CASE NOTES

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Case study: *C v NHS Trust*

Stress at work; existing vulnerabilty

The claimant (C) was a Matron employed by a University NHS Foundation Trust with 17 years' service. She was sexually and physically abused by her father as a child. In November 2013 her father was diagnosed with renal cancer and family members, unaware of the history of abuse, sought C's assistance in ensuring that he accessed appropriate treatment. C found it difficult to accept this responsibility which rekindled memories of the abuse. She took some time off work, consulted her GP, was prescribed Citalopram and arranged to have counselling. While still off work, towards the end of February 2014, C was found to have a possible abnormality in her breast. A three-week period of scans and biopsies followed. She had a lumpectomy and was then told she had a benign tumour.

The following month C saw the Trust's Occupational Health Physician (OHP) and revealed the personal problems she had been going through, including the fact that she had been abused as a child, that she was having counselling and taking Citalopram. The OHP wrote to C's line manager who at that stage was a Ms S, and reported the fact that C had been diagnosed with a depressive illness triggered by personal and ill-health related issues (without specifically mentioning the abuse), that she was on antidepressants and receiving counselling. The OHP recommended that C return on a phased basis to her substantive role as Matron of Renal Services but without additional roles, including dealing with complaints or partaking in disciplinary hearings.

In subsequent meetings C was assured she would be returning to her substantive role but that she may also be asked to undertake the roles of Matron for Cardiology and for Breast Care. C expressed concern about this as it would mean a substantial increase in her responsibilities, and she said that she did not think she would be able to cope with it.

C was assured that her concerns had been understood and the OHP advice would be followed. Despite this, in a subsequent meeting C was told that she would indeed have to undertake the additional roles in both Cardiology and Breast Care for a number of months.

C reiterated the concerns that she had expressed previously and was told they would be passed on to her new line manager, Ms T, with whom she met on 6 May 2014. During this meeting C made it clear that she considered the responsibilities required of her were too great for her to deal with alone, and that she would not be able to manage the caseload. In what was plainly an indication of the level of C's concern about what she was being asked to undertake, she decided to reveal to Ms T that the reason she had been suffering from depression was related to physical and sexual abuse that she had suffered as a child, and that she was having counselling and taking Citalopram. C believed that in revealing such personal information she would receive a sympathetic hearing. Sadly, that did not prove to be the case.

C reluctantly undertook the additional responsibilities that were demanded of her. She continued to reiterate concerns about the size of her caseload. It transpired that she had responsibility as Matron for the three separate services from 1 July 2014 until mid-October 2014, meaning she had oversight of 53 Band 7 nurses. Replies to Part 18 questions later showed that this was more than double that of her nearest comparator, who took charge of 25 Band 7 nurses.

To keep on top of her workload C had to work long hours while continuing with her medication and counselling.

During C's annual appraisal in September 2014 she was informed by Ms T that she was performing poorly, that she would be marked on the lowest rating and that consideration was being given to placing her on performance management. C became tearful and expressed frustration about the size of her

caseload, and noted that she had already complained that it was too large to manage. Ms T said that to take account of this she would not place C on performance management and would instead mark her on the middle rating for the appraisal. C was, however, warned that performance management remained an option in the future if improvement was not demonstrated.

The following month C's responsibility for Cardiology Services was transferred to another matron. She retained, however, responsibility for Renal Services and Breast Care and she was given responsibility for two other services, namely Infectious Diseases and the Out-Patient Antibiotics Team. This meant C now had responsibility for around 41 Band 7 nurses, still substantially more than the nearest comparator.

C persisted in working long hours to try to keep on top of her work, but continued to struggle to establish control of her workload.

In March 2015 C was asked by her previous line manager, Ms. S, to carry out a nursing metrics audit on a Stroke ward. She set aside time to do this but was then asked by Ms. S to attend a bed meeting on behalf of another speciality.

C told Ms. S that although the meeting clashed with the time she had set aside to undertake the nursing audit she would, if need be, attend work over the weekend to complete the job As it transpired, however, C had a personal problem over the course of the weekend that prevented her from going into work.

On the next occasion C attended work she was confronted by Ms. S who angrily shouted at her for failing to undertake the audit. C became tearful and during the ensuing discussion revealed that the reason why she had been off work during early 2014 was related to child abuse.

Two weeks later C was asked to attend a meeting with Ms T who confirmed that she had received a report from Ms. S regarding her failure to carry out the nursing audit. She also raised other concerns about C's performance at work including delays in preparing paperwork for a disciplinary hearing of another member of staff who was off work with work-related stress.

During this period C's PA, who would usually undertake the task of preparing papers for hearings, was off work recovering from surgery, and the Trust had not been able to obtain stand-in assistance.

At the meeting with Ms T, C was again tearful and denied the allegations of poor performance. Ms T, however, informed C that the performance management process would be commenced and that in accordance with the Trust's Capability Policy she would have to attend a capability meeting.

During the capability meeting on 8 April 2015 Ms T listed a number of criticisms of C's work. C said that she thought the criticisms were unfair, reminded Ms T that she had been feeling unwell and stressed and of the problems that she had been having in her personal life. C also argued that she had not been supported on her return to work.

Despite this, C was informed that she was being formally managed under Stage 1 of the Capability Policy and that without immediate improvement, she would be progressed to Stage 2.

C, believing she faced the real risk of losing her job, suffered a breakdown. Being successful in her career was the method through which she had been able to cope with what happened in her childhood and it gave her the confidence to lead a normal life. She now thought that this was in jeopardy, leaving her feeling vulnerable and extremely emotional.

She was suicidal after the meeting and suffered a major depressive disorder and suicidal ideation. She never returned to work with the NHS.

C approached union lawyers who advised her that she did not have a claim. Fortunately, a friend of C's, a lawyer, saw things differently and she was referred on.

After consideration of the occupational health and personnel files, a detailed proof was taken and this formed the basis of a lengthy letter before action with an extensive request for disclosure. It was alleged that the Trust was negligent in unreasonably invoking the Capability Policy, requiring C to undertake excessive work, and in failing to:

- adhere to the recommendations of the OHP;
- provide appropriate support to the claimant; and
- heed her concerns about her workload.

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Liability was denied. The Trust asserted that there were other methods of meeting the OHP recommendations, that C had indicated that she was content with undertaking the additional responsibilities, that the decision to invoke the Capability Policy was a reasonable response to C's performance, and that appropriate support was provided at all times. It was also denied that C's responsibilities were in excess of other Matrons.

Extensive discussions regarding disclosure followed. The parties agreed to attempt mediation and prior to this, they exchanged evidence from psychiatrists and schedules of loss on a without prejudice basis.

C's psychiatric expert, Professor Fahy, reported that she suffered a relapse of depression following the Capability Hearing which represented an abrupt escalation of formal procedures.

He considered that an alternative managerial approach could have involved an OHP referral, a review of workload and advice to consult a GP. The Trust's approach to the management of C's work problems made a material contribution to the relapse of the depressive disorder from which she had been previously suffering, and made it unlikely that she would be able to return to her job.

She was, however, considered free from diagnosable psychiatric illness since around mid-2016. Professor Fahy considered that, but for the conduct alleged to be in breach of duty, C may have required a period of several weeks of sick leave and a temporary reduction in responsibility until the personal stresses had diminished. After that, he could see no reason to conclude that she would not have been able to continue at her previous level until retirement.

For the defendant, Dr Friedman noted that C had experienced episodes of stress in the past and yet had been able to return to work. He concluded therefore that had it not been for the history of abuse leading to her becoming unwell, then the work situation would not have deteriorated to the extent that she found it necessary to leave work altogether.

He said he was unable to see evidence that C was managed in a way that was objectively harmful or beyond normal stresses associated with work as a matron. While accepting that C developed more profound symptoms of depressive illness in early 2015 and after leaving work in 2015, he thought that was best considered part of the same depressive illness from which she had been suffering in early 2014. He thought there was no reason why C couldn't work, for instance, as a manager of a care home, that the prognosis was good, and she was not generally handicapped in the labour market.

The mediation went ahead in September 2018 but failed without a compromise being reached.

Proceedings were subsequently issued and served in December 2018. A defence denying liability was served. In February 2019, the defendant made a Part 36 offer to settle the claim for £150,000 plus costs (£25,000 more than its final offer in the mediation) which was rejected.

A CCMC was held in August 2019. Permission to obtain reports from experts in pension loss and updated psychiatric reports was granted. The defendant was subject to an extensive order in relation to disclosure, including key word searches of specific email accounts and the provision of mandates from key individuals employed by the Trust to enable access to text messages from Trust held mobile phones.

C's future costs were budgeted at £269,000 and the figure for the defendant was £158,000.

The defendant later served its pension evidence early and simultaneously offered £120,000 plus costs (without withdrawing its earlier lower offer) under Part 36. That was rejected. Shortly before witness evidence was exchanged, the defendant made a further Part 36 offer to settle the claim for £185,000 gross, which was also rejected. Following exchange of witness evidence, subsequent telephone negotiations were conducted which culminated in the defendant making an improved offer to settle the claim for £200,000 gross plus costs. Making a small allowance for litigation risk on liability and the potential for some vulnerability discount, this was considered reasonable and it was accordingly accepted.

On an approximate basis damages were broken down as follows: £25,000 for PSLA; £7,000 for past miscellaneous losses; £32,500 for past loss of earnings; £22,500 for future loss of earnings; £111,000 for pension loss.

David Holland BSc, CSci, FFPM-RCPS (Glasg)

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Richard Edwards of Potter Rees Dolan, Manchester and Daniel Lawson of Cloisters, London, acted for the claimant

Victoria Hemsell of Browne Jacobson and Saleem Khalid of 1 Chancery Lane, London acted for the defendant

AM v St George's University Hospitals NHS Trust

Quantum: failure to diagnose appendicitis: faecal peritonitis, anaphylactic shock, IBS-D, increased risk of pelvic adhesions, facial telangiectasia, PTSD and a mild depressive episode

Settlement: 23 September 2020

The claimant (C), a 44 year old woman, received £600,000 after a delay in diagnosis of appendicitis.

Background

On 23 September 2014 C attended the Emergency Department at St George's Hospital complaining of pain in the right side of her abdomen and nausea. Investigations were undertaken. She was reviewed by a doctor who noted gradual onset of right iliac fossa pain over the previous 24 hours. Her blood profile showed a raised CRP. The impression was recorded as an ovarian pathology and unlikely appendix.

She was referred to a gynaecologist for a USS. No abnormalities were seen on the USS. C was advised that she had unexplained abdominal pain. C was discharged without further investigations. Her pain did not improve and two days later on 25 September 2014 she collapsed at work. She was taken back to A&E.

On review the surgical team noted the history of abdominal pain and considered she had a perforated appendix. The laparoscopic appendectomy was undertaken on 26 September 2014. Post-operatively C had severe abdominal pain. There was leakage from the drain and fluid from the drain showed a growth of multi-resistant E.coli. C was given Ertapenem on 29 September and within 40 minutes suffered an anaphylactic shock, and was administered adrenalin and hydrocortisone. She was admitted to ITU for observation. She was discharged home four days later.

D admitted liability, specifically that there was a failure to ensure C was re-assessed in ED on 23 September 2014. Had she been assessed, laparoscopic appendectomy would have been undertaken on 24 September 2014.

Causation was disputed in respect of recovery after discharge.

Injuries

C sustained faecal peritonitis, anaphylactic shock, IBS-D, increased risk of pelvic adhesions, facial telangiectasia, PTSD and a mild depressive episode.

C's medical evidence suggested the IBS would not have occurred but for the perforation and subsequent sepsis. As C had suffered persistent symptoms for more than four years, the symptoms could be regarded as permanent.

D's medical evidence suggested a 60% improvement in IBS symptoms with further treatment.

C's medical evidence was that the facial telangiectasia was caused by an adverse reaction to ertapenem. But for the index incident, the skin condition may have occurred later, by up to 20 years, and slowly progressed with increasing age, but would have

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