The State Claims Agency
Newsletter
Gníomhaireacht Éileamh an Stáit

State Claims Agency Newsletter, September 2013

Home Births: The HSE Indemnity Scheme

The recent decision of Ms Justice Iseult O'Malley - 16th August, 2013 - in the case of **Aja Teehan -v- Health Service Executive and the Minister for Health** is to be welcomed for the clarity of its statement of the law in relation to the Memorandum of Understanding (MOU) which governs the relationship between the HSE and self-employed community midwives (SECMs) who attend at home births.

The MOU sets out the basis upon which professional indemnity is afforded to SECMs. In particular, it sets out defined clinical criteria for home births where professional indemnity will or will not be afforded to SECMs, in conformity or not with those criteria.

In the particular case, the plaintiff, inter alia, sought the following reliefs:

- A declaration that the failure to consider her case on its merits amounted to the application of a "blanket" policy and fettered the discretion of the HSE.
- A declaration that the Minister for Health's policy on home birth services and its implementation by the HSE, which precluded the provision of a service to mothers who have had a previous Caesarean section, was unlawful.

The Judge concluded that the effect of the plaintiff's claim would be to compel the HSE to accept, or rather, to consider in good faith whether it should accept, liability for a risk that it did not believe was justifiable. She held, as a matter of law, that the plaintiff was not entitled to that claim. She held that the plaintiff was not just asking for her case to be considered on its particular merits but that she was also requesting the HSE to assume the burden of liability relating to a risk that it considered, on reasonable grounds, was better avoided.

In the circumstances, Ms Justice O'Malley refused the reliefs sought by the plaintiff.

In holding that the issue of indemnity/insurance lay at the heart of the particular case, Ms Justice O'Malley was clearly of the view that the State should not be required to take on a disproportionate liability exposure and that it was entitled to establish reasonable clinical criteria to underpin the indemnity relationship between it and SECMs attending mothers in respect of home births.

NATIONAL EARLY WARNING SCORE (NEWS)

Recent evidence and international experience has identified that a systematic approach to the identification and management of the deteriorating patient can improve patient outcomes, prevent death and reduce morbidity. Early warning scores have been developed to facilitate early detection of deterioration by categorising a patient's severity of illness thus prompting nursing, and other health care professionals, to request a medical review at specific trigger points, utilising structured communication tools and following a definitive escalation plan.

The adoption of NEWS, and the associated education programme, now means that there is a nationally agreed practice for recognising and responding to clinical deterioration. This is the first of its kind, internationally, and the first guideline to undergo the rigorous approval process of the National Clinical Effectiveness Committee (NCEC) which was ultimately signed

CONTENTS IN THIS ISSUE

off by the Minister for Health, Dr James Reilly T.D. The Minister stated, at the recent launch of this first national guideline, that he expects regular implementation progress updates and compliance reports to be submitted by all hospital managers to his office. Forty one acute and single speciality hospitals have implemented the policy in varying degrees to date.

The deteriorating patient issue/problem has long been identified by the State Claims Agency, the operators of the Clinical Indemnity Scheme, as a very specific problem. The Agency, thus, welcomes the introduction of NEWS and IMEWS (Irish Maternity Early Warning Score) as significant safety and quality initiatives leading to better and safer health care for all patients.

Ciarán Breen, Director of the State Claims Agency

National Adverse Events Management System Upgrade

The State Claims Agency (SCA), in conjunction with the Department of Health, HSE, voluntary enterprises and other key stakeholders, are upgrading the National Adverse Events Management System (NAEMS, previously known as STARSWeb).

The NAEMS was originally selected through a formal international procurement process, in 2004, by the then Department of Health and Children. The NAEMS underpinned the establishment of the SCA's clinical indemnity scheme and provided a national clinical adverse event reporting and management system that was the first of its kind in Europe.

The system was rolled out across the health care sector and 52 State bodies by 2006. Health care enterprises and the Irish Prison Service have access to web based reporting and analysis via the NAEMS. All other state bodies forward hard copies of reports to the SCA who log the event on the NAEMS.

In excess of 100,000 events are recorded annually by over 700 direct users. The NAEMS database provides key information at national and local level to assist in identifying and managing personal injury, clinical and third party property damage risks. It helps Risk Managers to identify and analyse developing trends and patterns of adverse events and informs root cause analysis at a local level.

NAEMS is hosted from within the secure National Treasury Management Agency (NTMA) on the secure government VPN line and is not available through public internet. As an IT system, NAEMS performance has been very impressive. The system has been continuously available to users since 2006 and has been unavailable only for maintenance and upgrade purposes. There have been no data breaches or data loss since its inception.

WHAT IS TO BE GAINED FROM AN UPGRADE?

After many years of use, the technology and various interview screen designs require updating and refreshing. The entry form has no built-in intelligence and so can slow the data entry process. The report functionality for the web based users is limited and does not make full use of the system's capabilities. Additionally, the reporting operating model involves paper report forms being completed at point of occurrence (e.g. at ward level) and sent to a central data inputter to be entered onto the system.

This planned upgrade will radically improve the data entry and reporting functionality of NAEMS. The pick list choices will reflect the current World Health Organisation (2009) taxonomy. User feedback has been overwhelmingly in favour of point of occurrence entry.

PROJECT DELIVERABLES

The project commenced in 2012. The first year was mainly dedicated to scoping a clear picture of user and business requirements. The SCA consulted widely with user groups and key stakeholders during this process. The project will be completed in a number of phases during the remainder of 2013 and throughout 2014. On completion of the project, the key project deliverables are:

- **Improved adverse event entry screens** - From a data

entry perspective it will deliver simple user friendly interview entry screens in plain English as opposed to using risk, clinical, legal terminology or claims language. The form will be clear and will allow a user to select pre-determined routes, based on previous questions.

- **Leading edge reporting capabilities** - Reporting will be greatly enhanced with the addition of dashboards to allow users to customise screen views. Risk management information will be readily available. Customised reporting capability will be available to meet specific requirements for individuals/enterprises e.g. for CEOs/General Managers, Risk Managers, HSE Senior Management and the SCA. Additionally, for a limited number of high level users, there will be a reporting tool that will provide even more comprehensive data.

- **Point of occurrence reporting** - this will be implemented incrementally to all those State authorities/ health and social care enterprises.
- **End to end management of adverse events** - this will allow information, following investigation, to be captured on the system about adverse events so that they may be flagged to relevant persons/sections in an organisation, remedial actions identified, assigned and tracked to close.
- **Audit tool** - will be available to those State authorities/ Healthcare Enterprises that would like to avail of this tool. National, regional or local level audit tools can be built on the system to facilitate auditing and performance scoring.
- **Performance benchmarking** - the system will allow key values, such as service user bed hours, employee numbers, appointment volume, number of employee sick days, number of clinical procedures performed etc. to be recorded. This, combined with the number of adverse events reported, will facilitate performance benchmarking between enterprises. Over time, when these processes have been improved, the system could play a key part in risk pooling and licensing.

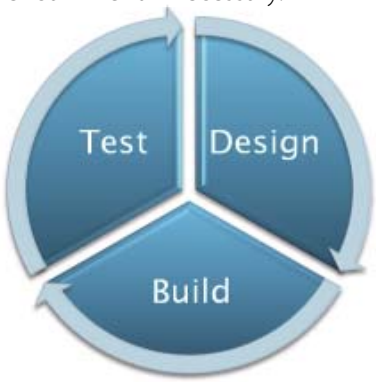
In order for the enhanced system to be successful, it will need to be accompanied by a communication, information and training process. This commenced in early 2013.

Together with the Department of Health, the HSE and voluntary hospitals, the Agency is designing a training programme which is likely to be delivered in multiple formats including briefings, e-training, and formal half and one day training sessions.

As recently as the 24th of July 2013, in a letter to the Director General Designate of the HSE the Secretary General of the Department of Health re-affirmed that *"NAEMS is the national system which is to be utilised by all hospitals without exception."*

STAKEHOLDER INVOLVEMENT

The design team consists of 6 dedicated individuals, supported by IT and business analyst professionals. To support this design team, stakeholders group consisting of relevant parties from the HSE, voluntary healthcare enterprises and other State indemnified bodies, are being consulted as part of an iterative review process. During this iterative process, a single element shall be designed and brought to stakeholders for review and testing. Changes shall be agreed as appropriate, built in and the design then bought back to the stakeholder group for further comment if necessary.



By the end of this phase it is envisioned that all State authorities, public healthcare enterprises and the large number of agencies under the remit of the SCA will be using this singular and cost effective adverse event reporting solution.

The Agency is confident that, as an adverse event management system, NAEMS will deliver a risk management tool that surpasses any other system available in the country.

The Agency will continue to keep its readers updated on progress and looks forward to the 'go-live' day in your workplace. In the interim, local users are encouraged to continue the good work and ensure that reporting levels are maintained (or improved) and used locally to inform risk management programmes and initiatives.

Pat Kirwan, Deputy Director, SCA

The Introduction of Clinical Risk Management to Irish Prison Services - A Collaborative Approach

BACKGROUND – SCA / CIS

Under the National Treasury Management Agency (Amendment) Act 2000, State authorities are obliged to report adverse incidents promptly to the State Claims Agency (SCA) and to facilitate any subsequent investigation. This allows the SCA, in conjunction with State authorities, to be in a position to identify and analyse developing trends and patterns and assists with claims investigation and management should the incident progress into a claim.

The SCA's remit covers personal injury and third party property damage risks against certain State authorities, including the State itself, Government ministers, the Attorney General, Health Enterprises, the Commissioner of An Garda Síochána, Prison Governors, Community and Comprehensive Schools and various other bodies. The responsibility for managing risks associated with clinical activities and the management of subsequent claims was delegated to the SCA in 2002 and these clinical risks and claims are managed by the SCA under the Clinical Indemnity Scheme (CIS).

HEALTHCARE WITHIN IRISH PRISON SERVICE (IPS)

The Irish Prison Service (IPS) provides prisoners with access to the same range and quality of healthcare services as that available under the Medical Card scheme in the community. A wide range of services are provided which include: Primary Care, Pharmacy Service, Mental Health Services, Drug Treatment Services, Dental Services and other services, e.g. optician, chiropody.

The IPS prison healthcare service is responsible for the primary medical care of all prisoners including:

- The health and medical assessment of all new prisoners on committal
- The ongoing general medical care of prisoners
- Prescribing an appropriate course of treatment and monitoring that treatment for its duration
- Referral for specialist opinion, where appropriate. If a prison doctor refers a prisoner to a secondary service, the prisoner will be placed on the public waiting list and once he/she is called for the appointment, his/her escort to the appointment will be facilitated by the IPS.
- Liaison with other professionals involved in the overall care and well-being of the prisoners
- Screening prisoners for relevant diseases
- Ensuring the provision of vaccination programmes for prisoners.

Each prison has a minimum of one prison doctor who attends the prison Monday to Friday and also provides an out of hours on call service. The times of attendance of each doctor varies between prisons. Nurses provide 24 hour cover in all closed prisons. The doctor and nurses are the first point of contact for prisoners seeking medical treatment and provide services similar to those available in a GP practice in the community. Prisoners can request to see the doctor or nurses at any time

IPS ADVERSE EVENT REPORTING PROTOCOL

In order to comply with statutory and common law requirements with regards to the identification and reporting of adverse events, in particular clinical adverse events, the Irish Prison Service Healthcare Compliance Subgroup have developed a procedure for reporting, investigating and recording clinical adverse events across the IPS.

The main aims of this procedure are to ensure that:

- Standardised documentation and reporting mechanisms are implemented service wide.
- Comprehensive adverse event and near miss procedures with supporting systems are in place to allow staff to effectively report these events;
- The health and safety of those affected is the primary focus of attention;
- Adverse events are reviewed, rated and assessed;
- Appropriate corrective action can be identified and implemented reducing the risk of re-occurrence;
- Aggregate data can be reviewed to assist in identifying trends and higher risk factors;
- The regulatory requirement to report adverse events to the State Claims Agency is complied with.

PROCEDURE FOR CLINICAL ADVERSE EVENT REPORTING

In order to ensure a standardised procedure is implemented across the IPS, the following guidance was developed to assist those responsible for reporting, investigating and recording clinical adverse events. The IPS Healthcare Compliance subgroup, with assistance from CIS and SCA risk advisors, dev-

eloped, designed and agreed the Clinical Adverse Event Notification Form for use across the Prison Service. Following extensive consultation, an IPS specific pick-list of adverse event types, based on the pick-lists currently available on NAEMS (formally known as STARSWeb), was also agreed and developed.

ADVERSE EVENT IDENTIFICATION

When an adverse event is identified, the first responsibility is to ensure the safety, health and welfare of the person/s affected. Any care that is required must be provided without delay and circumstances reported. The adverse event should be thoroughly investigated and the form completed. The form should include a factual description of what happened, details of any equipment included or medication, the initial risk rating and outcome of any ameliorating action taken. The individual conducting the investigation must ensure an investigation is undertaken to determine:

- What happened
- The people who have been or may be affected
- Why (what were the causes)
- What needs to be done to ensure it does not happen again or if this is not possible, to ensure the risk of recurrences is reduced as far as is reasonably practicable.

As part of the agreed reporting pathway, any adverse events which have an operational impact should be reported to the safety co-ordinator for action. This is done by completing Section 7 of the Clinical Adverse Event Notification form and forwarding it to the relevant Governor. It is the responsibility of each local Healthcare area to assess and manage minor adverse events to prevent re-occurrences and where appropriate, escalate issues via the agreed reporting structures that may have implications IPS-wide. The completed form should be forwarded to the Chief Nurse Officer (CNO) of each prison as all CNO's have been trained and assigned responsibility for inputting the data onto the NAEMS database.

On receipt of the form, the CNO should:

- Notify Healthcare Management immediately i.e. Director, Chief Pharmacist, Coordinator of Prison Nursing Services of any red risk ratings via email;
- Contact the investigator where additional information or clarification of details is required;
- Input the information into NAEMSWeb (formerly known as STARSWeb);
- Complete the necessary details on the risk rating table which should be forwarded to the healthcare management on a weekly basis.

The adverse events will be periodically reviewed by the Risk Management Committee to identify any gaps, patterns or areas which require attention and also to ensure that the event is properly and safely managed and identify any additional actions as part of the quality assurance process.

STAFF BUY-IN – FORMALISED TRAINING SESSIONS

While there are many advocates for the introduction of a clinical risk management programme to support adverse event reporting and patient safety amongst the IPS Healthcare Compliance Sub-group, it was agreed that additional support and training for all levels and grades was crucial to ensure buy-in and co-operation of healthcare staff at local level. With that in mind, while Mountjoy Campus was agreed as the pilot site for initial implementation, a comprehensive information and training schedule for the multidisciplinary team was developed to support the introduction of the initiative service wide. An information session was provided on the General Practitioner Study Day; CNO's from all Healthcare sites across IPS had both formal presentations and practical training sessions with regard to incident reporting and data inputting onto NAEMS; CNO feedback to frontline staff regarding the proposed introduction of the reporting system was an essential part of this journey so as to reassure staff as to the rationale and purpose of incident reporting. Finally, the majority of the multidisciplinary healthcare staff from Mountjoy Campus participated in additional training whereby they had a theoretical session followed by practical sessions where they had the opportunity to review, discuss, report and rate IPS specific incidents followed by the opportunity to discuss contributory factors in an IPS specific serious adverse event scenario. In addition, in order to support the education and training programme and to provide guidance for frontline staff, a comprehensive booklet *Clinical Adverse Event Notification Form Guidelines and Clinical Picklists* has been developed by SCA/CIS risk advisors which will be available to all IPS healthcare staff.

IMPACT TO DATE?

While it is early days and the rollout of the education programme has yet to be delivered to healthcare staff IPS wide, it was heartening to note that within 24 hours of the Mountjoy

The Introduction of Clinical Risk Management to Irish Prison Services - A Collaborative Approach ***cont.***

Campus training session, the following comment was relayed to the Agency by a CNO:

"I have found that the new system for reporting is proving very beneficial for TWO reasons so far!

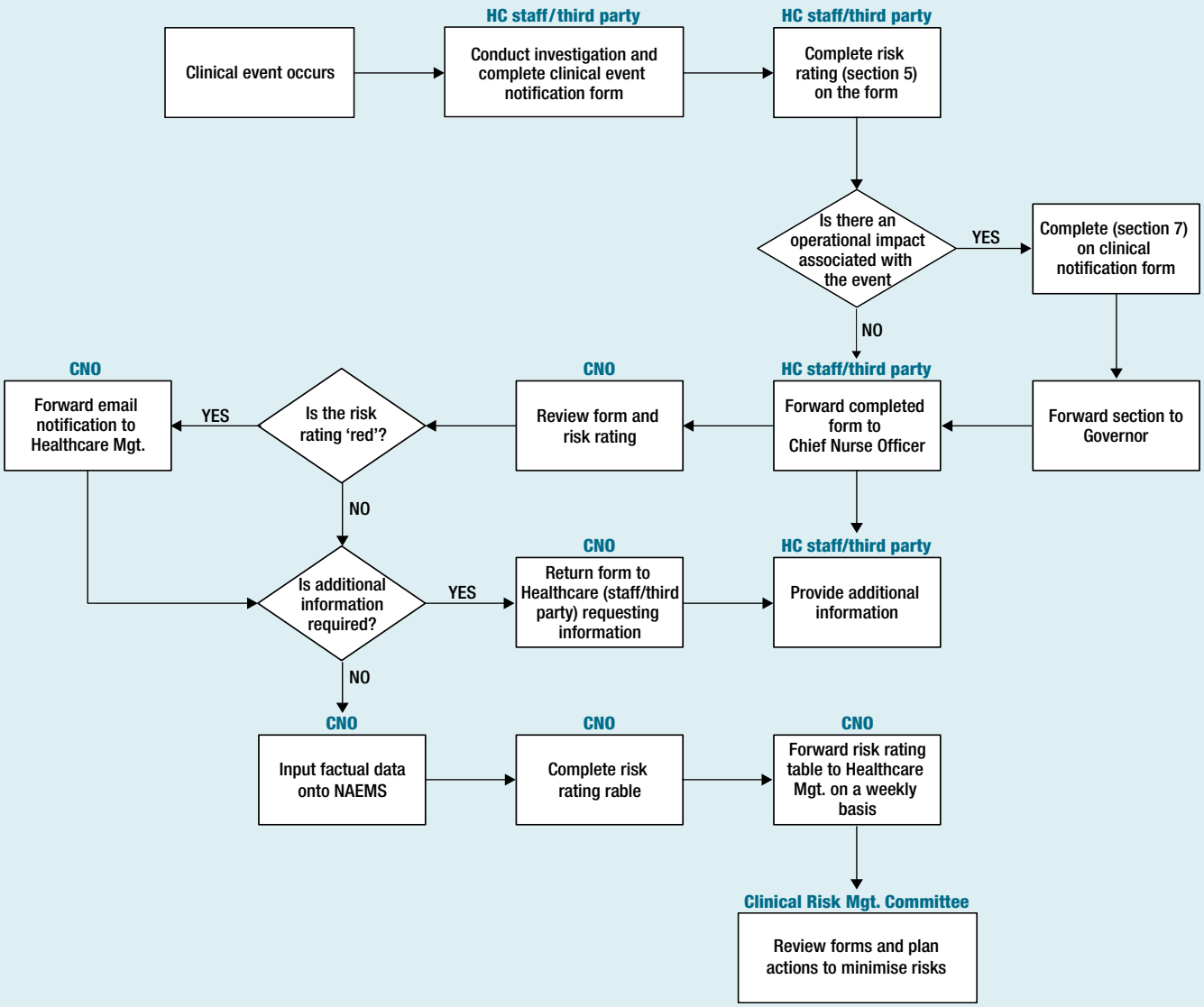
1. The reporting and the rationale behind it (risk management and safety)

2. With IMMEDIATE effect I am noticing that there is now a concentration on putting remedial action in place when/where possible and writing up what has been done. This is evident on PHMS for any of the CIS reports done - For instance nursing staff are following up on anyone who may have been released without medication or linking with external services etc. (e.g. ringing them at home, contacting the GP etc.) "

In addition, there has been a marked increase in the number of clinical adverse events reported in the immediate aftermath of the training with approximately an 81% increase in reporting to date.

Anne Marie Oglesby, Clinical Risk Adviser, CIS

IPS HEALTHCARE PROCESS MAP FOR THE REPORTING OF CLINICAL ADVERSE EVENTS



Vulnerable Patients Who Abscond

On May 12th 2012, a patient with dementia walked out of a ward in St. James's Hospital as visitors were entering.

This patient was noted to be missing within 10 minutes by a healthcare worker who raised the alarm. A full search was immediately carried out on the ward by staff. It was identified this was a vulnerable patient and the hospital has in place a number of procedures for staff to follow in order to aid the prompt location and safe return of missing patients. The Absconding/Missing Patient Protocol was followed and Security, Site Nurse Manager, Clinical team, next of kin and Gardaí were notified. It was electronically recorded as an Adverse Incident. The Gardaí attended the ward and met with family to establish possible addresses that the patient may have travelled to. Internally a full site search was carried out by Security personnel and CCTV footage was reviewed by both Gardaí and Security. Gardaí issued a description to transport agencies and an alert went out across the city. Once a photograph became available this was also circulated by the Gardaí with family consent. Family were kept briefed by the Gardaí throughout this event.

This patient was found eighteen hours later; disoriented and unable to clarify where she spent the night. She was returned to the hospital and a full examination was carried out. She did not appear to have suffered any ill effects from her ordeal. The family were debriefed by the Gardaí, the primary physician and hospital management.

A review of this incident was carried out on instruction from the CEO. The team, chaired by the Deputy Chief Executive Officer agreed Terms of Reference for a systematic review of the circumstances surrounding this incident.

SYSTEMS ANALYSIS

The Patient: This patient, genteel in nature, was fully mobile and preferred to dress in outdoor clothes each day. While confused at times she did not have a history of wandering. A risk assessment did not identify her as requiring a one-to-one observation. She had an identity band in place on her wrist.

The Ward: Activity levels on the ward were described as typical for a weekend day. All wards have controlled access which means staff must swipe their identity badges on an electronic panel to gain access while visitors use an intercom to enter. This secured access offers a level of safety and protection for both patients and staff and offers a limited barrier to confused patients from leaving their environment. The ward access control on both sets of doors was fully operational.

The Staff: The ward was fully staffed and the patient was well known to all the staff present who quickly noted she was missing.

CCTV: There was CCTV nearby and the camera was in working order. A review of footage failed to detect this patient leaving the building.

Location: St. James's Hospital is serviced by Dublin Bus, the Luas, and taxis. These transport services could have been used by the patient who was dressed and had money on her person.

RECOMMENDATIONS

The review team considered the circumstances surrounding this event and felt that all reasonable measures were in place for this patient based on her risk assessment at the time.

The hospital has a wander detection system (Wanderguard™) in place on some wards. The patient who is at risk of wandering wears a bracelet that alarms when the patient goes near the exit doors. This is effective when utilised. It was agreed that all vulnerable patients should be assessed to determine the requirement to use Wanderguard™. Patients admitted to wards without this security system should be transferred to Wanderguard™ areas as a matter of priority. The hospital is now moving to sophisticated technologies to assist with the management of vulnerable patients. The new system enables the responsible person and security to know the location of a patient through a Real Time Location System (RTLS) over the hospital's WiFi network. Through RTLS, alarms are sent simultaneously to responsible person and security notifying them a vulnerable patient has left the ward, the patient can then be tracked and safely returned to the ward.

The hospital currently retains (with consent) photographs of patients in the Hospital's residential unit. It was recommended that the hospital expand this capacity where required with vulnerable patients and with the consent of family. The availability of photographs assists both internal staff and external agencies in the search of the missing patient. The Hospital has been granted approval by the Patient Advocacy Committee to advance this initiative. To ensure compliance with the Use and Recording of Patient Photography Policy, all photos will be taken by the Hospital's Clinical Photographer following an electronic request on the patient order system.

Staff report all patients who abscond or leave the ward area without notifying staff on the Adverse Incident Reporting system. The system prompts the staff to clearly identify the risk factors associated with this patient being missing. This is immediately notified as an alert to both the Risk Manager and Security. Recording this detail on the Adverse Incident reporting system allows for comprehensive audit and evaluation and assist with policy development as well as timely notification to the Clinical Indemnity Scheme.

Una Healy, Risk Manager, St. James's Hospital

No Right to Assisted Suicide

Suicide was decriminalised in Ireland in 1993, but the act of assisting another to take their life remains a criminal offence, punishable by up to 14 years imprisonment.

In 2011, Marie Fleming, a terminally ill woman issued High Court proceedings seeking to overturn the absolute ban on assisted suicide contained in Section 2(2) of the Common Law Act 1993. The pleadings for the case also contained a number of alternative remedies which Ms Fleming would seek from the Court if she did not succeed in her ultimate objective of having the ban overturned. These alternatives included an Order compelling the DPP to issue guidelines setting out the factors she would consider in determining whether or not to prosecute an individual accused of the crime of assisted suicide. Ms Fleming submitted to the Courts that her aim was not to legalise euthanasia but to protect individuals who assist another in taking their own life. The Attorney General opposed the application as she said it would raise very serious issues of public policy. In particular, the AG argued that any regime which legalised assisted suicide could be subject to abuse and would likely be availed of by vulnerable patients, not through choice, but because they do not want to be a burden on their families.

The legal issue at the heart of Ms Fleming's case was the scope of the constitutional "right to die" and whether the right to an assisted suicide was a necessary corollary to that right. She argued that any individual unable to exercise the right to die themselves, must have the right to be assisted in the taking of their life. If Ms Fleming was correct, the legislative ban on assisted suicide would be a clear breach of the constitutional right to die. She also argued that the ban on assisted suicide was incompatible with the constitutional principle of equal treatment on the basis that it impacts disproportionally on those who lack the necessary physical capacity to exercise their right to die. Finally, she argued that the ban infringed the European Convention of Human Rights (ECHR).

Ms Fleming failed in both aspects of her claim before the High Court. The High Court found that the absolute ban on assisted suicide was constitutional and compatible with the ECHR. Ms Fleming appealed this decision to the Supreme Court.

The Supreme Court upheld the decision of the High Court. The Supreme Court was influenced by the potential for abuse and exploitation which could result from a regime of assisted suicide. It found that the decriminalisation of suicide did not create a constitutional right to commit suicide or to determine the timing of one's own death. Similarly, the Court found that a right to die is not a natural consequence of the constitutionally protected right to life. The Court considered the case of In Re a Ward of Court where the Supreme Court had held that the right to life included a right to die a natural death and permitted the withdrawal of artificial nutrition and hydration of a patient in a near persistent vegetative state for more than 20 years. The Court found that there was a distinction between the positive act which would be necessary to end Ms Fleming's life and the withdrawal of nutrition and hydration as comprehended in the Ward case. Similarly, the Court said that there was a distinction between a competent adult exercising his/her constitutional right to refuse life saving treatment and the act of a third party taking steps to end the life of another. The Court also found that the prohibition on assisted suicide did not constitute unequal treatment as had been argued by Ms. Fleming.

Finally, the Court found that although the ECHR placed an obligation on member states to uphold an individual's right to life, it did not create a corresponding obligation to protect an individual's right to die. The Court also found that the right to privacy created by the ECHR could be restricted by member states, and that the restriction in this case was justified given the potential for abuse and exploitation associated with any regime of assisted suicide. The ban therefore was not incompatible with the ECHR.

Commentators do not believe that Ms Fleming will bring an appeal to the European Court of Human Rights, primarily because it is unlikely to result in a different outcome. Ms Fleming and her family may therefore have exhausted the legal remedies available to them. Since the judgment of the Supreme Court was issued, Ms Fleming's partner has indicated to the press that he remains willing to assist Ms Fleming in taking her life when she chooses to do so and that he will accept the consequences of his actions.

Shauna Carmody, Solicitor/Clinical Claims Manager

Case Report - Assault

The Plaintiff, in this case, was a resident in sheltered accommodation provided by the local health authority. One evening following her return to the hostel, a dispute broke out with another resident over the use of kitchen utensils.

The Plaintiff was, at that time, a 41 year old woman who suffered with bipolar affective disorder. Throughout her medical records, she was described as an angry person. The resident accused of the assault was also 41 - she suffered with a mild mental retardation, epilepsy and was described as *'unstable and impulsive'*.

By day, a psychiatric nurse and care attendant visited the house and a care assistant was resident in the house in the evening time. On the day of the assault, the hostel was visited twice by nursing staff, and, once by a care attendant.

On the evening of the assault, both women returned from work and in the kitchen of the hostel a heated argument broke out over the use of kitchen utensils. The argument escalated very quickly, and the defendant pushed the Plaintiff head first through a glass panelled door. Unfortunately, the Plaintiff suffered extensive facial lacerations, the lacerations were deep and necessitated repair in theatre. The injuries also resulted in noticeable facial scarring. The Plaintiff claimed that she needed much in the way of psychiatric treatment following the incident.

The thrust of the Plaintiff's case was - on the day in question, the resident who assaulted the Plaintiff was not an appropriate patient to be housed in the hostel because of her known violent propensity, and, because of the danger she presented to the Plaintiff and other patients in the hostel.

The Plaintiff also alleged that the staff knew that the resident, in the weeks prior to this incident, had previously assaulted other patients in the house, and, she should have been removed to a secure psychiatric unit. The Plaintiff further alleged that an adequate psychiatric assessment of the plaintiff was not made to eliminate the risk of assaults and violent behaviour towards the plaintiff.

As indemnifiers acting for the local health authority, the SCA was charged with investigating this case. It sought assistance from several experts including a consultant psychiatrist who opined that the supervision in the hostel was inadequate at the time as there were no staff members in attendance to "de-escalate matters as they arose". He was also critical of

the local health authority, in that no medical review of the resident was ordered in the days leading to the assault, despite her unstable condition. They were also aware that she had assaulted two other residents of the hostel in the weeks leading up to this incident.

This matter was settled a number of weeks before trial as there was no realistic possibility of defending the matter, should the case have run to a full hearing. The Plaintiff was compensated for her facial scarring but no damages were paid for the alleged escalation of her psychiatric difficulties as the Plaintiff did not provide any evidence to support this allegation.

Nicola Murray Hayden, Solicitor/Clinical Claims Manager

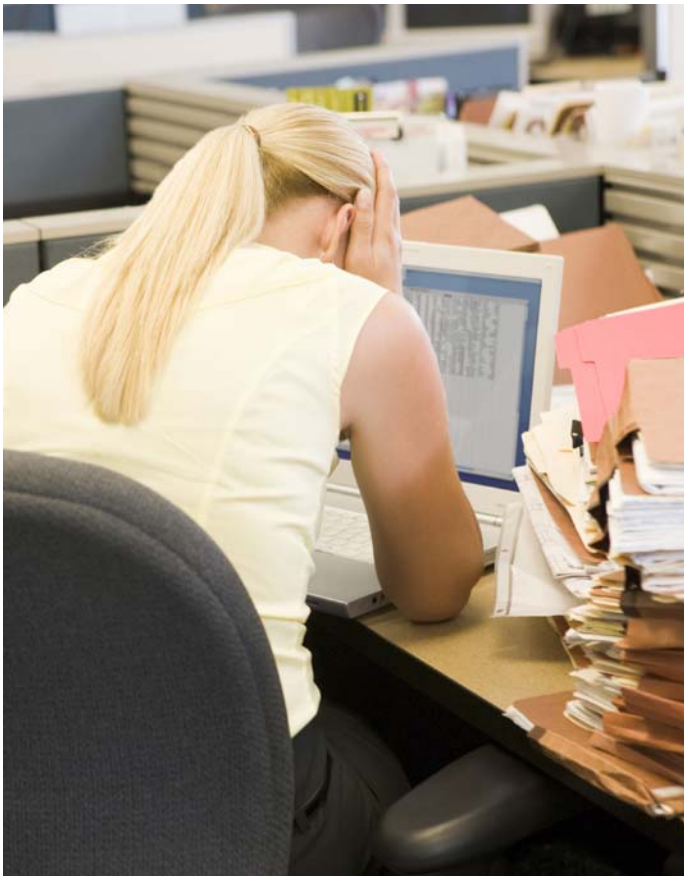
FOCUS ON POST-TRAUMATIC STRESS DISORDER IN THE WORKPLACE

A Review of Litigation Risk

In compliance with the State Claims Agency's (SCA) statutory duty, to advise and assist State authorities under its remit on measures to prevent or reduce the incidence of claims, a review of the litigation risk in State authorities posed by critical incident stress leading to post traumatic stress disorder (PTSD) was completed by the Agency.

Those who experience or witness a traumatic event may be at risk of Post Traumatic Stress Disorder (PTSD). A traumatic event is defined as an event, or series of events, that causes moderate to severe stress reactions. Traumatic events are characterised by a sense of horror, helplessness, serious injury, or the threat of serious injury or death. Within the HSE, various staff categories may be exposed to traumatic events - the emergency services, acute hospital sector, disability services etc.

The SCA found that as a litigation risk, PTSD is controllable. Pre and post event interventions, such as those provided through Critical Incident Stress Management (CISM) programmes, can be used to successfully defend PTSD-type personal injury claims. Certain authorities, notably The Defence Forces, have successfully defended PTSD claims by demonstrating how they apply their CISM programmes. Due to the relatively recent delegation of HSE claims, in 2010, alleging personal injury to employees, the SCA was not in a position to include HSE claims in the study due to the immaturity of the portfolio. Similarly, the agency was not in a position to assess the management of critical incidents in the HSE. Nonetheless, the results and associated recommendations would, no doubt, be equally applicable in any organisation, including healthcare providers, and the study should serve to signal to and remind management that critical incident stress management is an issue that cannot be ignored and must be addressed.



LEGAL BACKGROUND

Stress arising from a critical incident is a recognised psychosocial workplace hazard and under the Safety, Health and Welfare at Work Act, 2005, employers are obliged to assess the level of this risk, prepare risk assessments and record the findings in a safety statement. In the context of the CISM programme, a number of other statutory provisions in the Act place additional requirements on the employer, including the provision of information on each employee's role and responsibility, training e.g. training to HSE managers on stress and stress management (including, for example, CISM) and supervision as necessary. In civil law cases, the courts' understanding of stress, psychiatric injury and shock is influenced by advancements in the fields of psychiatry and psychology. There appears to be some lag time between professional advancements and court findings. As a result, court awards and judgements have a varied past as they attempt to keep pace with the latest direction taken by psychiatrists and psychologists.

The Scottish Law Commission recognised this gap and produced a report entitled *'Report on Damages for Psychiatric Injury'* (2004) with recommendations to bridge the knowledge gap between the courts' understanding of psychiatric injury and that of leading professionals. In a second review, the UK Court of Appeal reviewed four cases, collectively known as the Hatton case, and produced its own guidelines (The Hatton Guidelines - see page 14) which have been adopted by the Irish courts, most notably in the *McGrath v Trintech* case. This article outlines several relevant Irish cases in a separate section and summarises conclusions that can be drawn from a review of the case law.

Focus on post-traumatic stress disorder in the workplace ***cont.***

SUMMARY OF CONCLUSIONS FROM CASE LAW

- Where sources of stress, such as traumatic events, are not reasonably foreseeable, the employer is not likely to be found negligent. However, once the employer has knowledge, it should take measures to eliminate or reduce to a manageable level the sources of stress/trauma.
- Where an employee presents with PTSD symptoms, where the source of the PTSD is possibly work-related, which could be considered as obvious and are readily recognisable, the employer must intervene. This requirement emphasises the need for managers to be trained to recognise obvious indicators of PTSD, including changes in employees' behaviour, uncharacteristic periods of absence and other indicators which could be considered by a court as readily identifiable indicators.
- Where an employee is provided with appropriate interventions following a critical incident, which applies the most contemporary knowledge, the courts are likely to rule in favour of the employer. The introduction of a holistic approach to CISM is the most effective defence against claims for psychiatric disorders brought on by acute stressful events as in PTSD.
- Where employers are found liable for physical injuries they may also be liable to compensate employees for psychiatric injuries or mental ill health.
- In Irish courts, the common law principles of negligence are the only considerations. These are:
  - the employee must establish a duty of care;
  - the employee must prove that his/her employer breached this duty or the employer's actions fell below a certain standard of care;
  - the employee must have suffered a recognisable psychiatric injury (damage);
  - there must be a clear link between the breach of duty and the damage suffered by the employee (causation).

Aside from the requirements detailed in civil case law, it is important to remember that State authorities may be criminally prosecuted for a failure to manage PTSD. Any statutory breach erodes a State authority's ability to offer a defence should subsequent claims arise.

PTSD CLAIMS AGAINST THE STATE

A review of claims managed by the SCA found that a significant number of claims had PTSD cited in the statement of claim. The events which triggered these claims included:

- exposure to a violent episode e.g. discharge of a weapon, threatened assault;
- road traffic accidents, whether passengers or witnesses;
- false detention, held against will, trapped;
- exposure to a physical or biological hazard e.g. needle-stick, spat at, brucellosis, TB;
- rescue and recovery;
- witnessed a death or present at the time of death;
- death of a relative in custody;
- mismanagement of data and wrongful accusations;
- witnessed/involved in an accident other than a road traffic accident.

A further detailed review was carried out to determine if PTSD cited in the statements of claim could be justified. The criteria used by the SCA to establish whether a claim could be accurately classed as PTSD was based on the criteria used by the courts, influenced in particular by the Hatton guidelines. In particular, the classification process focused on the type of traumatic event, individuals' reactions to the event and a professional clinical assessment of the claimant (these were available in the majority of cases). From the initial sample of cases, 23% could justifiably be classed as PTSD claims.

A review of this sample group found that where PTSD claims are successful, the cost to the State can be high. Where claims for PTSD are made by State employees, they often retire early, prior to the settlement, and are absent from work for extended periods of time, significantly increasing special damages[1] costs. PTSD awards made to State employees were particularly high in value. PTSD awards made to members of the public tended to be comparably lower.

Where an employee suffers PTSD, there are often indirect or hidden costs, which are often overlooked and can actually outweigh the direct costs. At organisational level, indirect costs may include, significant absenteeism, substitution of personnel resulting from absenteeism, additional administration, loss of service, loss of expertise, presenteeism[2] and extra supervisory time.

Focus on post-traumatic stress disorder in the workplace ***cont.***

When approximating the indirect costs of accidents, it is generally recognised that indirect costs tend to be a multiple of direct costs[3]. The SCA conservatively estimates that a ratio of 1:2 (direct costs to indirect costs) may be appropriate in the case of PTSD claims.

The SCA conservatively estimates that the direct and indirect cost of PTSD claims to the State will be in the region of €11 million. This estimate is only part of the picture of the cost of PTSD claims taken against the State, when one considers the large number of claims citing this injury made to other compensation schemes such as the Garda Compensation Scheme and the Scheme of Compensation for Personal Injuries Criminally Inflicted on Prison Officers. Additionally, the scope of this review did not include the public emergency services such as the Health Service Executive and the Fire and Emergency Services. Thus, the total cost to the State far exceeds the above, initial estimate.

REDUCING COSTS - RECOMMENDATIONS

The recommendations of the SCA review, although not focused on healthcare enterprises, can still be applied in hospitals, health centres and similar groups.

It is difficult for health care management to reduce costs after the event has occurred and the injury has been sustained. The use of planned preventative structured interventions can play an important role in reducing the amount of damages or in preventing claims in the first instance, providing that programmes have been implemented appropriately at all stages. In cases where pre and post event interventions controls, such as those provided through CISM programmes have been put in place, the State has successfully managed to defend claims for PTSD injury.

All healthcare enterprises should review their activities to identify employees who are at risk of being exposed to a traumatic event. A formal written risk assessment should be prepared and recorded in the authority's safety statement.
The SCA is working in conjunction with the Health and Safety Authority to produce a template for risk assessing the issue *(see note on CISM Risk Assessment at end)*.

As part of control mechanisms, management should assess the need for and/or accessibility to their psychosocial support programmes by those employees at risk, including any pre-crisis preparation. To control the risk adequately, employers must adopt, as formal policy, the use of best practice and standardised psychosocial support programmes, such as CISM, after a traumatic event, in order to provide appropriate support, thereby reducing the likelihood of claims. Any psychosocial support programme must reflect contemporary practices and knowledge, and be provided by competent persons only, who actively participate in programmes of continual professional development and who have access to appropriate forms of professional mental health support.

Main finding of the SCA PTSD Review

As a litigation risk, PTSD - type claims resulting from critical incidents is controllable. Pre and post event interventions, such as those provided through Critical Incident Stress Management (CISM) programmes, can be used to mitigate and successfully defend PTSD - type personal injury claims.

FOOTNOTES

[1] Special damages compensation awards include medical expenses, lost earnings (wages and pensions) and lost opportunity (overtime and bonuses).

[2] Presenteeism is the loss in productivity that occurs when employees come to work but function at less than full capacity because they may not fully recovered or may be unwell.

[3] Bird Jr, F.E. & Germain, G.L. (1985) Practical Loss Control Leadership. Loganville, Georgia: Institute Press

The Agency wishes to take this opportunity to draw your attention to the HSE Policy on Preventing and Managing Critical Incident Stress. Its purpose is to assist employees following exposure to a critical incident or traumatic stressor. This policy is an integral part of the HSE overall workplace stress policy, Prevention and Management of Stress in the Workplace.

Focus on post-traumatic stress disorder in the workplace ***cont.***

CASE STUDIES - PTSD IN THE IRISH COURTS

A review of case law can be used to aid the design of CISM strategies and programmes. Court judgments can provide practical propositions for consideration in PTSD-type personal injury claims, as can be seen in the three examples hereunder.

Plaintiff 'A' v. Minister for Defence:
High Court, Dublin, January 1999

While on his third tour of duty in the Lebanon, between November 1992 and April 1993, the Plaintiff was exposed to traumatic incidents, as a result of which he developed PTSD. The Plaintiff claimed that the Defence Forces failed to recognise or treat his PTSD. Because of this failure, the Plaintiff claimed he suffered a personal injury in the form of chronic PTSD.

The Court found that *"there was negligent failure on the part of the Plaintiff's superiors to recognise his obvious symptoms of stress".* Finding for the Plaintiff, the Judge made the following comments:

- the Defence Forces failed to recognise the Plaintiff's symptoms;
- the Defence Forces failed to refer the Plaintiff to a doctor;
- if treatment had been afforded at an early stage then the evidence suggests that PTSD could have been avoided or reduced;
- the Defence Forces must keep abreast with contemporary knowledge in the field of reduction in the effects of potential afflictions to which soldiers are inevitably exposed in the course of duty.

The Plaintiff was awarded IR £218,900 in damages and costs.

Plaintiff B v Minister for Defence and Others:
High Court, Dublin, April 2006

The Plaintiff, a soldier, had volunteered to go on four tours to the Lebanon firstly in 1991, then in 1993 and two tours back to back in 1997. As a result of witnessing traumatic events, the Plaintiff claimed that he suffered PTSD. During the trial, the Defence Forces proved that they had kept abreast of international developments and had offered Critical Incident Stress Debriefing as well as other active interventions. The court did not accept the contention that the treatment the Plaintiff received after the incidents was inappropriate. The Plaintiff's claim was rejected by the court.

Following these and other cases, the Defence Forces adopted a CISM programme. The programme was seen by the courts as effective, appropriate and in line with contemporary knowledge and international best practice.

Plaintiff C v Trintech:
High Court, Dublin, October 2004

The Plaintiff worked with the company as an IT project manager. The Plaintiff claims that he was subjected to grave work-related stress and pressure which resulted in injury to his psychological health and well-being. The plaintiff was later made redundant and initiated legal proceedings against his employer.

Prior to joining the company, the Plaintiff had some psychological issues. The pre-employment medical report did not reference psychological history or mental health. This made it difficult for the employer to foresee the mental illness.

The court found that the Plaintiff was entitled to some compensation for the manner in which he was dismissed but did not find that the stress-induced injury was a consequence of a breach of statutory duty by the defendant.

Amy Costello and Elaine Byrne, Risk Managers, State Claims Agency

CISM
CRITICAL INCIDENT STRESS MANAGEMENT NETWORK IRELAND

In parallel with the review of PTSD, the State Claims Agency joined the Critical Incident Stress Management (CISM) Network Ireland. This network provides a forum for the promotion and exchange of best practice information on CISM and information on standards, availability and provision of training for CISM. The Network is run by an inter-agency National Steering Committee (NSC) comprising a wide range of representatives, including statutory, voluntary, emergency, military, and other agencies.

Members include the Pre-Hospital Emergency Care Council, The National Ambulance Service and the HSE (emergency management and mental health). This Network is the first of its kind in Ireland and is the leading group to advise, work with, and support the emergency services (and others) in implementing CISM in Ireland.

In particular, the network has produced an information leaflet for emergency personnel that is available, along with other resources, from **www.cismnetworkireland.ie**

CISM Risk Assessment

CISM Ireland, the State Claims Agency and the Health and Safety Authority are working on a joint initiative to develop an agreed national risk assessment format. This is a very useful and helpful development as a common methodology; no methodology exists for the assessment of the level of risk from critical incidents in an organisation. The SCA has secured a dedicated project resource to complete this project over a 5 month period.

Focus on post-traumatic stress disorder in the workplace ***cont.***

THE KEY HATTON GUIDELINES

1. *There are no special control mechanisms applying to claims for psychiatric (or physical) illness or injury arising from the stress of doing the work an ordinary employee is required to do. The ordinary principles of assessing whether damage had been suffered as a consequence of a failure in duty of care apply.*
2. *The threshold question is whether psychiatric or psychological harm to an employee was reasonably foreseeable. This has two components, (a) an injury to health which (b) is attributable to stress at work.*
3. *An employer can usually assume that the employee can withstand the normal pressures of the job unless he knows of some particular problem or vulnerability.*
4. *There are no occupations which should be regarded as intrinsically dangerous to mental health.*
5. *Factors likely to be relevant in answering the threshold question include:*
   - *The nature and extent of the work done by the employee, is the workload much more than normal?*
   - *Is the work particularly intellectually or emotionally demanding for this employee?*
   - *Signs that others doing this job/in the department are suffering harmful levels of stress e.g. abnormal level of sickness or absenteeism.*
   - *Signs from the employee of health problems that may be attributable to stress at work e.g. a particular problem or vulnerability, illness, frequent or prolonged absences?*
6. *The employer is generally entitled to take what it is told by its employee at face value.*
7. *Signs of work related stress must be plain to trigger action.*
8. *The employer is only in breach of duty if it has failed to take the steps which are reasonable in the circumstances.*
9. *An employer can only reasonably be expected to take steps which are likely to do some good.*
10. *An employer, who offers a confidential advice service, with referral to appropriate counselling or treatment services, is unlikely to be found in breach of duty.*
11. *If the only reasonable and effective step would have been to dismiss or demote the employee, the employer will not be in breach of duty in allowing a willing employee to continue in the job.*
12. *In all cases, it is necessary to identify the steps which the employer both could and should have taken before finding it in breach of its duty of care.*
13. *It is not enough to show that work-related stress has caused the harm; it must be proven that a breach of duty also occurred and this contributed to the harm suffered. An employer is only liable for the proportion of the harm suffered which is attributable to its wrongdoing.*
14. *The assessment of damages will take account of any pre-existing disorder or vulnerability and of the chance that the employee would have succumbed to a stress-related disorder in any event.*

ADVISORY NOTICES

Tuberculosis

The SCA has received notification of 60 claims relating to outbreaks of Tuberculosis since 2001. In light of this, we wish to remind management across healthcare settings of the need to have formal policies, procedures and protocols to deal with suspected cases of Tuberculosis outbreaks in the workplace, to protect service users and staff.

We urge management to revisit such policies they may have in place and to remind staff of the contents.

Sharps Legislation

The implementation date for the Council Directive relating to the prevention of sharps injuries in healthcare was the 11th May 2013. While awaiting the Regulations, which will implement this Directive, the HSA has produced a guide to the proposed Safety, Health and Welfare at Work (Prevention of Sharps Injuries in the Healthcare Sector) Regulations, 2013, *"Guide to the proposed Safety, Health and Welfare at Work (Prevention of Sharps Injuries in the Health-care Sector) Regulations, 2013"*

www.hsa.ie/eng/Your_Industry/Healthcare_Sector/Biological_Agents_/Sharps_/Directive_on_Sharps_/guide_to_the_proposed_regulations.pdf

Guidance on the Prevention and Management of Musculoskeletal Disorders (MSDs) in the Workplace

This guide gives practical information on actions to be taken to prevent and manage MSDs in the workplace and includes policy, risk assessment, safe system of work, training, accident/near miss investigation, injury management and internal auditing. The guide covers MSDs related to manual handling, use of display screen equipment at computer workstations and work activities with increased risk of upper limb disorders.

A copy of the guide can be accessed at www.hsa.ie

Claims Management Case Study - Fraudulent and Exaggerated Claims

Under Section 26 of the Civil Liability and Courts Act 2004, if false testimony is given or a false affidavit of verification sworn, the court can dismiss a claim, unless it would result in an injustice being done. The rationale for this is to provide defendants with a defence to an exaggerated claim and discourage fraudulent claims.

Section 26 of the Civil Liability and Courts Act, 2004, provides for what has been described as a "draconian" remedy to be applied where a Plaintiff has knowingly given false and/or misleading evidence in a material respect which he/she knows to be false or misleading or where the Plaintiff swears an affidavit in respect of any information which is false or misleading in any material respect. In short, a Plaintiff's claim will be dismissed where the person gives evidence dishonestly with the intention of misleading the court.

The application of this particular provision of the Act, by the courts, is gathering pace and the case of **X v Minister for Justice, Equality and Law Reform 2012**, is a case in point.

The Plaintiff was involved in a road traffic accident on which occasion she was travelling as a front seat belted passenger in a motor vehicle. Following a collision with a Garda vehicle, she alleged significant injuries to her neck, right shoulder and lower back. Liability had been conceded at an early stage in the proceedings.

The case went to a full hearing in the High Court in July and October 2012 and was very vigorously contested by both sides. The plaintiff gave evidence that she had been denied the opportunity to pursue her chosen career and submitted a very significant six figure loss of job opportunity claim on that basis.

The Defendants, on conclusion of the case, made an application pursuant to Section 26 of the Civil Liability and Courts Act, 2004, to dismiss the Plaintiff's case on the grounds that she gave false and misleading evidence and had sworn an affidavit of verification of pleadings that was untruthful.

The Defendants alleged that the Plaintiff, in her evidence, had grossly exaggerated her complaints and engaged in material non-disclosure to all of the medical doctors who examined her, by failing to disclose a subsequent road traffic accident in June 2010. The Defendants alleged that this non-disclosure had the effect of misleading the Defendant's doctors in relation to the substantive nature of her injuries. In addition, the Defendants contended that the Plaintiff's claim for the alleged loss of job opportunity, arising out of her inability to pursue her chosen career, was grossly exaggerated.

In his Judgement given in October 2012, the Trial Judge held that the Plaintiff had no intention of pursuing the career she alleged she intended to pursue and that this was a false claim which she intended to inflate her claim for damages.

The court rejected the Plaintiff's evidence of ongoing significant injury and found that material non-disclosure of certain facts had painted an unreliable picture to the court of the true state of the Plaintiff's condition. It found she had demonstrated a determination to maximise her damages by manipulating the evidence and by deliberately lying to the court during the course of the trial.

The Court held that the Plaintiff's conduct in the circumstances warranted a dismissal of her claim under the provisions of Section 26 (1) of the Civil Liability & Courts Act 2004. The Judge awarded the costs of the proceedings to the State. The Plaintiff has lodged an Appeal against the dismissal of her claim to the Supreme Court and this is pending.

Simon Watchorn, Head of Claims (non-clinical), State Claims Agency

Non-Clinical Reports/Guidelines

Non-Clinical Reports/Guidelines produced by the SCA are available at:

http://www.stateclaims.ie/RiskManagement/risk.htm

Including:

- *Guidance Document on State Indemnity for Personal Injury and Third Party Property Damage in the HSE*
- *Survey of Child Protection and Welfare Management in Community and Comprehensive Schools*
- *Guidance on risk assessments, Statutory Inspections, noise, asbestos and mould.*

Although some of this is related to specific authorities the advice may still be utilised in the HSE. All the guidance aims to provide practical tools to assist in litigation risk management.

3rd Patient Safety Conference

The Minister for Health launched three new clinical governance documents at the 3rd Patient Safety Conference held earlier this year.

- Quality and Safety Committee(s): guidance and sample terms of reference
- Quality and Safety Walk-rounds: toolkit
- The Safety Pause: Information Sheet

These are available on the HSE website (with word versions of the toolkits for adaptation) at www.hse.ie/go/clinicalgovernance.

Welcome

The SCA welcomes new joiners Claire and Mary to the CIS team and Sharon to the SCA team.

Claire O'Regan

Mary Godfrey

Sharon Gallagher

Anything to share?

Have you a quality initiative that you would like to share, if so contact

Claire O'Regan at coregan@ntma.ie

- Approx 700 words
- Made/making a difference to delivery of care
- Project/study does not necessarily have to be complete

NTMA Annual Report

The NTMA Annual Report (2012) was launched in June 2013 and will be available on the SCA website; it shall contain some general information about the SCA and information on claims under management.

Comments and Submissions

can be forwarded to

info@stateclaims.ie

The SCA newsletter is also available on our website @ www.stateclaims.ie under CIS Publications section

The State Claims Agency,
Treasury Building,
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