The State Claims Agency
Newsletter
Gníomhaireacht Éileamh an Stáit

State Claims Agency Newsletter, March 2013

Looking forward to the new State Claims Agency Newsletter

The State Claims Agency Risk and Claims Management Teams

** not all CIS and SCA team members are represented in this photo*

I would like to take this opportunity to welcome our readers to our rebranded and extended State Claims Agency Newsletter which formally reflects our extended statutory remit for the employers, public, property damage and clinical negligence exposures of the HSE and the clinical negligence exposure of the Voluntary Hospitals Group. The aim of our new look Newsletter is to bring you more topical issues concerning claims and risk management.

LEGAL COSTS UPDATE

Previously, this editorial has commented on the disproportionately high level of legal costs associated with clinical negligence actions. Recently, the SCA decided to contest the plaintiff's Bill of Costs in the case of ***Isabelle Sheehan (an infant, suing by her mother and next friend, Catherine Sheehan)-v-David Corr***. Due to medical negligence, the plaintiff sustained injuries resulting in her suffering from Dyskinetic Cerebral Palsy. The defence, on behalf of the defendant, admitted a breach of duty of care but denied causation. Following a five-day hearing,

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in October 2011, an interim settlement was reached between the parties which was approved by the High Court such that the plaintiff would recover against the defendant the sum of €1.9 million and costs of the action. The settlement sum of €1.9 million included two years cost of future care, the cost of future care into the future beyond that date to be re-visited in the context of the long anticipated legislation providing for Periodic Payment Orders in these types of cases.

The plaintiff's Bill of Costs was listed before Taxing Master O'Neill on 11th and 12th September 2012 and the Taxing Master delivered his reserved Judgement on 7th November 2012. The Taxing Master reduced the plaintiff's solicitors' professional fee, claimed at €485,000, to €270,000. Similarly, the Taxing Master reduced Senior Counsel's brief fee, claimed at €125,000, to €65,000. Junior Counsel's brief fee was reduced to €32,500 i.e. 50% of senior counsel's brief fee.

What is of significant importance, however, is that the Taxing Master enunciated a number of principles which will be of considerable assistance to practitioners in relation to the taxation of costs. These principles are as follows:

- The Taxing Master did not accept an argument, advanced on behalf of the plaintiff, that there was an element of novelty or uniqueness attaching to the particular case which should bear on the level of the instructions fee.
- He stated that the higher the level of complexity and the harder a case is fought, the higher the instructions fee is likely to be. In the particular case, he held that it did not fall within the higher range of complexity or extent of work insofar as the nature of the solicitor's work on liability and causation was concerned.
- He stated that specialist skills were demonstrated by the plaintiff's solicitor of the type which might reasonably be expected in a solicitor undertaking litigation of that sort.
- He did not see the necessity for the attendance of two specialist solicitors, both of whom, in his view, were eminently qualified to advise the plaintiff and take part in negotiations in their own right. He held, therefore, that the cost of attendance of the second and additional senior solicitor was not recoverable on the party and party basis.
- He held that the plaintiff, in the case, was fully and expertly represented at all stages by solicitor and counsel and he heard no compelling argument as to why the attendance of the additional solicitor was necessary for the attainment of justice on behalf of the plaintiff.
- He stated that in his experience the high rate of Court Duty payable by the indemnifying party, following taxation of costs, provides an almost irresistible incentive to such paying party to settle the costs without recourse to taxation. He stated that to achieve this, a more generous approach has been adopted in relation to the measurement of fees and that this has been the position for many years. He therefore held that the validity of any cited comparators must, at least, be questioned.
- He held that the nature and extent of work as shown on the papers is the proper approach to the measurement of the instructions fee.
- He stated that he could not take into account the fact that two senior counsel were briefed on behalf of the plaintiff.
- In relation to the issue of 5-star accommodation for the experts on behalf of the plaintiff, he held that it was a policy of the particular solicitor to arrange accommodation in one particular hotel of this standard. He stated that, to him, this was a luxury in respect of which the defendant was not obliged to indemnify the plaintiff. Accordingly, the Taxing Master reduced the overall cumulative expenses by €500, which reduction he believed did justice between the parties.

This reserved Judgement by the Taxing Master set out clear principles. These principles constitute a welcome set of guiding principles for plaintiffs' and defendants' practitioners alike as to how costs should be measured in catastrophic injury medical negligence actions. The Taxing Master's reserved Judgement represents a considerable step forward in the understanding of how legal costs are measured at taxation.

Ciarán Breen, Director of the State Claims Agency

State Indemnity versus Insurance

Following the delegation of the management of risks associated with adverse events involving employees and members of the public (non-clinical) it became apparent to the SCA that there was some confusion on the scope and terms of State indemnity versus insurance within the HSE. In this article we hope to address this and set out the differences between State indemnity and insurance.

There is a general and mistaken perception that insurance is legally required. In this jurisdiction the only legally required insurance is third party motor insurance required by all drivers of road vehicles. Insurance effectively is a commercial product, its purchase by an organisation is a strategic decision based on whether the product being offered provides value in terms of balancing the cost of the premium and the recoveries of the policy, against likely losses, taking into account the other services the insurance company can offer.

To fully understand the difference between State indemnity and insurance, it is instructive to look at the various ways in which organisations may deal with the risks, and associated financial losses, they encounter as part of their daily activities, as set out below:

1. Organisations may choose to avoid the risk by not carrying out the activity. This is not generally possible and less so in the case of a public service body such as the HSE.
2. The risk may be shared, for example, by contracting the activity to another organisation. Again the opportunities for the HSE to do this are limited and there is a financial cost to this risk sharing which will be subsumed in the contracting cost.
3. The organisation may accept the risks and manage them using appropriate mitigating controls. In these cases some of the financial losses associated with the risks can be transferred, i.e. you can purchase insurance, which means that the financial losses will be borne by the insurance company if the loss occurs. Obviously, there is also a cost to such a strategy. However, some organisations may also choose to absorb the financial loss themselves or, in other words, to self-insure the risk and associated financial losses.
4. There are a number of alternatives to conventionally insuring all of the risks your organisation encounters, many of which have to do with the degree to which you insure the financial losses associated with the risk. For example, an organisation may decide to insure against catastrophic risk, (cover for extreme losses only), or alternatively decide to manage the lower financial losses through an excess on their policy. Either of these options may result in a smaller premium as the organisation is retaining more of the risk and associated financial losses.

SO WHEN AND WHY DO ORGANISATIONS OPT TO PURCHASE INSURANCE?

If we consider this question in the context of our own personal lives, the main reason we all purchase insurance is that we realise that such a loss would be so significant that we could not absorb it based on our normal income e.g. house fire, road traffic collision, serious illness. Thus, we pay a premium for an insurance policy, many of us for many years without, hopefully, ever making a significant claim on it. The cost, therefore, of purchasing insurance is based on the risk being covered, a charge for administration costs and a profit margin for the insurance company.

It is similar for small companies where one significant personal injury claim may have a serious impact on cash flow and could endanger the business as a whole. The additional advantage of purchasing insurance is that you are provided with a service. When a claim occurs, you have a team of people who are available to your organisation that are experts in dealing with the claims process. Additionally, many insurance companies also provide a risk management service. Many large companies opt for a self-insured model. Again, this can take many forms, but the simplest form is that the organisation decides not to insure any of the possible financial losses associated with its activities, but to absorb any incurred losses through the day to day finances of the organisation.

WHAT IS STATE INDEMNITY?

'State indemnity' which is used in respect of the HSE and other Government departments, State bodies, Public bodies and State agencies is effectively a 'self insurance' model.

An indemnity (whether given by the State or not) is an agreement to compensate a third party or individuals for a loss. In the case of State indemnity, an indemnity is given to State bodies, or individuals, by the State to compensate third parties for any losses that they incur, as a result of the activities of the State body in question. However, the State body covered by State indemnity must have been negligent in some way.

This approach to insurance is set out in the **Public Financial Procedures, Department of Finance, 2008, C8, Section 11, Insurance** and states, '*the general rule is that no insurance*

should be affected against the risk of any loss which, if it arose would fall wholly and directly on public funds'.

WHAT ARE THE BENEFITS OF A STATE INDEMNIFIED APPROACH?

The Government decision to operate a State indemnified approach is based on the financial savings that result, as set out below:

- Many of the risks associated with the activities that the State carries out are uninsurable, and this is the case for the HSE. Even if these risks were insurable, they would attract extremely expensive/prohibitive premiums to insure commercially.
- In respect of the risk with which this newsletter is concerned i.e. personal injury and third party property damage, the State is large enough to absorb any of the associated financial losses.
- If we consider the total cost of the claims in these categories of personal injury and third party property damage, on average, year on year, across all State authorities, including the HSE, the total annual spend on claims is approximately €100 million. While this is a significant amount of money and a figure that all State authorities, in conjunction with the SCA, endeavour to minimise, it can be absorbed as part of day to day spend once provision has been made in each State authority's vote. Organisations that purchase insurance will also pay for the services the insurance company provides i.e. claims management, legal advice and risk management. However, in respect of personal injury and third party property damage risk, the State has established a dedicated professional team in the SCA to provide these services to State authorities the cost of which is born by the exchequer.

The SCA handles certain categories of risks and claims, on behalf of delegated State authorities, as the result of a specific State indemnity which was provided under legislation. There are other categories of risks which are covered by State indemnity, but whose risks and associated claims are not managed by the SCA. These are dealt with either by the HSE directly or another organ of the State on behalf of the HSE.

The role of the SCA, and the service provided, is discussed in further detail in Section 2 - "What is the State Claims Agency?"

Case Study - HSE

Since 2010, the HSE no longer purchases conventional insurance for personal injury (non-clinical activities) and third party property damage risks and as such do not pay the associated insurance premium costs. Analysis has demonstrated that the State's cost of dealing with claims directly is significantly lower than the premium cost of insuring the risk. When the HSE were commercially insuring these categories of risk they were paying in excess of €21 million in insurance premia per annum. This means the HSE would have paid approximately €63 million over the past 3 years in dealing with claims that have occurred since 2010. Approximately €1.9 million has been expended to date in the management of claims which occurred since 2010 yielding an immediate cash flow saving for the HSE of approximately €61 million.

The management of the claims portfolio is in its infancy and as more complex claims mature, we can expect the expenditure to increase accordingly. To assist in predicting future costs, the SCA assigns an estimated value to all claims received. This is based on the SCA's best estimate of the ultimate cost of resolving a claim; it includes all foreseeable costs such as settlement amounts, claimant legal costs and defence costs (such as fees payable to legal counsel, engineers, consultants etc.) This estimated value may be revised on a regular basis in light of any new information received. The current estimated value of HSE personal injury (non-clinical activities) and third party property damage claims that occurred since 2010 is €35 million. This estimated value relates to the lifetime of the claims rather than the estimated amount that would be spent in any given year.

Based on the current outstanding estimated liability associated with personal injury (non-clinical activities) and third party property damage risk, a long term saving of at least €25 million will be achieved for the HSE by managing these claims on the "pay as you go" basis operated by the SCA.

Pat Kirwan, Deputy Director, State Claims Agency

Best Professional Project Award - Graduate Diploma in Healthcare, UCD

ON THE ROUNDS: PRACTICAL PERSPECTIVES ON SHORT TERM JUNIOR MEDICAL STAFFING

Doctors have traditionally worked in systems of onerous rotas and high working hours, with cover for absences provided by in-house staff. More recently, factors including legislative requirements[1], contractual entitlements[2], service developments and personal lifestyle choices are changing this work culture, with an associated increase in demand for locum cover to maintain service rotas.

A locum is a registered medical practitioner generally covering a service for short periods, recruited either directly by the hospital or through an agency. While robust systems exist for professional registration of this group, anecdotal evidence, incident reports and informal complaints indicate concern that this sector of the workforce is not as closely regulated as is required for safe patient care.

There has been increasing attention paid to quality of medical staffing in recent years. The debate about the bi- annual changeover of junior medical staffing and its impact on patient care is international. Known as the 'July phenomenon' in the US, the literature recommends safer practices, more supervision and adequate staffing arrangements[3]. In the UK, the August changeover of medical trainees has attracted much media attention, particularly following publication of a controversial paper which reported a 6% increase in mortality in the days following commencement of new trainee medical staff[4]. Other studies in the UK and USA found similar effects on patient care for out of hours and weekend periods[5]. While no published research was found on patient outcomes associated specifically with the use of locums, risk factors identified in these studies such as unfamiliarity with local systems, lack of supervision and effects on teamwork should be equally applicable to this sector.

AIMS

This project sought to collate a service level perspective of the quality and risk issues associated with this sector as it relates to junior medical staffing in an Irish hospitals context and to prepare an action plan based on recommendations of the key stakeholders and published best practice.

RESULTS

A total of 15 key informant interviews, including locums, were conducted across a range of disciplines and specialties within hospital care teams.

Qualitative information was then collated into categories of:

- Induction/Handover
- Effects on Teamworking
- Supervision and Appraisal.

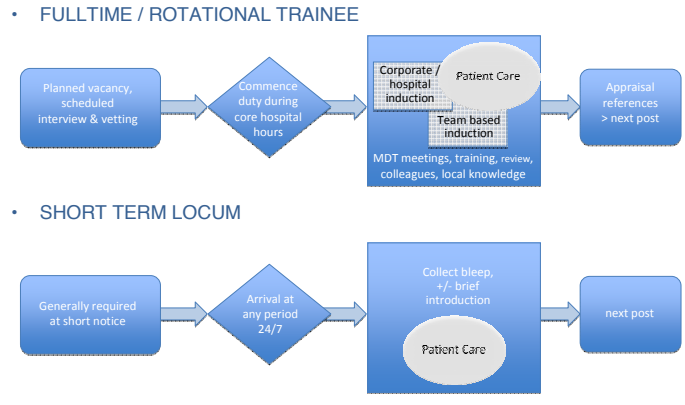
Sample responses are included in Table 1 below.

Findings Table 1

Theme 1 Overall Quality/Risk Views	Overall concern Reported; Eliminate need; Variable perceptions of risk	• "it would be worse to have no cover" • "we're stuck either way..." • "unfamiliarity causes delays rather than errors... unless of course the delays cause errors"
Theme 2 Induction & Handover	Significant gaps identified; Requires attention; Mixed views on solutions	• "this is a huge issue for us" • "I expect them to find out what they need to know" • "what if it (i.e. induction) put them off?"
Theme 3 Team Working	Varying effects Reported; Some speciality Variation; Needs more structure	• "it takes time to build team trust" • "the locum won't know how Dr. X likes things done" • "it would be less stressful if systems were similar"
Theme 4 Supervision & Appraisal	Significant gaps identified; Reliance on Nursing; No appraisal	• "I certainly don't want more paperwork" • "the nurses are excellent for spotting problems"

All interviewees expressed some reservations about this sector, acknowledging the valuable contribution of many high quality locums, but querying the balance of risks between service gaps and locum usage. The predominant view was that staffing numbers should ensure self-sufficiency, but budgetary constraints and current configuration of services were recognised as challenges. Areas requiring attention included some discrepancies between actual locum competence and references, limited or no induction and variable levels of handover, particularly out of hours. Substantial differences between pathways of full-time and locum staff were highlighted (Figure 1).

Comparative Pathways: full-time v locum Figure 1



No additional supervision of locums was generally reported, with some specialty variations. Nursing staff were generally relied on to highlight difficulties and structured appraisal was not conducted, with management of poor performers mainly by not re-appointing. Potential to minimise the impact on teamwork was highlighted, including multidisciplinary briefings which would allow for introductions, establishing team rapport, highlighting of key issues for particular shifts. Inconsistency in clinical guidelines and protocols across hospital sites was noted as a particular difficulty.

Best Professional Project Award - Graduate Diploma in Healthcare, UCD ***cont.***

DISCUSSION

While there was consensus that the need for this sector should be eliminated, the more realistic position based on worldwide trends is that this sector will have a long term role, both averts and contributes to risk and therefore requires control measures. The multiple factors involved in this change are outlined in Figure 2.

Current practice in induction and supervision of a short term locum needs urgent attention would not meet current health-care governance standards[6]. Evidence of compliance with requirements under the Professional Competence Scheme[7] will contribute to assurances for employers. Standardised guidelines through the national Clinical Care Programmes[8] will eliminate some of the unnecessary variation across sites, but some local differences will always occur. Patient safety is fundamentally linked to robust communication with all staff, irrespective of duration of contract.

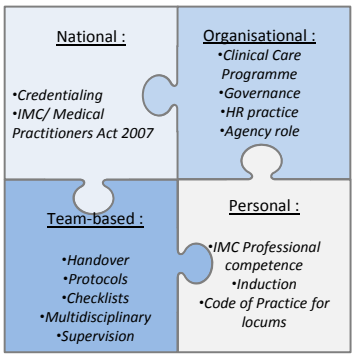
CONCLUSIONS AND SUMMARY RECOMMENDATIONS

The locum sector provides a valuable resource but has significant scope for improvement. Rather than focus on unrealistic expectations of eliminating need, a safer system can be achieved through local, national and international actions.

A summary of key recommendations for action include:

- More robust referencing, complementary to agency processes
- Increased handover, induction and supervision for locums, with written appraisal following appointments
- Active facilitation of teamworking
- Utilisation of e-learning for induction and dissemination of guidelines
- More active appraisal rather than passive avoidance of poor performance, contributing to overall quality within this sector.

Potential Solutions Fig. 2



Anne Pardy, Medical Manpower Manager, HSE *Footnotes online*

Presentation of the State Claims Agency Bursary for Best Professional Project - Graduate Diploma in HealthCare (Risk Management and Quality), UCD 2011-2012

Pictured left to right are: AsimSheikh, Barrister-at law, UCD, Anne Pardy, Medical Manpower Manager, HSE and Dr. Ailis Quinlan, Head of Clinical Indemnity Scheme (CIS) State Claims Agency

High Court finds for Defendant Hospital on both causation and liability

Judgment of Mr. Justice Sean Ryan was handed down on the 14th July 2012 in patient *X, a minor suing on his behalf by his mother-v-Hospital A*. The learned Judge dismissed the claim holding that the Plaintiff had not proven negligence on the part of the hospital either in terms of causation or breach of duty/failure of care.

BACKGROUND

Patient X was delivered by caesarean section on 18th July 2002 in Hospital A at 30 weeks gestation with low birth weight. During the second week of his life he contracted meningitis which caused severe brain damage leaving him with profound physical and mental disabilities. It was alleged that the hospital should have carried out a Lumbar Puncture (LP) thus enabling diagnosis and treatment of meningitis. It was claimed that, in the alternative, if the hospital did not carry out a LP, meningitis-specific medication should have been administered in any event.

On day eleven of life patient X was noted to be pale. He had foetal blood sample (FBS) and C Reactive Protein (CRP) tests carried out. Gentamicin and benzylpenicillin antibiotics were started. That evening he had low grade pyrexia. There was no obvious source of infection but a second CRP reading was abnormal. Blood samples taken however did not culture.

At midday on the 31st July a Registrar and a senior Neonatologist had serious concerns with X's right eye. He had low grade pyrexia with more frequent desaturations. They noted proptosis (bulging) of the eye, corneal opacification, inability to differentiate pupil from iris, conjuctival injection *(i.e.*

Best Professional Project Award - Graduate Diploma in Healthcare, UCD ***cont.***

FOOTNOTES

[1] Directive 93/104/EC – The European Working Time Directive

[2] Contract of Employment for Non-Consultant Hospital Doctors (22nd January 2010 HSE)

[3] M P Wise, P J Frost 'Hospital Mortality and junior doctors' handover: the role of medical schools and consultants' QJ Med (2010): 103: 895-896

[4] M H Jen, A. Bottle, A. Majeed, D. Bell, P. Aylin 'Early In-Hospital Mortality following Trainee Doctors First Day at Work' PLoS ONE (2009) 4(9): e7103. doi:10.1371/journal.pone. 0007103

[5] R W Crowley, H K Yeoh, G J Stukenborg, R Medel, N F Kassell, A S Dumont 'Influence of weekend hospital admission on short-term mortality after intracerebral haemorrhage'. Stroke (2009) Jul;40(7):2387-92. Epub 2009 May 21

[6] Theme 5 'Workforce' From: Draft Standards For Safer Better Healthcare HIQA October 2010 www.hiqa.ie accessed 15 February 2012

[7] Medical Practitioners Act, 2007 s11.

[8] Health Service Executive: Service Plan 2012

High Court finds for Defendant Hospital on both causation and liability ***cont.***

inflammination), pus discharge and no light reflex. Urgent transfer to hospital B for ophthalmological review was arranged. A serious eye infection was suspected.

No infection was found in X's right eye on examination in hospital B. He was treated conservatively with antibiotic drops. He became very seriously ill that night, suffering a severe multisystem breakdown with convulsions throughout the following morning. He was given Cefotaxime, (an anti-meningitis antibiotic).

The following evening there were concerns about infection in the eye and Ceftazidime was prescribed - a very powerful antibiotic. The following day the Ophthalmologist felt the eye was badly infected. On the 4th August the eye perforated. The cornea had broken down. Swabs from the eye still did not grow cultures and only showed scant growth of commensals, even though the eye was in a disastrous condition.

On the 7th August, surgery to eviscerate the right eye was carried out. The following day *pseudomonas endophthalmitis* was grown from the eye - a devastating organism with a very poor prognosis. Results of a LP done on the 2nd August revealed sterile spinal fluid. It did however indicate that X had previously had meningitis at some point in time.

JUDGEMENT

Lumbar Puncture

Various authorities were put before the court in relation to the indications for carrying out a LP. On the balance of all the information provided to the Judge, he found that considerable doubt existed about whether LP should be performed routinely on a baby with suspected sepsis unless there are other pointers towards a diagnosis of meningitis.

He concluded that if it is a matter of clinical judgement then there was no basis for holding there was negligence in not carrying out the LP. He accepted the evidence of the defendant's factual and expert witnesses - there was nothing in the presentation of the baby that indicated the likelihood of meningitis and it was reasonable to wait and see how the situation developed. He said, applying the test in patient X -v-Hospital A, there was a reasonable difference of opinion among doctors.

Causation

The defendant's experts were of the view that the infection in the orbit of the eye (orbital cellulitis) caused by *pseudomonas endophthalmitis* had spread into the vein and caused meningitis with multi organ collapse and consequent brain damage.

The Judge accepted the evidence of the treating registrar and neonatologist that they observed infection in X's eye. He recognised their concern was such that urgent transfer to another hospital for ophthalmic care was required.

He relied on the neonatologist in NMH regarding the value of Gentamicin in the treatment of meningitis. The medical literature submitted was evidence of the effectiveness of this drug in treating meningitis and its employment by doctors and hospitals, the Judge found.

The Plaintiff argued that Cefotaxime administered in hospital B on 1st & 2nd August cleared the meningitis. If a LP had been done on 30th July meningitis would have been diagnosed and Cefotaxime given c.22 hours earlier, and patient X would have escaped all/most of the devastating damage to his brain.

It was argued that the meningitis had not been caused by pseudomonas but by another *"unknown"* infective agent which was sensitive to the drug regime patient X was on, specifically Cefotaxime. The two most common causes of meningitis are enterococci (gram positive bacteria) and e-coli (gram negative) both sensitive to Cefotaxime. The meningitis-causing organism was treated successfully by drugs that are usually no good against pseudomonas meningitis, ie Cefotaxine and Gentamicin.

On the Plaintiff's theory of causation an important element was that there was no infection in patient X's eye on arrival at hospital B. Another was the premise that Gentamicin does not effectively treat pseudomonal infections in the spinal fluid. They opined, medication that killed the "other" bug" may have left the door open for pseudomonas which is nosocomial and notoriously opportunistic.

The Judge found the path of causation charted by the plaintiff's experts was *"not founded in fact or medical science"*.

The Judge concluded it was probably impossible to know precisely what the mechanism of infection was in this case or how it progressed. On the balance of probabilities, however, he was satisfied that the defendant's experts were correct in saying that there was one infective process that began in the baby's eye and progressed to his brain.

This judgement is currently under appeal by the plaintiff.

Ita Guilfoyle, CIS Clinical Claims Manager/Solicitor

Case Report - Plaintiff discontinues cataract removal claim

The State Claims Agency was recently involved in a claim where a Plaintiff discontinued his action against the HSE after three days at hearing in the High Court.

BACKGROUND

Patient M was admitted to Hospital X to have a right cataract extraction under local anaesthetic. The surgery was carried out by a Specialist Registrar who had also taken consent from the patient and explained the risks of surgery to him. There were complications during the surgery, namely a rupture of the posterior capsule of the eye which resulted in two fragments of the lens falling back into the eye. This complication was dealt with during the course of the surgery however it was decided that no implant should be inserted into the right eye at that time and should be deferred to a later date. Due to the rupture some of the cataract remained in the eye and the patient required a number of further procedures to remove the residual cataract and insert the implant. There were no complications in the post operative period.

THE CLAIM

The patient issued proceedings against the Hospital in the High Court two years following the surgery. It was claimed on behalf of patient M that the surgery was carried out negligently by a surgeon that was not sufficiently qualified or competent, that there were three unnecessary procedures carried out in order to remove the lens material from the eye and that there was a failure to refer the patient to a Vitreorentinal Surgeon. It was also alleged that the patient had an increased astigmatism in his eye which would not have occurred if the operation had been carried out properly. Furthermore the patient alleged that he was too afraid to have cataract surgery on his left eye which was necessary in order to balance both eyes and to relive his visual difficulties.

EXPERT EVIDENCE

The Defendant obtained supportive expert evidence from two Consultant Ophthalmic Surgeons. It was noted by them that there was a strong indication that this patient needed the surgery as he had a very definite significant cataract and poor vision. They both stated that the rupture of the posterior capsule is a well recognized complication of cataract surgery and can occur in the absence of any negligence. It was also noteworthy that the patient was specifically warned of the risk of this happening. Both experts were also confident that the Specialist Registrar was more than competent to carry out the surgery having carried out over a hundred similar surgeries prior to the date.

THE HEARING

Approximately 12 months before the hearing date the Defendants asked the patient and his legal team to discontinue the case based on the supportive expert reports obtained. This was done in an effort to save legal costs but unfortunately the patient was adamant about continuing with the case. The patient produced a supplemental expert report the day before the hearing commenced that withdrew the allegations that the Specialist Registrar was not competent and that the consent was not adequate. They maintained that the patient should have been referred to a Vitreoretinal Surgeon. However it was pointed out to them by the Defendants that the patient was in fact under the care of such a surgeon in the Hospital. The patient's legal team also made an allegation that the surgeon should have carried out a vitrectomy instead of proceeding with conservative treatment, following the complications, as this would have lessened the amount of procedures he ultimately required. This was refuted by the Defendant's expert who maintained that conservative treatment at this time was reasonable. The Judge indicated dissatisfaction with the changing case that the patient and his team were presenting. On the third day of hearing the patient agreed to discontinue his case. Unfortunately the State incurred a substantial amount of legal costs due to the late stage at which the patient discontinued his case.

Neasa Seoighe, CIS Clinical Claims Manager/Solicitor

Open Disclosure - A National Pilot Project, Year 1.

In January 2007, Mary Harney, Minister for Health & Children established the Commission on Patient Safety and Quality Assurance ("the Commission") and instructed it, among other tasks, *to develop clear and practical recommendations which would ensure the safety of patients*. In July 2008, the Commission completed its report entitled *Building a Culture of Patient Safety*. The report was published in August 2008 and approved by the Government in January 2009.

One of the key recommendations of the report is the development and support of a culture of open disclosure to patients and their next-of-kin, following an adverse event resulting in harm to a patient. Open Disclosure is defined by the Australian Commission on Safety and Quality in Health Care as "an open, consistent approach to communicating with patients when things go wrong in healthcare. This includes expressing regret for what has happened, keeping the patient informed, providing feedback on investigations and the steps taken to prevent a recurrence of the adverse event."

Ireland currently has no protective legislation to assist the open disclosure process; it is envisaged that this status will change in the near future. It is anticipated that the upcoming Health Information Bill will contain a provision(s) in it, affording some degree of protection for healthcare personnel. On publication of the Bill the State Claims Agency will then be able to comment further. A consultation paper by the Law Reform Commission, in 2008, recommended that "a statutory provision be considered which would allow medical practitioners to make an apology and explanation without these being construed as an admission of liability in a medical negligence claim".

PROJECT DETAILS

In October 2011, the HSE and the State Claims Agency commenced a national pilot project in relation to Open Disclosure. The Project Leads are Ann Duffy from the State Claims Agency and Angela Tysell from the HSE. Two pilot sites were identified as follows: The Mater Misercordiaie University Hospital, Dublin and Cork University Hospital, Cork City. The project objective is to provide training and support for doctors and other health care professionals to support them in engaging in the open disclosure process with a view to the development of a national guidance document on Open Disclosure and the roll out of this guidance and training across all healthcare organisations.

PROJECT PROPOSAL

A draft project proposal was drawn up by the national project leads. The proposal outlined (a) the responsibilities of the pilot sites in relation to the implementation of open disclosure, (b) examples in relation to how compliance with these responsibilities may be demonstrated and (c) the supports which were available to them by the SCA, HSE and National Project team. The responsibilities of the pilot sites were broken down into the following categories:

- Preparation
- Leadership
- Local policy
- Visibility
- Support for Staff and Patients
- Training
- Audit
- Evaluation

The aim of the proposal was to assist the pilot sites to take a structured change management approach towards implementing Open Disclosure within their organisations in line with international best practice and in keeping with the principles of open disclosure. The National Project Leads have emphasised the importance of staff support and the de-briefing of staff who have been involved in an adverse event. This is also incorporated as part of the staff awareness sessions delivered by the national project leads and also covered in detail in the half day Open Disclosure workshops. Awareness sessions are approx 45 minutes long and provide an informed overview of open disclosure and the pilot responsibilities. These sessions were open to all staff, with all sessions evaluated.

In preparation for the pilot project both pilot sites were asked to complete a staff patient safety culture survey. While it was recognised that the HSE were in the process of developing a staff patient safety culture survey, a decision was made to use the *Manchester Patient Safety Framework (MaPSAF) survey tool in the interim to prevent a delay in the project.*

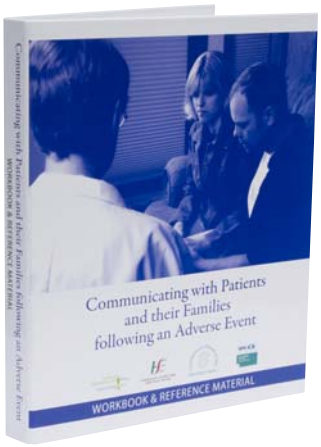
TRAINING

The national project leads developed a half day workshop to be delivered to all staff identified by the pilot sites as lead disclosers or, who would be assisting staff and patients/their families during the disclosure process. The workshops are CPD accredited with the Royal College of Surgeons in Ireland, Royal College of Physicians in Ireland and An Bord Altranais. The national project leads developed a practical workbook

Open Disclosure - A National Pilot Project, Year 1 ***cont.***

and reference folder based on the ROI healthcare system, using predominantly ROI healthcare system case studies. The reference material used in the workbook is evidence based from countries that have previously introduced disclosure programmes. A workshop evaluation tool was also developed to assess each workshop.

The release of staff to attend workshops is a designated responsibility of the pilot sites as per the project proposal. In addition the alignment of internal training programmes to include open disclosure has commenced at both sites to include induction programmes and materials, relevant internal policies, staff handbooks etc. CUH project lead, Deirdre O'Keefe and the MMUH project lead, Catherine Holland were instrumental in driving, highlighting and supporting the



project to assist in implementing the proposal and training.

The OD pilot is more than a just a pilot, it is also a change management project that requires a significant cultural shift. In the next edition of the SCA newsletter, a summary of the learning's from Year 1 and Year 2 of the project will be outlined.

Ann Duffy, Clinical Advisor, State Claims Agency.
Angela Tysall, Project Manager, National Advocacy Unit, Quality and Patient Safety Directorate.

What is the State Claims Agency?

For those in the HSE that have been operating under the CIS you may be familiar with the SCA and the services provided. This article is aimed at those of you whose actions are now covered by the State indemnity and are unfamiliar with the Agency.

The SCA has two key objectives:

- to provide risk management advisory services to State authorities, including the HSE, with the aim of reducing, over time, the frequency and severity of adverse events and in so doing also reducing subsequent claims;
- where claims do arise to manage these claims so as to ensure that the State's liability and associated legal and other expenses are contained at the lowest achievable level.

SCA REMIT

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 SCA's remit has been significantly expanded since its establishment. For example responsibility for managing risks associated with clinical activities and the management of subsequent claims was delegated to the SCA in 2002. These clinical risks and claims are managed by the SCA under the Clinical Indemnity Scheme (CIS).

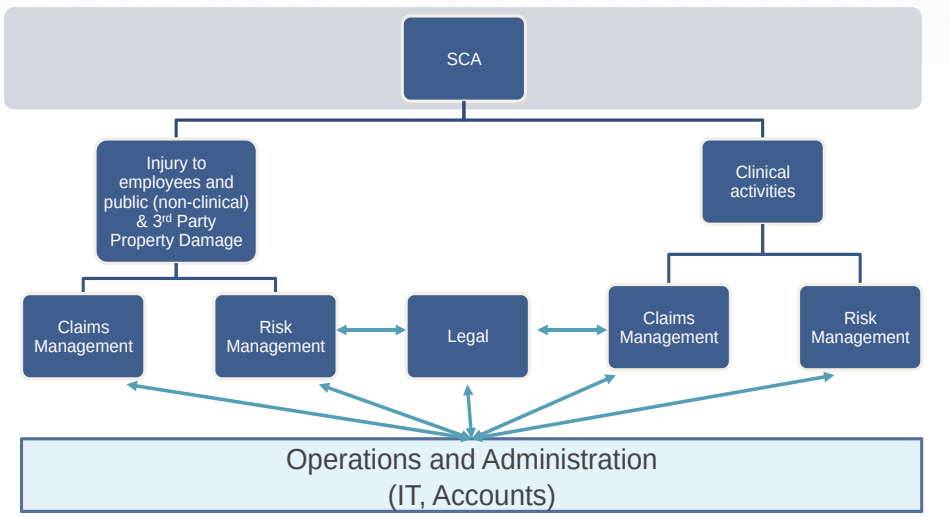
As stated previously, one of the more recent and significant delegations occurred on the 1st January 2010 when the management of HSE non-clinical personal injury and third party property damage claims and the associated risks was delegated to the SCA under the National Treasury Management Agency (State Authority) Order, 2009.

STRUCTURE OF SCA

The SCA has approximately 65 staff in total working across the following teams:

- Risk management for injuries to employee and members of the public (non-clinical) and third party property damage Risk Management
- Claims management for injuries to employees and members of the public (non-clinical) and third party property damage Risk Management
- Risk management for clinical activities
- Claims management for clinical activities
- Legal Section
- Operations and administration (includes STARSWeb helpdesk)

What is the State Claims Agency? ***cont.***



customs inspections and Prison Officers. The "risk universe" also includes:

- approx 6,000 vehicles of various sizes including prisoner escort vehicles, military vehicles, emergency service vehicles and specialised vehicles used for enforcement purposes;
- 5,000 prisoners;
- 60,000 students in Community and Comprehensive schools;

RISK MANAGEMENT

The SCA's risk management objective is to advise and assist State authorities on measures to be taken to prevent the occurrence, or to reduce the incidence, of acts or omissions that may give rise to adverse events that could subsequently result in claims. The risk management process incorporates the following:

- identifying litigation risks with a particular attention to high risk activities and possible mass action claims. The identification of risks is conducted through analysis of claims' data, reviews of occupational risks, safety audits and site inspections;
- assessing the adequacy of measures already in place to counter such risks including the extent to which each authority fulfils its common law and statutory duties;
- providing risk advice and assistance, including training, so as to ensure that the each State authority (including the HSE) is fully aware of the measures necessary to address any risks highlighted.

The "risk universe" indemnified by the State, and managed by the SCA is extensive. In total within the State, over 200,000 employees are covered encompassing a core of high risk public services such as clinical care in emergency departments, Defence Forces personnel on operations overseas, members of An Garda Síochána on operational beat duty,

- over 3.5 million visitors annually to various tourist attractions via the Office of Public Works sites, National Museum of Ireland, The Houses of the Oireachtas and other Authorities;
- failure to provide various regulatory service that may damage public health such as food inspection or the failure to provide adequate care to members of the public;
- public services availed of by most of the population at some point including social services, FÁS, Agriculture, The Courts Service etc.

Looking at the HSE alone, the "risk universe" indemnified by the State includes the following (Sourced from HSE Annual Report, 2011):

- over 1.39 million people who received inpatient or day care treatment;
- over 1 million people who attended Emergency Departments;
- over 75% of the population or over 3.4 million people who avail of services through 425 Primary Care Teams;
- 70,000 babies delivered annually;
- a broad range of services in the community including health promotion, prevention, and protection delivered to all sectors of society including children and families,

What is the State Claims Agency? ***cont.***

older people, persons with disabilities, persons with chronic illness;

- over 5,000 properties owned and occupied by the HSE;
- fleet of emergency service vehicles, buses, cars and various other vehicles;
- over 100,000 employees.

ANNUAL PROGRAMME

Annually, the SCA plans and implements, in association with client State authorities, litigation risk management work programmes, which include the minimisation of litigation risk factors, and the implementation and audit of risk management systems. You may already be familiar with certain initiatives by the SCA clinical risk team such as systems analysis training. These annual programmes, implemented by the non-clinical personal injury and third party property damage risk management team in conjunction with client State authorities, typically include:

- Production of guidance or completion of a review of the risks posed to the State where the potential for mass litigation exists or high value claims may arise. Examples include noise exposure to State employees, asbestos, radon and mould. Another area where the SCA is actively engaging with State authorities is the issue of Fire Safety. Following a self-assessment on-line survey of over 700 State buildings and collation of results for participants, the SCA held a series of seminars. The aim of which was to provide practical knowledge to deal with and coordinate fire safety management. These included practical exercises and demonstration with the assistance of Dublin Fire Brigade.
- Issuance of reports following reviews of identified risks in individual Authorities. These included a report on the management of firearms in An Garda Síochána and compliance and maintenance systems in the Irish Prison Service. Most recently, the SCA has completed a survey of child protection and welfare management in Community and Comprehensive schools.
- Issuance of technical guidelines such as, Inspection, Testing and Maintenance of Equipment and Machinery.
- The SCA also works with client State authorities to implement robust and sustainable risk management systems.

The SCA's core principle, from the outset, has been to persuade State authorities of the value (reputational, financial, legal, etc) of adopting good risk management practices and to work in conjunction with the authority to achieve this objective. State authorities who have actively engaged in these initiatives have shown significant reduction in numbers and costs of adverse events and likewise a reduction in subsequent claims.

CLAIMS MANAGEMENT

As previously mentioned, the SCA's claims management objective in relation to personal injury and third party property damage is that claims should be managed so as to minimise the State's liability. This has the following practical implications:

- in cases where the State is considered liable or which involve an apportionment of liability as between the State and the claimant, the SCA's approach is to settle such claims expeditiously, in so far as it is possible to do so, on reasonable terms;
- in cases where liability is fully disputed by the State, all necessary resources are applied to defending such claims robustly.

The SCA manages a claim from the point of claims notification through to final resolution. Claims are investigated in a thorough and timely fashion in order to facilitate early decision-making in relation to liability and strategy. The SCA uses panels of service providers, such as solicitors, medical consultants and engineers to provide expert advice on the State's behalf.

Gemma D'Arcy, Risk Manager, State Claims Agency

New Guidance Produced by SCA and HSE on State Indemnity

Following the delegation of non-clinical personal injury and third party property damage risks in 2010, the SCA has received thousands of requests for advice on risk management and indemnity issues. To address some of the more frequently asked questions, the SCA has prepared a document entitled *"Guidance on State Indemnity for Personal Injury and Third Party Property Damage in the Health Service Executive"*. The SCA has also produced a Confirmation Statement which is used in lieu of a conventional insurance policy to assure third parties that the Health Service Executive (HSE) is indemnified against appropriate liabilities.

GUIDANCE DOCUMENT

A guidance document on State indemnity was jointly developed, reviewed and launched by the HSE and the SCA in September 2011. It is available at **www.stateclaims.ie/Risk Management/risk.htm.**

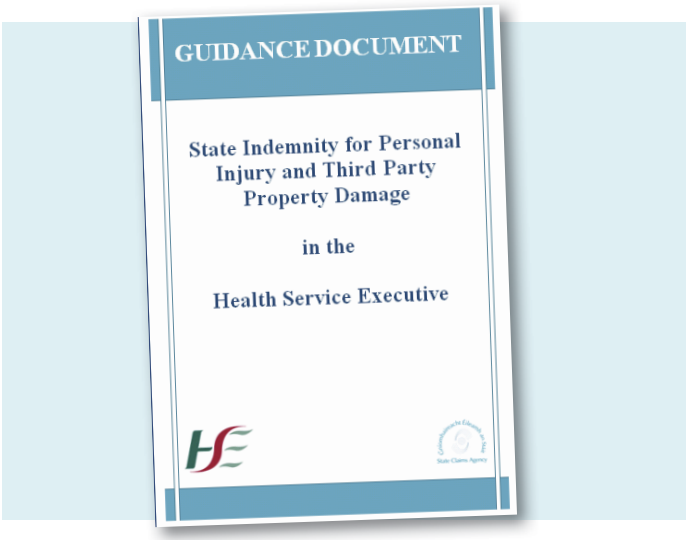
This document provides guidance for the HSE on the implications and the application of State indemnity for non-clinical personal injury and third party property damage risks and the role of the SCA in this process.

The guidance is aimed at HSE management, including hospital managers, service managers, estates and property managers, insurance managers, and deals with the following:

- The background, scope and general implications of State indemnity for the HSE;
- The role and function of the SCA;
- Application of State indemnity to specific activities - the information contained in this section of the guidance document (Section 5.0) should assist in answering many common queries on State indemnity with the aim of containing the HSE's risk exposure to a minimum level.

The following topics are addressed:

- Work Placements/Work Experience/Volunteers
- HSE Clients/Service Users Undertaking Work Placements/ Work Experience in Third Party Organisations
- Volunteers - professional and otherwise
- Use of HSE Premises by third parties
- HSE renting/leasing/licensing third party premises



- Use of HSE vehicles
- Lease/Hire of Third Party Vehicles for HSE Business
- Authorised HSE Staff Using Own Private Vehicles on HSE Business
- Contractors providing service to the HSE and HSE Service users
- Agencies in Receipt of Funding/Grants from the HSE
- Third Party Property Damage/Loss
- Third Party Individuals or Organisations Using HSE Medical Equipment (excluding HSE vehicles)
- Inspections by Third Party Organisations.

CONFIRMATION STATEMENT

HSE managers are regularly required to provide confirmation concerning State indemnity to third parties. Such requests may be made in respect of students on work placement, use of HSE premises by third parties such as community groups, HSE renting/leasing/licensing third party premises etc. To assist in this regard a *Confirmation Statement* setting out briefly the scope of State indemnity is available on request from HSE Insurance Managers.

Prior to issuing the *Confirmation Statement,* a HSE manager must be satisfied, with reference to the contents of the guidance document that State indemnity does apply in the circumstance in question. In particular, State indemnity in respect of non-clinical personal injury and third party property damage applies to HSE enterprises/activities that are directly controlled, fully funded and wholly managed by the HSE.

New Guidance Produced by SCA and HSE on State Indemnity ***cont.***

State indemnity in respect of non-clinical personal injury and third party property damage does not extend to voluntary bodies, including voluntary hospitals (voluntary bodies are indemnified by the State in respect of clinical activities only). It should be noted that issuance of this *Confirmation Statement* in circumstances not covered by State indemnity would not act in lieu of insurance cover.

Health Service Executive

State indemnity for Personal Injury and Third Party Property Damage

Under the National Treasury Management Agency (Amendment) Act, 2000 and subsequent orders the management of the Health Service Executive (HSE) personal injury and third party property damage claims was delegated to the State Claims Agency (SCA).

The SCA confirms that the HSE, its servants and/or agents, will be indemnified by the State in respect of any claims for personal injury and third party property damage, arising from the negligence of the HSE, its servants and/or agents. The State indemnity is unlimited.

This indemnity extends to cover only the negligence of the HSE, its servants and/or agents, and does not extend to indemnify any third party, its servants and/or agents concerning any negligent act or omission by the latter by reference to Statute or at Common Law.

The following classes of claim are expressly excluded from the SCA's remit under the enacting legislation:

- claims involving a question as to the validity of any law having regard to the provisions of the Constitution;
- claims made in respect of infection, directly or indirectly, with Hepatitis C or the human immunodeficiency virus (HIV), or both, through the administration of blood or blood products or in respect of related matters;
- claims in which torts other than negligence are pleaded.

Issuance of this *Confirmation Statement* in circumstances not covered by State indemnity would not act in lieu of insurance cover.

As State indemnity is enshrined in legislation, this document operates in lieu of a certificate of insurance and shall not be subject to change or require renewal unless there is a change in legislation.

Ciarán Breen
Director
State Claims Agency

This document operates in lieu of a certificate of insurance and shall not be subject to change or require renewal unless there is a change in legislation. There is also no requirement to re-issue the Confirmation Statement on an annual basis.

The *Confirmation Statement* should only be issued by personnel at an appropriate level within the HSE as authorised by the Assistant National Director of Finance, HSE, (typically HSE Insurance Managers) and must be used in conjunction with the guidance document above.

This guidance document shall be a first point of reference and shall assist with the majority of risk and indemnity queries. The SCA are, of course, always available to deal with more complex or unusual queries. Please contact your HSE Insurance Manager in the first instance. Where he/she cannot address your query they shall forward it to the SCA's risk management unit for reply.

Amy Costello, Lead Risk Manager, State Claims Agency

What to expect in future editions of this section of the SCA newsletter

In this, the first edition of the newly re-launched SCA newsletter, the intention is to provide you with background information on, and an introduction to, State indemnity.

In future editions, we shall be adopting a more formatted structure and shall include regular items such as:

- Spotlight on various topics related to the application of State indemnity, for example the use of volunteers, students, use of third party premises etc.
- Sharing of learning gained from past projects and current initiatives undertaken by the SCA, the HSE or other State bodies
- Closed claims analysis
- Case studies on the true impact and cost of accidents.

The State Claims Agency
Newsletter
Cíoróg Teacht Éileamh Stáit
State Claims Agency Newsletter, March 2013

Looking forward to the new State Claims Agency Newsletter

The State Claims Agency Risk and Claims Management Teams

CONTENTS IN THIS ISSUE

LEGAL COSTS UPDATE

Previously, this editorial has commented on the disproportionately high level of legal costs associated with clinical negligence actions. Recently, the SCA decided to contest the plaintiff's Bill of Costs in the case of ***Isabelle Sheehan (an infant, suing by her mother and next friend, Catherine Sheehan)-v-David Corr***. Due to medical negligence, the plaintiff sustained injuries resulting in her suffering from Dyskinetic Cerebral Palsy. The defence, on behalf of the defendant, admitted a breach of duty of care but denied causation. Following a five-day hearing,

Reporting of Adverse Events in the HSE

One of the impacts of State indemnity is that all state indemnified State authorities, including the HSE, are legally obliged to report all adverse events promptly to the SCA. This allows the SCA, in conjunction with the HSE, to be in a position to identify and analyse developing trends and patterns and assists with claims investigation and management should the adverse event progress to a claim. To facilitate this all adverse events (clinical and non-clinical) in the HSE can be reported by means of the HSE National Adverse Event Management database (NAEMS) previously known as STARSWeb.

This is hosted by the SCA for the HSE, other Healthcare enterprises and other State authorities. The Department of Health together with the HSE have confirmed that this database is the primary recording and management system for all adverse events that occur in the HSE.

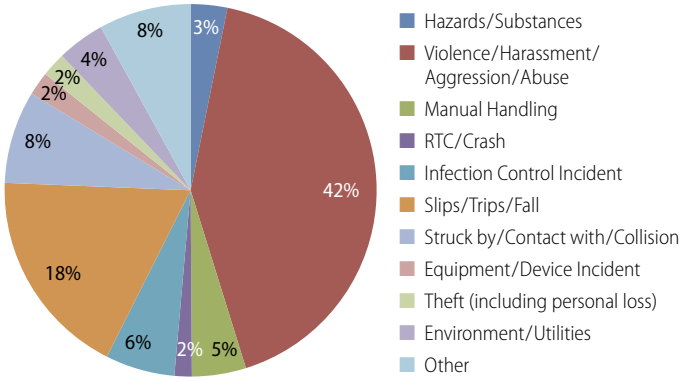
The SCA, in conjunction with the HSE and other Key Stakeholders, are upgrading the database to better meet the requirements of our client users and to improve its adverse event entry and reporting capabilities. Phase 1 of this project will be completed by September 2013.

However, the database in its current configuration can provide the user with some key information at national and local level to assist with identifying and managing key risks. This database has been used to produce the statistics that you may have seen in previous newsletters and the recent joint HSE/SCA press release on adverse event reporting in 2011[1].

Now that the SCA is managing both clinical and non-clinical personal injury and third party property damage risks, STARSWeb can therefore present a full picture of all associated adverse events in the HSE. Over 100,000 reports have been recorded in these categories.

Breakdown of Adverse Events

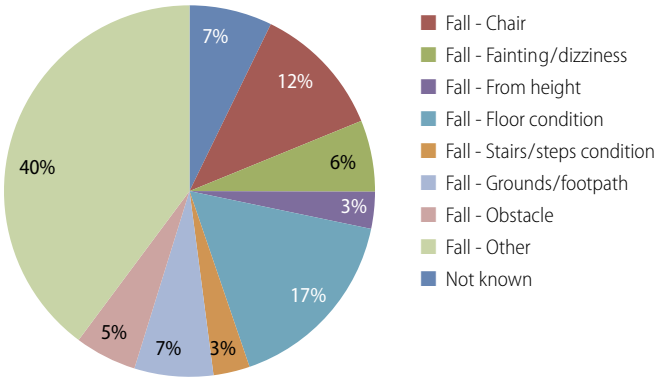
(non-clinical personal injury and Third Party Property Damage)



[1] *available at www.hse.ie/eng/services/News/newsarchive/2012archive/Oct2012*

Slips/Trips/Falls by Sub-Category

(non-clinical personal injury and Third Party Property Damage)



We can also break down these adverse events further using available categories on the database. For example, we can analyse who was injured (employee or member of the public for example). In the example above, Slip/Trip/Fall events have been further broken down into specific causes.

CLAIMS ACTIVITY

The database is also utilised by the SCA for claims management and can provide data on the volume of claims under management. At the end of 2012, the SCA had 905 non-clinical personal injury and third party property damage claims under management on behalf of the HSE.

Active Claims	
Claims brought by employees	576
Claims brought by members of the public (non-clinical)	289
Third party property damage	40
Total	**905**

The table below illustrates the volume of claims received by the SCA relating to non-clinical personal injury and third party property damage in the HSE.

Claims received by year				
	Claims brought by employees	Claims brought by members of the public	3rd Party Property Damage	Total
Claims received 2010	185	103	106	**394**
Claims received 2011	235	150	131	**516**
Claims received 2012	252	138	115	**505**
Total	**672**	**391**	**352**	**1,415**

The bulk of these claims relate to slip/trip/falls, Road Traffic Collisions (RTCs), or violence/harassment/aggression. Although RTCs tend to be higher in number but lower cost, manual handling can be lower in number but higher in cost. This is due to several large value claims involving serious back injury. This mirrors trends in other State authorities and, in particular, An Garda Síochána.

Amy Costello, Lead Risk Manager, State Claims Agency

Seminars

The HSE plans to hold a series of seminars on personal injury (non clinical) and third party property damage categories of risk and associated claims in 2013. These will be aimed at the HSE RDO Group and Corporate Managers, Hospital Managers as well as those with posts of responsibility for risk management/co-ordination.

Winners of Irish Medical Times, Healthcare Awards 2012

Anne Marie Keown (Programme Manager, National Acute Medicine Programme), Professor Shane O'Neill (Co-sponsor for the National Early Warning Score Project, Consultant Physician, Beaumont Hospital), Avilene Casey (Chair - National Early Warning Score Advisory Group & IADNAM Representative), Eilish Croke, (Chair & National Lead for the National Early Warning Score and COMPASS Programme), Professor Garry Courtney (National Lead - National Acute Medicine Programme and Co-sponsor for the National Early Warning Score Project) and Anne Marie Oglesby (Clinical Risk Advisor, Clinical Indemnity Scheme, 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.

Rebranding STARSWeb

The SCA has made a strategic decision to re-brand the national incident reporting system, STARSWeb, as the National Adverse Event Management System. This is designed to encourage enterprises indemnified by the SCA to embrace it as their own, and also correlates with a significant upgrade of the current system. A team within the SCA has been established to oversee this project, with roll-out of the new system scheduled for Q3, 2013.

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

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