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Shared Services Partnership
Legal and Risk Services

@LegalRiskWales

Legal and Risk Services
Personal Injury Department
Lessons Learned
1 April 2019 to 30 September 2019

At Legal & Risk Services, we endeavour to provide generic risk advice to clients to reduce risk of future incidents. We have chosen a selection of cases and suggested lessons to be learnt in each.

1. On the frontline

The Claimant received a code message to respond to an aggressive patient. The Claimant asked the patient to return to the ward but the patient kept going to the unit. Eventually the patient went back to the ward however on doing so the patient suddenly ran past the Claimant back to the unit. The patient leapt over the desk, grabbed a nurse by the throat with his left hand, putting his right hand to her neck. The Claimant and his colleague freed the nurse and a struggle ensued. It became apparent that the patient had a knife. The brave Claimant suffered two large lacerations to his face and one to his arm. The Claimant states that there should have been another porter on duty at the time of the incident.

Lessons Learnt: Ensure all patients are properly risk assessed on their admission to the hospital. Assess the patient's needs and observations to make sure all staff and other patients are safe, and make sure staffing levels are followed to a satisfactory level of safety. Patients should not be able to bring knives into a hospital. The risk of a deterioration in condition means something perceived as harmless can become extremely dangerous.

2. Forewarned is forearmed

The Claimant was a lawful visitor, he parked his car and as he went to make his way to the hospital, he fell on black ice.

Lessons Learnt: Ensure inspections of the area are made during cold weather to avoid hazards. Implement an effective gritting procedure for when ice is present in and around the hospital. Have a logical gritting policy and ensure weather alerts are monitored.

3. Heads up

The Claimant was cleaning a 'scope cupboard' when the x-ray scope fell off the bracket and hit her on the top of the head.

Lessons Learnt: Ensure equipment is safely put away and does not create a hazard for other staff.

4. Watch your step!

The Claimant was walking along a pavement and fell down the step. The Claimant alleges that she was not aware of the step; it was not visible because the pavement was sloping at an angle and it was not marked.

Lessons Learnt: Ensure that all walkways and pavements are safe for the public to walk on and regular maintenance carried out. Following this incident a hand barrier was erected for people to negotiate the path safely

5. Close the door on violence!

The Claimant was working in an office when a patient went into the office and accused the Claimant of hitting him in his sleep. Later the patient accused the Claimant again in the larger office, when a member of staff was going to shut the office door, the patient assaulted the Claimant and punched him in the head repeatedly.

Lessons Learnt: To ensure staff are made aware of the risks presented by patients who have a history of aggression. Appropriate supervision levels and risk assessments should be put in place. If patients are allowed to interact with non clinical staff, those staff should be made aware of any risks.

6. Training is key

We are seeing a growing trend of bank staff working on mental health wards who are not trained in PMVA / SPIT training. In one particular claim a Patient required 2:1 staff for intervention due to aggression which was being followed, but only 1 staff member had training which meant that a 2 person hold could not be executed when the patient became aggressive. This resulted in a staff member sustaining an injury.

Lessons Learnt: This is a reminder to ensure that all staff on mental health wards must have training, appropriate to the risks they face.

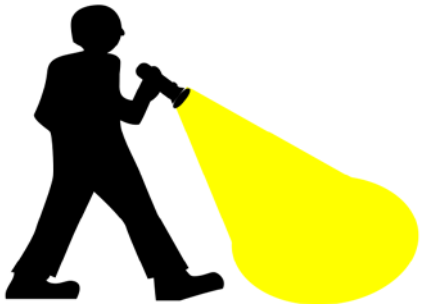
7. Corroborate the incident

We have dealt with a number of cases where the Claimant completes Datix herself / himself and the Manager tasked with investigating the accident simply accepts the Claimant's version of events and does not take steps to verify the Claimant's account by speaking to witnesses. This can lead to evidential difficulties when dealing with a claim.

Lesson Learnt: Managers should properly investigate at the time, as gathering evidence becomes extremely difficult later.

It also means a more accurate picture can be established before reactive measures are put into place.

8. Daylight savings



The Claimant suffered injuries after tripping over a raised manhole cover leading to the side entrance of the hospital. The adequacy of the Health Board's regular system of inspection was called into question. The defect was not identified on routine inspection on 19 January 2017 but a further inspection on 20 January 2017, prompted by the Datix, called for remedial work. This suggests that the manhole was not included or was missed during the routine inspections despite being in a prominent area. It came to light during the investigation that occasionally routine inspections of external paths are sometimes conducted when it is dark, which is unacceptable.

Lessons Learnt: This is a reminder to ensure that there is a clear site plan of areas to be covered in routine inspection and that inspections should take place in daylight.

9. Empty your pockets please

The Claimant sustained an injury to his hand from a needle. The Claimant was provided with clean scrubs which had been laundered by the Health Board's internal laundry. There was a 'drawing needle' and a theatre hat in one of the pockets of the scrubs which pierced the Claimant's hand.

Lessons Learnt: This is a reminder to ensure pockets are checked before sending scrubs to the laundry so that needles are disposed of correctly.

10. Safety shouldn't be an inconvenience

The Claimant fell as a consequence of the poor condition of the floor outside a dental clinic. There was a longstanding problem with the condition of the flooring in the accident location and previous incidents. The clinic liaised with the Health Board's works and Estates Department in relation to repairs in November 2018 (possibly earlier) but requested that the work be postponed until March 2019 because the clinic would need to be closed and patient appointments had already been booked until March 2019. The clinic did not want to cancel any appointments so the repair work was arranged for 5 March 2019. The Claimant's accident occurred in the meantime.

Lessons Learnt: This is a reminder that if patient safety is not addressed then the Health Board will bear the consequences.

11. Categorise the call correctly

The Claimant slipped as a consequence of a leak from a shower room which had seeped under the door and into a corridor. The leak was discovered before the accident and reported to the Health Board's Works and Estates Department via the switchboard. The switchboard wrongly categorised the call and logged it as minor i.e. 'non essential request' requiring a response within 7 days and also sent the call to an electrician as opposed to a plumber. The call was not responded to until following the accident.

Lessons Learnt: This is a reminder to ensure that switchboard staff are trained to ascertain the true nature of a fault and correctly log the call.

12. Cost effective solution

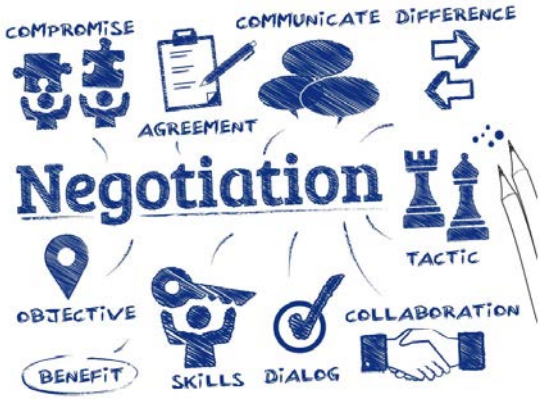
The Claimant tripped over a loose wire which was trailing from equipment in an Endoscopy theatre. There were cable ties in place to secure the original wire but when a new wire was installed the cable ties were not suitable and could not hold the wire. Following the accident new cable ties were installed which was a simple and cost effective solution which reduced the tripping hazard.

Lessons Learnt: This is a reminder to conduct a visual risk assessment when replacing all equipment.

13. Preparation is key

High savings on costs and damages following a discontinued claim highlighted the importance of preparing thoroughly with witnesses and counsel in advance of a trial. It also reminded that however low and tempting an offer may be, claims should in the right circumstances be defended to trial. Such result will have a wide impact on the whole community.

14. Interim payments on costs



This matter concerned a midwife who had turned to walk away from a patient's bed when she slipped on a wet floor. As a result the Claimant suffered knee injuries. The case was settled but costs remained outstanding. The Claimant's Bill of Costs was received months after settlement in the sum of £31,600. The Health Board was advised to make an initial offer and pay it as an interim. This was done shortly after. An agreement could not be reached and the matter proceeded to initial assessment, following which, further negotiations took place. We argued that the Claimant should accept our offer as we had paid the interim and therefore only limited interest would apply. Our final offer of £26,000 was subsequently accepted.

Lessons Learnt: It is essential that the Health Boards continue to make interim payment on costs promptly as those limit the interests on costs a Claimant may obtain. It is important to remind Claimant's solicitors of the same when negotiating.

15. Failed to report

This case is concerned with a Claimant who fell down the stairs during her working hours. There was white powder present which caused the claimant to slip. The Health Board had not put in place clear directions to report spillages.

Lessons Learnt: It is suggested that posters are on display with a contact number to report spillages.

EXAMPLE: If you see a spillage or other slipping hazard, please call the Domestic Services Hotline immediately. 0123456789