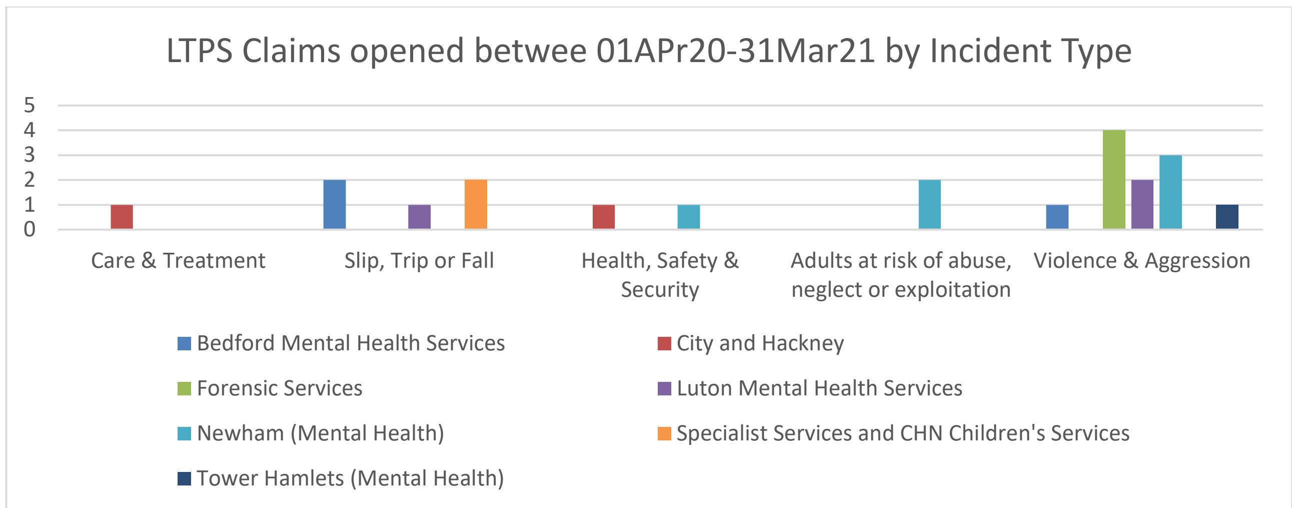
3.37 We have also had a claim from a member of staff who complained of nerve pain following receipt of the flu jab. The Director of Nursing for Mental Health explained that the injury alleged by the claimant is a rare, known risk and is highly likely due to an incorrect injection site. That being the case, the Trust believes that it would be difficult to reject the claim and, following receipt of medical evidence, we are settling this claim.

4.0 EMPLOYER LIABILITY AND LIABILITY TO THIRD PARTIES (LTPS)

4.1 LTPS claims received between 1st April 2020 and 31st March 2021.

4.2 Between 1st April 2020 and 31st March 2021, 21 claims were received under the LTPS scheme.

4.3 The graph below shows number of claims received during this period broken down by type and Directorate

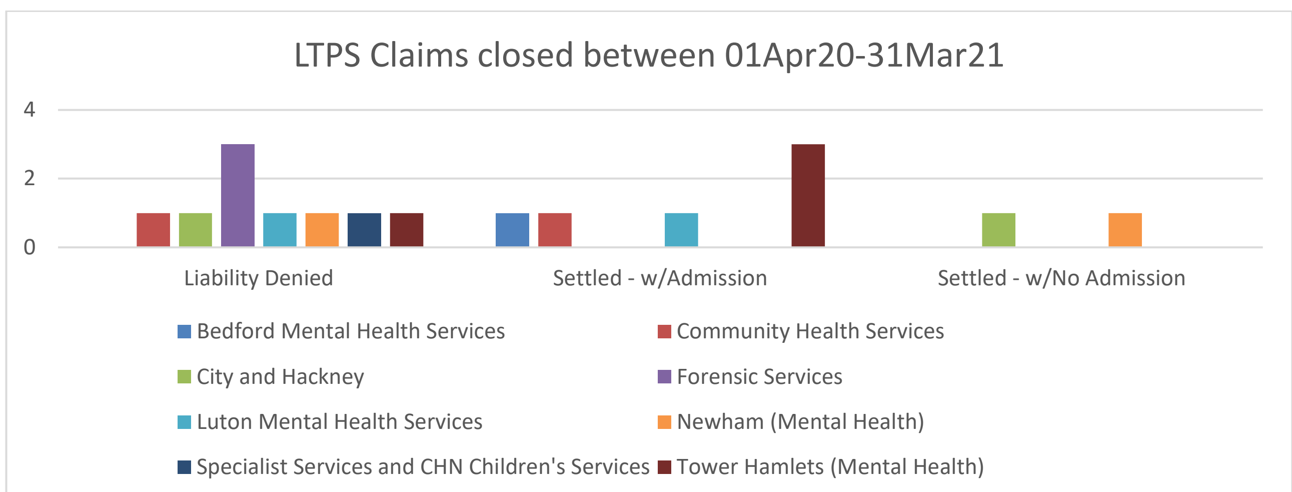


4.4 The highest number of claims received during this period were for slips, trips and falls and violence and aggression.

4.5 Outcome of LTPS claims closed between 1st April 2020 and 31st March 2021.

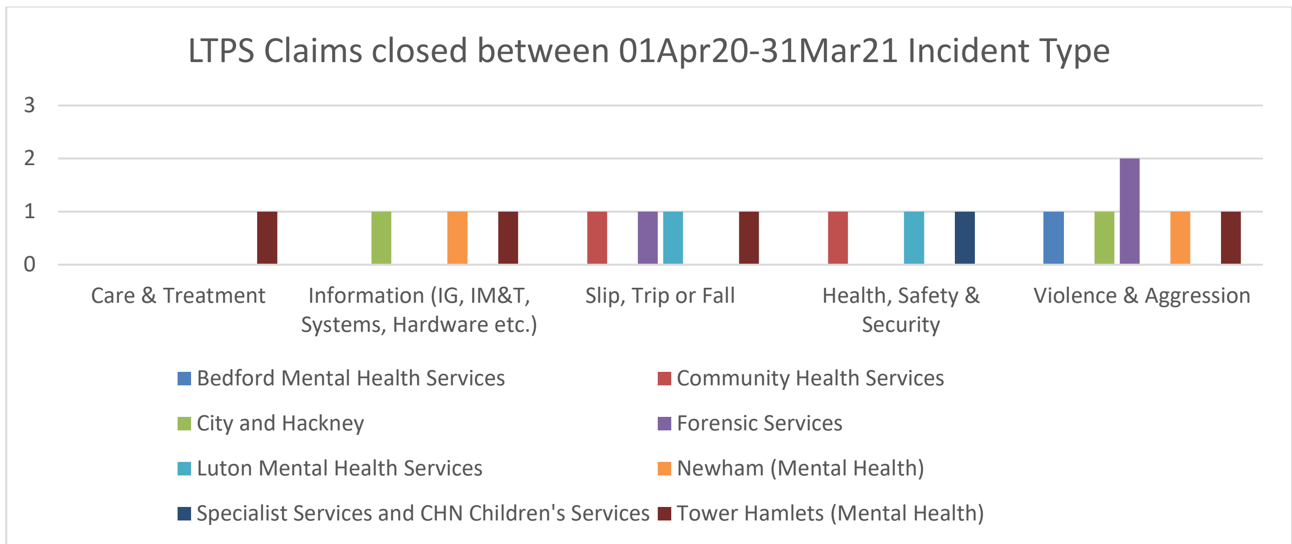
4.6 Between 1st April 2020 and 31st March 2021, 17 claims were closed under the LTPS scheme.

4.7 The graph below shows the number of claims closed during this period split by outcome and Directorate.



4.8 Following the investigation of these cases liability was denied in approximately 53% as investigation showed no breach of duty.

4.9 The graph below shows the number of claims closed during this period broken down by Incident type and Directorate

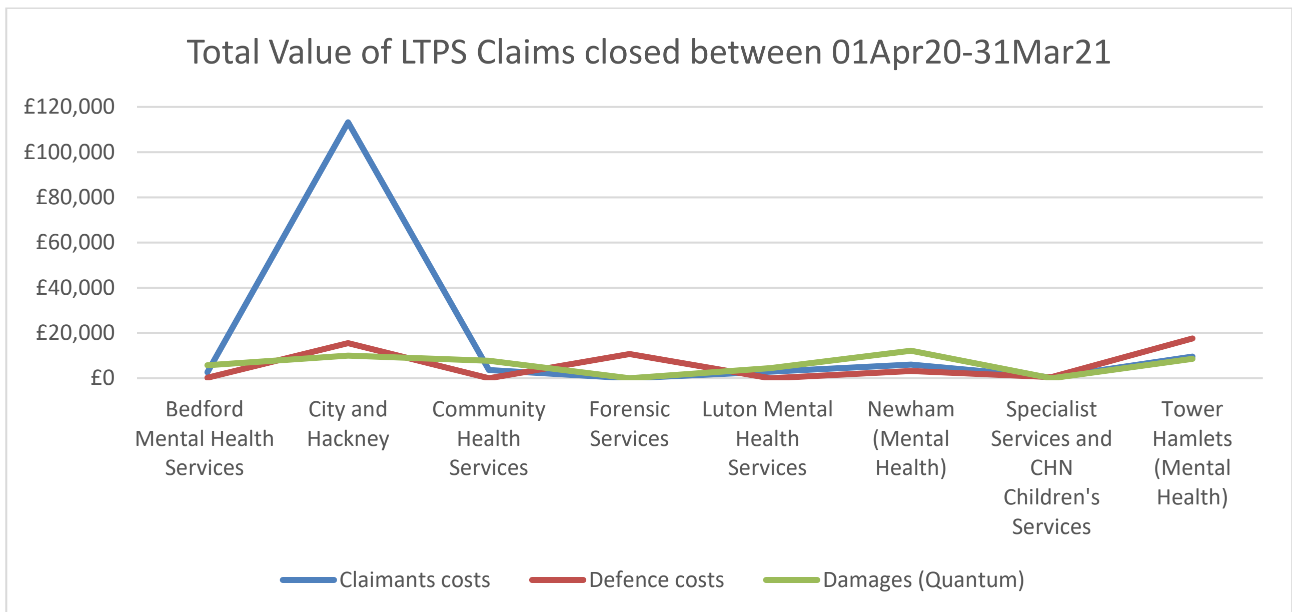


4.10 Total value of LTPS claims closed between 1st April 2020 and 31st March 2021.

4.11 The Trust pays an Excess only on LTPS claims. This is £10,000 for staff claims and £3,000 for other LTPS claims.

4.12 The number and value of claims each year has an impact on the Trust's contribution to NHSR's LTPS scheme the following year.

4.13 The graph below shows the total value of the claims closed between 1st April 2020 and 31st March 2021.

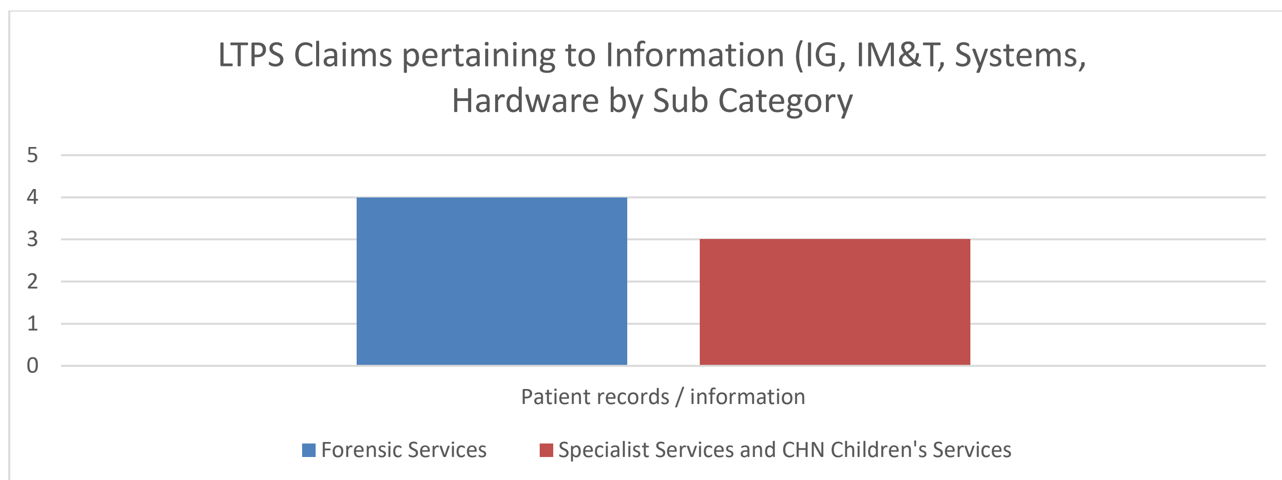


4.14 Qualitative information regarding LTPS claims brought against the Trust.

4.15 The top three categories of all open LTPS CNST claims as of 19th May 2021 (set out in the graph at paragraph 2.5) are: Information Governance, Health, Safety & Security and Adults at risk claims.

4.16 Information Governance

4.17 The graph below shows the number of open claims pertaining to Information (IG, IM&T, Systems, Hardware) by Sub Category.



4.18 We currently have 4 claims emanating from Forensic Services that centre on a data breach. The background is that a staff member accidently sent a spreadsheet containing details of 85 forensic patients to a relative of a patient via email. Immediately, the staff member attempted to recall the email but was unsuccessful. He then called the relative to delete the email to which the relative confirmed he had and did not open this. All patients involved were notified via duty of candour letters. NHSR has recommended that we settle all claims in this matter as it is clear that clear breach has occurred.

4.19 The spreadsheet included 85 patient's details. The information included is as follows: Inpatients (47 in total): full names, legal status, wards they are currently on, estimated discharge, care coordinator, consultant, social supervisor and additional notes. Community patients (36 in total): full names, legal status, current location, psychology, SUSS, OT, Systemic, Last HCR-20, HCR-20 and Proposed referral date to CMHT. Advice and liaison (2 in total); full names, Rio number, date of referral, date and form of advice given and additional notes.

4.20 Actions taken: duty of Candour letters have been written to individual service users to explain what personal information was contained in the spreadsheet. Subsequently, staff members became aware that there were hidden columns that contained the community patients' legal status and locations. As such, we have written again to those service users.

4.21 Liability - NHS Resolution have reviewed the information provided and advise it would be difficult to argue that the information disclosed had not caused stress and anxiety. Therefore, it will be necessary to admit a breach and settle the Claimant's claim on best possible terms. NHSR Resolution hope to be able to achieve settlement between £500 and £750 for each service user – once we confirm agreement. (It is highly likely that as settlements are reached more patients will make claims).

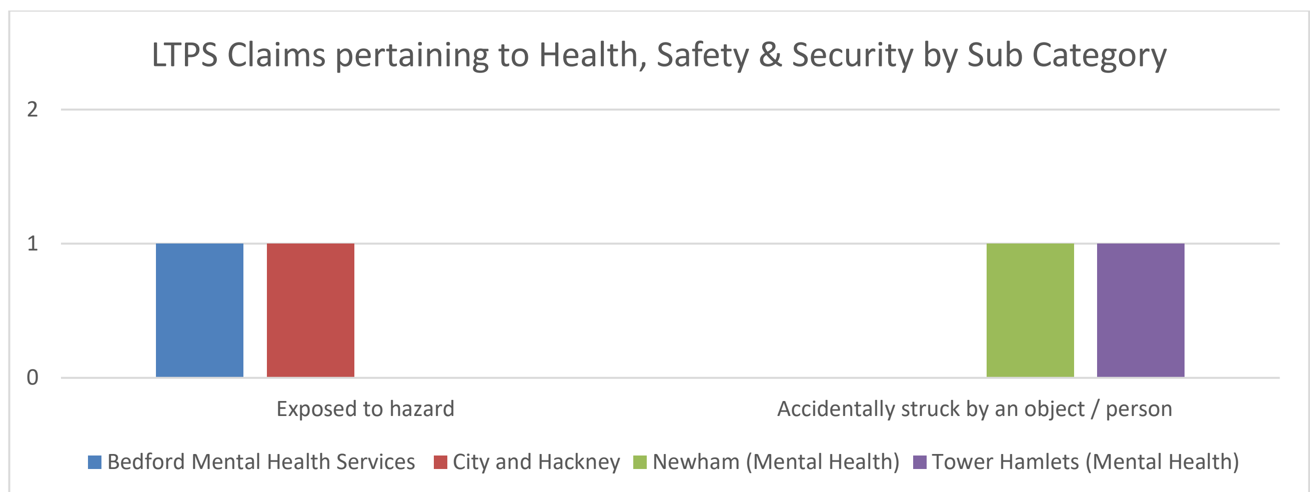
4.22 Unfortunately a further data breach occurred when one of the duty of candour letters was sent to a patient in error (who had the same name as one of the patients whose data was breached). This means that a further breach has occurred with respect to one patient's data. We have written to both patients to apologise and explain what happened.

4.23 Another data breach claim of note has arisen in Newham CAMHS. It is reported that in September 2020 an email was sent to a potential referrer who had requested a new referral

form. It was discovered that a referrals spreadsheet was uploaded in error, instead of a blank new referral form, as was requested. This spreadsheet contained the names and review outcome details of 206 newly referred CAMHS service users. Service user A was one of the 206 new referrals. As soon as the error was identified, administrative staff and care-coordinators were made aware of the breach of confidentiality and awareness of the correct administrative processes was reinforced, the recipient was contacted and asked to delete the document attached to the email be deleted, and offered an apology and a Duty of Candour letter was sent to all affected families, notifying them of the error and offering an apology. A 48 hour report was requested but the incident did not meet the threshold for a full investigation. This matter was subsequently reported on the Data Security & Protection Toolkit's incident reporting function but did not meet the threshold for subsequent reporting to the ICO. Following the Duty of Candour letter, the CAMHS Team received the letter of claim from Service User A's solicitors in which they state that they are bringing a claim for Misuse of Private Information, breach of confidence and breach of the Human Rights Act 1998 and breach of GDPR. As breach of data claims fall under the category of automatic settlement, we have asked the NHSR to settle this matter on best possible terms.

4.24 Health, Safety & Security

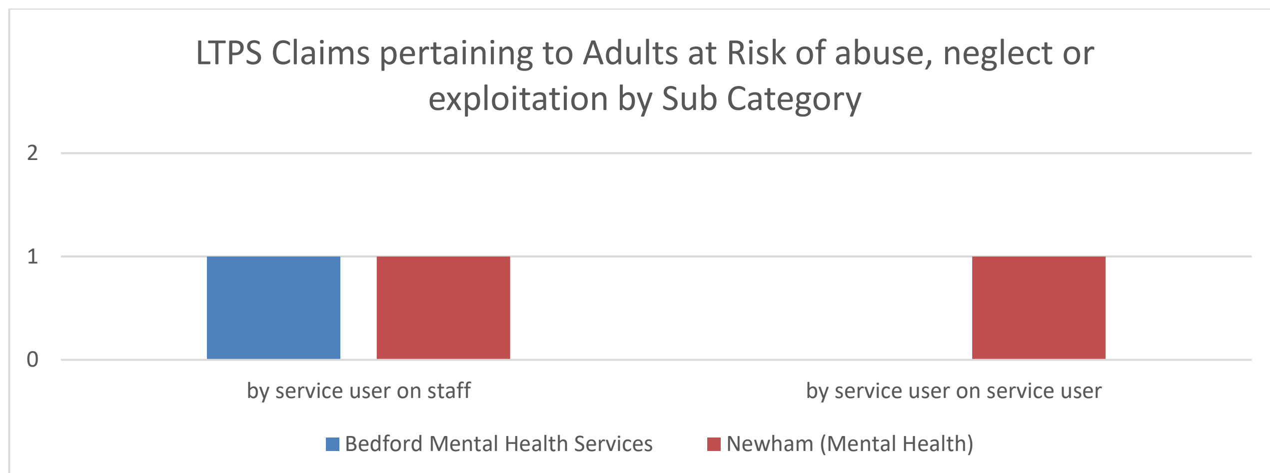
4.25 The graph below shows the number of claims regarding Health, Safety & Security by Sub Category



4.26 The most significant of these claims is from a service user claiming that a staff member shut the office door on his finger causing it to be amputated. We have decided to admit liability and settle on best possible terms as staff confirmed CCTV shows nurse closed door even if unknowingly. The maximum potential damages for this claim is £28,000.

4.27 Adults at Risk of abuse, neglect or exploitation

4.28 The graph below shows the number of claims regarding Adults at Risk of abuse, neglect or exploitation by Sub Category



4.29 The first of these cases concerns a member of staff alleging to have been sexually assaulted by a service user. We are admitting liability in this case with the maximum damages estimated at £23,000. Our SI established as follows: the patient had been involved in a number of aggressive incidents prior to this one and enhanced observations (2:1) had not been utilised; PRN medication provided appears to have been ineffective; and handover notes are missing. Lessons learned were: patient should have been escalated to 1:1 arms-length or 2:1 or given additional medication or secluded to prevent further incidents.

4.30 The second of these claims is a female service user reporting that a male service user entered her room during the night on 28/02/18 and sexually assaulted her. We are also admitting liability in this case also with the maximum damages estimated at £55,000. Our SI review established that: the Duty Senior Nurse's decision to admit this patient to male mental health admission ward because of the sexual risk that he posed was not followed, and the Duty Senior Nurse was then not informed of male patient's arrival at the Newham adult mental health in-patient service as had been the original plan. This resulted in the male patient being admitted to the acute mixed sex mental health triage ward making the management of his sexual risk more challenging. Further, despite the concerns raised by the Duty Senior Nurse who received the referral, the male patient's sexual risk to others and his Sex Offender Registration status, sexual risk was not specifically addressed by his admission care plan, and the decision to place him on 15 minute intermittent observations on a mixed sex ward was not informed by consideration of the level of sexual risk he posed. This increased his risk to other vulnerable adults of both sexes on the ward.

4.31 The final case was brought by a sessional member of staff who alleged that her right breast was grabbed by a service after a yoga session. Prior to every session the process was for the sessional member of staff to receive a handover of any issues pertaining to attending service users. On this occasion she was informed that the service user had been agitates and was using sexually inappropriate language, however she was not informed that two days prior to the class, the service user had inappropriately grabbed a female staff member's bottom. An investigation was undertaken and the findings stated that 1) there should have been another member of staff present during the session. The service user was unwell and having initially been removed from the session, he came back in as there was no one to stop him from re-entering. 2) There is no policy for sessional workers. This is now underway. The conclusion of investigation was that the claimant had been sexually assaulted and it was agreed that this matter be settled on best possible terms. The NHSR agreed that there has been a breach of duty and that this matter should be settled but disagreed with the claimant's GP's PTSD diagnosis. The NHSR stated *"a GP would not be able to diagnose PTSD as it would be outside of their expertise. In addition, that "diagnosis" would only have been a*

couple of weeks after the index incident. It is unlikely that PTSD would be diagnosed in such a short period." An offer of £5,000 has been made and yet to be accepted.

4.32 Qualitative information regarding closed LTPS claims brought against the Trust

4.33 Of the 17 LTPS claims closed in this reporting period, 6 of these related to violence and aggression (service member on staff); 3 related to health and safety (including faulty door and cabinet causing injuries); 4 related to slips and trips; 1 related to the adequacy of an interpreter for a deaf service user; and 3 related to information governance issues. We denied liability in 9 claims, admitted in 6; and settled without admitting liability in 2.

4.34 The spike in the graph at paragraph 4.13 relates to one of the information governance cases. This related to a breach on part of Trust where staff contacted claimant at home having asked that we should not do so. The statement from the member of staff's daughter also details of a conversation that took place in a store between claimant and members of London Borough of Hackney staff who were asking her details of absence from work that they should not have been privy too. Based on the above, we have been advised to settle this case on a 50/50 basis with LBH (with the total costs of this claim amounting to £138,000 including claimant costs).