LAW SOCIETY SUBMISSION

LAW SOCIETY OF IRELAND

EXPERT GROUP TO REVIEW THE LAW OF TORTS AND THE CURRENT SYSTEM FOR THE MANAGEMENT OF CLINICAL NEGLIGENCE CLAIMS

DEPARTMENT OF HEALTH

AUGUST 2018

ABOUT THE LAW SOCIETY OF IRELAND

The Law Society of Ireland is the educational, representative and regulatory body of the solicitors' profession in Ireland.

The Law Society exercises statutory functions under the Solicitors Acts 1954 to 2011 in relation to the education, admission, enrolment, discipline and regulation of the solicitors' profession. It is the professional body for its solicitor members, to whom it also provides services and support.

The headquarters of the organisation are in Blackhall Place, Dublin 7.

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1. Introduction

1.1. The Law Society of Ireland has been invited to make a submission to the Expert Group to review the law of torts and the current systems for the management of clinical negligence claims (the "Expert Group")

1.2. This submission is prepared by the Society's own internal Expert Group on Medical Negligence (LSI Group), which includes practitioners experienced in representing injured patients and in representing health care entities, relevant State Agencies and medical professionals in respect of medical negligence and personal injury claims.

1.3. The Society has previously provided submissions and contributions to the issue of medical negligence and clinical indemnity, including:

- Draft Agenda items for the Review of the Administration of Civil Justice (2018)
- Response to the Medical Protection Society's Report *Challenging the cost of clinical negligence – the case for reform* (2015)
- Presentation and attendance at the Joint Oireachtas Committee on Health and Children *Medical Indemnity Insurance Discussion* (2015)
- Submission to the Review of the Personal Injuries Assessment Board Act 2003 and the Injuries Board (2014)
- Submission on Part 15 of the Legal Services Regulation Act and Pre-Action Protocol Regulations

1.4. The Society continues to engage with stakeholders across the health and justice sector on clinical negligence issues, bringing the perspective of practitioners and the experience of private and institutional clients.

1.5. In presenting this submission, the Society has adopted the headings provided by the Review Group.

2. Heading A: Legal reforms, changes to process and system

Review the law of torts from the perspective of the management of clinical negligence and personal injury claims in order to assess the effectiveness of the legal framework and to advise on and make recommendations on what further legal reforms or operational changes could be made to improve the current system.

IMPROVEMENTS IN THE MANAGEMENT OF CLINICAL NEGLIGENCE CLAIMS AND CERTAIN CATASTROPHIC PERSONAL INJURY CLAIMS

2.1. The Society recommends the urgent implementation of the reforms proposed by the Working Group on Medical Negligence and Periodic Payments.[i]

Commencement of Pre-Action Protocol provisions and regulations

2.2. Pre-Action Protocols benefit both injured parties and healthcare providers/funders/indemnifiers. Crucially they will enable the parties to identify the issues which are ultimately in dispute at a much earlier stage; thus assisting in the earlier resolution of claims.

2.3. The earlier disclosure of patient records enables parties engage in mediation or alternative resolution processes in a meaningful way at an early stage.

2.4. Part 15 of the Legal Services Regulation Act 2015, and more particularly Section 219 of the Act, provide for Pre-Action Protocols. The provisions have not yet been commenced. A template is at hand from the Working Group[ii] which reflects submissions made by interested parties and the experience of England and Wales.

2.5. The requirements of a defence are set out in Section 12 of the Civil Liability and Courts Act 2014. However, they do not match the extensive requirements on the part of a plaintiff in the context of a Personal Injuries Summons (Section 10) in that the latter refers to the provision of "full particulars" and this phrase is omitted from Section 12 (c). This can result in the delivery of defences which lack essential particulars and are instead based on excessively broad statements such as "I complied with standard practice".

2.6. The Society recommends that the requirement to provide "full particulars" in pleadings should apply equally to all parties. It should be axiomatic that genuine adherence to Pre-Action Protocols, would give rise to a similar adherence to meaningful pleadings of either party that may arise thereafter.

2.7. Both Sections (10 and 12) of the Civil Liability and Courts Act 2014 contain sanctions for either party in the case of non-compliance:

Where a defendant fails to comply with this section—

(a) the court may—

(i) direct that the action shall not proceed further until the defendant/plaintiff complies with such conditions as the court may specify, or

(ii) where it considers that the interests of justice so require, give judgment in favour of the defendant/plaintiff,

and

(b) the court shall take such failure or refusal into account when deciding whether to make any order as to the payment of the costs of the personal injuries action concerned, or the amount of such costs.

(4) Where a defendant/plaintiff fails to comply with this section, the court hearing the personal injuries action concerned may draw such inferences from the failure as appear proper.

2.8. The Society recommends that greater application of the sanctions (to the offending party of either Section 10 or 12), may motivate a speedier and focused response to the relevant stage in proceedings and improve the management of these claims.

Statutory Limitation period must be extended

2.9. It is essential that the provision[iii] extending the limitation period applicable to clinical negligence actions to three years is commenced in tandem with the commencement of the Pre-Action Protocols.

Periodic Payment Orders

2.10. Part 2 of the Civil Liability (Amendment) Act 2017 supports the recommendations of the Working Group in respect of Periodic Payment Orders. It is regrettable that this Part has yet to be commenced.

Improved Case management

2.11. Module 3 of the Working Group (2013) identified extensive reforms which are available to the Expert Group for consideration. These reforms, if enacted purposefully, will have the effect of streamlining clinical negligence cases, avoiding unnecessary costs and easing to some degree, the anxiety and tension experienced by claimants.

2.12. Draft Rules have been provided by the Working Group which, if embraced similarly to the operation of the Commercial Court, would optimise Courts Service resources and the timely progress of litigation.

Statutory Protection of the Apology

2.13. Legislation has been enacted[iv] enabling health care providers to provide apologies in connection with an allegation of clinical negligence by an injured party. Such apologies are seen as part of a more sensitive and humane response.

2.14. A statutory protection has also been incorporated within the provision insofar as an apology is not an admission of liability nor does it invalidate insurance. Commencement of these provisions has yet to occur.

2.15. The issue of the form and parameters of an apology is fraught with difficulties, for medical professionals and healthcare providers. Insofar as the concept is advanced, issues remain with regard to timing of apologies and also for staff training in this regard.

Open Disclosure

2.16. The Society also notes the Government's intention to introduce mandatory disclosure of certain adverse events. The Society recommends that a protocol or reporting framework be considered, whereby only adverse events above a certain threshold of severity are mandatorily disclosed. It is incontrovertible that not all incidents lead to adverse outcomes.

2.17. Section 11 of the Civil Liability (Amendment) Act 2017 compels health service providers to have a written procedure for making open disclosure of patient safety incidents. Guidelines are awaited from the Department to assist health providers comply with this obligation.

2.18. In May 2018, the State Claims Agency came before the Oireachtas Public Accounts Committee[v] on the State Claims, Management of Legal Costs and Policy on Open Disclosure. During the hearing, the State Claims Agency confirmed that over the past three years adverse events reported on an annual basis increased from 130,000 to 170,000.

2.19. Furthermore, notwithstanding the Agency's reservations regarding its measurement, the Comptroller and Auditor General reported in 2012 that only 40% of claims notified to the Agency had been previously reported as adverse clinical incidents.

2.20. In addition, HSE evidence to the Public Accounts Committee[vi] is quoted as confirming that, in early 2018, approximately 20,000 of the 140,000 HSE staff had been trained in open disclosure.

2.21. A clear system of both apology and mandatory open disclosure should be established and appropriate thresholds of severity of incident identified to ensure that both are meaningful without becoming disproportionately burdensome on the hospital system.

2.22. It is acknowledged that the practice of Open Disclosure is complicated further in circumstances where third parties are contracted to provide health services or intermediate services within the broader delivery of the health services.

POSSIBLE TORT REFORM

No-fault liability

2.23. The introduction of a no-fault system has been previously canvassed in this jurisdiction.

2.24. If such a regime were introduced, it would presumably apply to all forms of personal injury claim. If it remains possible to contest causation, then the introduction of a no-fault regime will not represent any major change to cases currently litigated before the Courts.

2.25. Currently, the State provides supports and services to all citizens, yet it is frequently the case that access to such treatment and rehabilitation services and equipment is fragmented, often because of lack of resources. A no-fault system would require certainty and equality of access to facilities for all injured parties. This has immediate significant resource implications.

2.26. Funding of a no-fault system is ostensibly an additional tax on either all citizens or those eligible for services (for example, in the New Zealand model, a levy is applied to driver licence/registration fees as well as fuel, in respect of no-fault 3rd party motor accidents).

2.27. In New Zealand, the no-fault medical negligence system (Treatment Injury Account) is funded by a levy imposed on earners and non-earners. The earner's levy is currently $1.21 per $100 (excluding VAT) of liable income. Everyone who earns a salary in New Zealand pays the earner's levy[vii].

2.28. The Accident Compensation Corporation of New Zealand administers the no-fault scheme in New Zealand. The total number of claims (including clinical injury) for the full years 2016 – 2018 are set out below, confirming a total cost of $3.4bn (€1.97bn) to the State and its citizens.[viii]

Claims and total costs

Financial year	New claims	Active claims	Total cost
Jul 2016 - Jun 2017	1,783,106	2,277,750	$3,173,122,315
Jul 2017 - Jun 2018	1,807,240	2,318,005	$3,426,075,032

2.29. The table below indicates the upward trajectory of the number and value of claims for medical treatment claims alone. Claims relating solely to medical injury represent a total cost of $189millon (€109m) in respect of new and active claims.

Claims and total costs ⓘ

Financial year	New claims	Active claims	Total cost
Jul 2016 - Jun 2017	7,886	15,063	$178,749,284
Jul 2017 - Jun 2018	8,425	15,894	$189,545,458

2.30. Policy arguments for and against no-fault liability are numerous; including but not limited to the incentives that the tort based approach provides to healthcare providers in improving their clinical practice.[ix] Instituting a no-fault system also gives rise to the obligation of monitoring, enforcement and educational activities to ensure that the occurrence of any qualifying incident is minimised.

2.31. In 2012, the Scottish Government published its analysis[x] of a no-fault compensation scheme for clinical injury. It paraphrased its 2012 analysis as follows:

> *The study explored the potential expenditure implications of a no-fault scheme based on the analysis of data on closed cases. Estimates were calculated based on a range of assumptions about how a no-fault system might operate as well as costs of the current system in recent years. At the lower end estimates for a no-fault compensation scheme would be similar to the cost of existing schemes whilst at the upper end, costs could increase by one half.*
>
> *A no-fault scheme will not necessarily address non-clinical aspects of care. It is therefore important that any new scheme is linked into the wider process by which patients attempt to resolve disputes.*

2.32. In regard to a possible introduction of such a scheme into the health services in this country, a Group, chaired by Professor Peter McKenna of the Rotunda examined (in 2009) the feasibility of introducing a limited no fault scheme for infants who suffer from Cerebral Palsy. The report of this Group was communicated to the Departments for Health and Finance, but yet to be published.

2.33. Irrespective of the merits and demerits of a no-fault system, the right of access to the courts continues to be a Constitutional right. In McCauley v. Minister for Posts and Telegraphs[xi] Kenny J. held:

> *"That there is a right to have recourse to the High Court to defend and vindicate a legal right and that it is one of the personal rights of the citizen included in the general guarantee in Article 40.3, seems to me to be a necessary inference from Article 34.3.1 of the Constitution . . . if the High Court has this full original jurisdiction . . . it must follow that the citizens have a right to have recourse to that Court . . ."*

2.34. In State (McCormack) v. Curran[xii], Finlay C.J. stated:

> *"The right of access to the courts, stated in its broadest fashion, is the right to initiate litigation in the courts".*

2.35. The Society is adamant that such access to the Courts is retained and protected.

3. Heading B: Alternative mechanisms, dedicated schemes, no-fault

Consider whether there may be an alternative mechanism to the court process for resolving clinical negligence claims, or particular categories of claims, particularly from the perspective of the person who has made the claim. To do this, the Group will examine whether a mechanism can be established which would deal more sensitively and in a more timely fashion with catastrophic birth injuries, certain vaccine damage claims, or with claims where there is no dispute about liability from the outset. It will also examine whether an alternative dispute mechanism or a no-fault system would be effective in some cases.

Mediation as a dispute resolution mechanism

3.1. The use of mediation has grown significantly in clinical negligence claims. According to the latest National Treasury Management Annual Report (2017), the State Claims Agency resolves the majority of clinical claims by negotiating a settlement, either directly with the plaintiff's legal advisors or through a process of mediation. 98% of clinical negligence cases handled by the SCA are settled without the necessity for a contested court hearing.

3.2. The Mediation Act 2017 was supported and welcomed by the Society, as a key statutory tool for improving access to justice and an appropriate dispute resolution as agreed between parties. Additional court resourcing and policy changes that endorse early consideration of mediation are recommended.

3.3. When and if Pre-Action Protocols are introduced, they will allow for meaningful mediation to take place at an earlier stage. As both parties will have set out their respective positions, the scope for a quicker resolution exists. As noted above, commencement of Pre-Action Protocols must occur in tandem with the changes to the Statute of Limitations in relation to clinical claims.

3.4. The advantages of mediation are well versed. However, in the context of clinical negligence, where the injury is likely to have a deeply personal and transformative impact, the benefits are particularly acute:

- allows for the patient's voice to be heard
- the uncertainty and complexity of medical practice can be explained in plain language
- can assist the parties in ensuring lessons are learned
- permits other family members and those affected to engage in the process.

Possibility of a no-fault system of compensation

3.5. A no-fault system may not be realistic unless there is an increase in taxation. It would require a well-resourced and comprehensive regime by which the State provides full and timely supports to meet the needs of injured parties.

3.6. If such a system is contemplated, it must acknowledge the right of citizens to have recourse to the Courts, on foot of their Constitutional protections.

3.7. See our comments at Section 2.23 – 2.34 on this issue.

Redress Schemes

3.8. In the context of the Cervical Cancer Screening litigation, the issue of an appropriate redress scheme has been mooted, the purpose of which is to avoid unnecessary litigation and, in theory provide a speedier resolution.

3.9. Legal issues of negligence still arise and the position of other parties with a potential liability must be borne in mind if this option is pursued.

3.10. The Society believes that any redress scheme would have to be evaluated across a number of headings:[xiii]

- scheme design – in particular measures to reduce litigation costs
- accountability arrangements
- expenditure forecasting methodology
- effectiveness in meeting intended objectives and outcomes and
- the Constitutional right of access to the courts.

3.11. Other aspects and reservations that may arise include the narrow interpretation of the concept of 'justice' and limiting factors contained in the grounding statute, the administrative costs and process in the establishment of a Board and Review Committee, and the range of damages (General, Special, etc) that would have to be considered.

4. Heading C: The role of the HSE, care packages.

Examine the role of the HSE in addressing the problems encountered by persons involved in clinical negligence claims and addressing the health needs of persons affected by clinical negligence, with consideration given to whether particular care packages could be made available for persons with specific injuries, e.g. cerebral palsy following birth.

HSE/SCA Risk Management function

4.1. It is the experience of practitioners that risk management is key to preventing medical accidents and learning lessons. Risk management also performs a key role in relation to the management of claims.

4.2. Greater ring-fenced resources should be provided to the HSE to support it in carrying out a meaningful risk management function, to reduce patient harm and thereby minimize future claims.

4.3. In the absence of 'protected funding' and prioritization for the risk management function, day-to-day service pressures (Emergency Department activity levels, bed crisis, waiting lists) will hamper its effectiveness.

4.4. A systems-wide risk management training and development framework, coupled with appropriate IT reporting system is vital to ensure a uniform quality and speedy response to claims investigations. It is also essential that all health care professionals and staff are allowed time within their work time to engage in this process.

Care Packages

4.5. Any support that can be offered by the State, through the HSE or otherwise, will of course be welcomed by injured parties and their families. This is especially true for those with serious lifelong and life-limiting injuries.

4.6. There is a concern that, in order for care packages to operate, a threshold or severity of injury will have to be validated. It is unclear how injured patients who fall below that threshold would also be accommodated.

4.7. Careful consideration needs to be given to the equality of access throughout the country to necessary care services (eg psychiatry, pediatric care, neurology, physiotherapy).

5. Heading D: The role of the State Claims Agency

Examine the role of the State Claims Agency in managing clinical negligence claims on behalf of the HSE to determine whether improvements can be made to the current clinical claims management process.

5.1. The commencement of a number of statutory provisions should assist the State Claims Agency in its management of clinical negligence claims. These include:

- Pre-action Protocols - Legal Services Regulation Act 2015
- Apology - Legal Services Regulation Act 2015 / Civil Liability and Courts Act
- Statute of Limitations - Legal Services Regulation Act 2015
- Periodic Payment Orders - Civil Liability (Amendment) Act 2017

5.2. In respect of Pre-Action Protocols, the Society wishes to emphasise that any new procedures that are introduced should apply equally to both sides in a claim and that non-compliance with same should be matched with sanctions that impact all defaulting parties equally.

5.3. The issue of defences is one that is relevant to the SCA in its management of claims, as the State's principal indemnifier. It is recognised that, due to the complexity of the issues and the range of personnel involved at health-care level, the investigation of claims can suffer from delays thereby frustrating the aim of providing a thorough and detailed defence in a timely fashion. The introduction of Pre-Action Protocols should improve this situation and facilitate the delivery of full and timely defences as envisaged by section 12 of the Civil Liability and Courts Act 2004.

5.4. Distinct from the legal process, greater resourcing of the State Claims Agency and health care providers in respect of the standardisation of investigation protocols throughout the healthcare system, with the training of key personnel, is required.

5.5. The Society recognises the existing clinical governance and risk management programmes being rolled out by the Agency, and wishes to underline the importance of continuous development and training of key personnel as an organisational value. The Society acknowledges the Agency's efforts in relation to the Open Disclosure Pilot and trial of voluntary Pre-Action Protocols.

6. Heading E: Impact of tort system on patient safety culture, open disclosure

Consider the impact of current tort legislation on the overall patient safety culture, including reporting on open disclosure

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6.1. In a Dáil Debate on 15 May 2018,[xiv] Minister for Health, Deputy Simon Harris stated:

> *"Last week the Government approved proposals to provide for mandatory open disclosure, through the forthcoming Patient Safety Bill, in respect of serious patient safety incidents, including issues relating to screening.*
>
> *The new Bill will provide for*
>
> *a) mandatory external notification of serious patient safety incidents to the appropriate regulatory body, be that the Health Information and Quality Authority, HIQA, or the Mental Health Commission,*
> *b) mandatory open disclosure of serious incidents to the patients affected by them,*
> *c) ministerial guidelines for clinical audit and*
> *d) the extension of HIQA's remit to private hospitals, which is something that has long been sought."*

6.2. As it currently stands, open disclosure is voluntary and a matter of internal policy, rather than a statutory obligation. Mandatory disclosure will, as indicated previously, give rise to considerable costs. However it should bring greater clarity to clinical claims at an earlier stage, either allowing for mediation or more effective pleadings.

6.3. The Society's comments on open disclosure under this heading should be read in conjunction with our views at Section 2.16 – 2.22 of this document.

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[i] Working Group on Medical Negligence and Periodic Payments (2010, 2012, 2013)

[ii] Module 2 (2012) Appendix 1. Available at www.courts.ie

[iii] Section 221, Legal Services Regulation Act 2015

[iv] Part 15, Section 219 of the Legal Services Regulation Act, amending the Civil Liability and Courts Act 2004.

[v] As provided for under Part 4 Civil Liability (Amendment) Act 2017, and SI No.231/2018 – Civil Liability (Amendment) Act 2017 (Part 4) (Commencement) Order 2018

[vi] https://www.oireachtas.ie/en/debates/debate/committee_of_public_accounts/2018-05-10/ 10 May 2018

[vii] For more information, see: https://www.acc.co.nz/about-us/how-levies-work/paying-levies-work-or-own-a-business/

[viii] *Number Active*: The number of paid injury claims in the period (ie the number of claims where ACC made payments in the year, even though an accident may have happened and been registered in previous years). This includes new claims and ongoing claims.

*Total Cost ($000s):*Total cost represents the sum of all payments to active claims in the selected group. Amount of money paid out on active claims in that period. The total cost is net of GST.

[ix] Howell, Bronwyn (2004) Medical misadventure and accident compensation in New Zealand: an incentive-based analysis, Victoria University of Wellington Law Review, 35 VUWLR

[x] See https://www.gov.scot/Topics/Health/Policy/No-Fault-Compensation . The 2014 Consultation Report contains a wide range of stakeholder views and a number of Government actions, including increased investment in training and education, revised criteria of any proposed scheme, the formulation of a bereavement care package, a review of management and learning from adverse events, and other actions. They can be accessed at: https://www.gov.scot/Resource/0044/00447863.pdf.

[xi] 1966 IR 345

[xii] 1987 ILR 225

[xiii] For a detailed consideration of the issues surround redress schemes, see Comptroller and Auditor General Special Report, December 2016, *Cost of Child Abuse Inquiry and Redress.*

[xiv] Mandatory Open Disclosure: Motion, accessible at https://www.oireachtas.ie/en/debates/debate/dail/2018-05-15/34