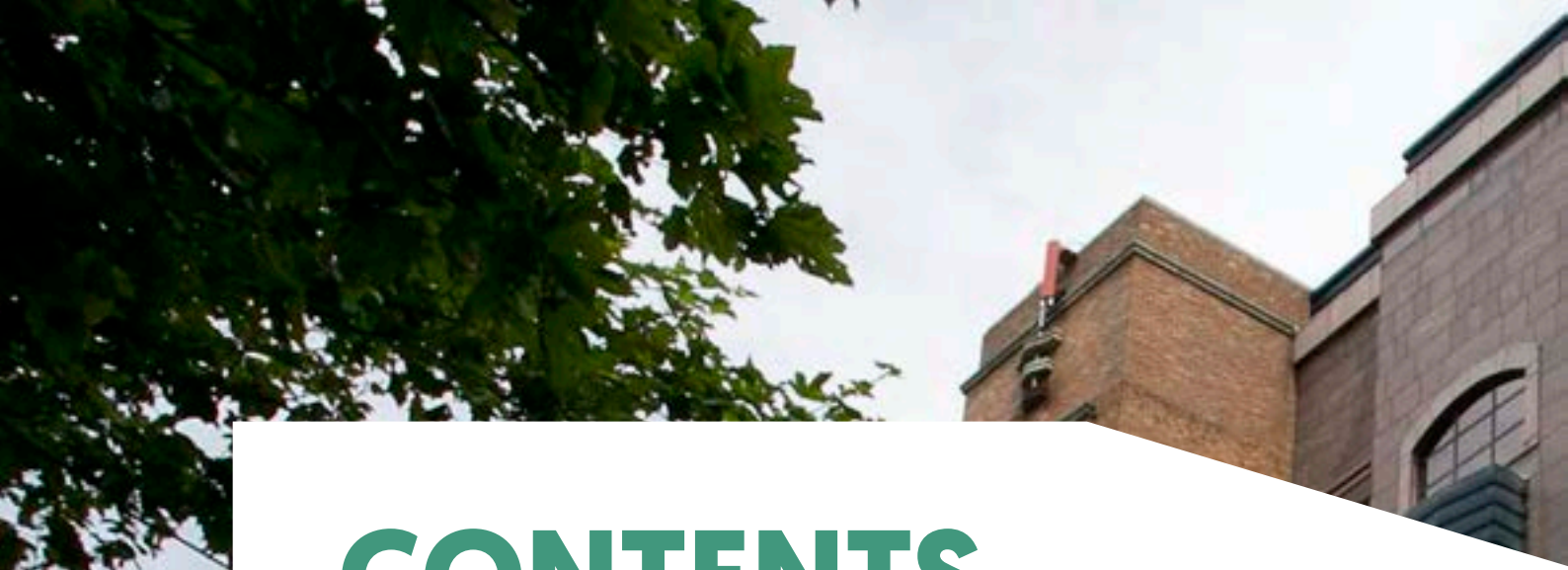
Gníomhaireacht Bainistíochta an Chisteáin Náisiúnta
National Treasury Management Agency

An Ghníomhaireacht Stáit um Éilimh
State Claims Agency

State Claims Agency eZine Launch



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Section 2 - General Indemnity Scheme (GIS)

Editorial

Welcome to the first edition of our new eZine which will be published, in future, on a biannual basis.

This edition includes many topics and articles which, hopefully, will be of interest to our diverse readership across the public and private sectors.

Given the time of year, it is appropriate to look back on the year just passed, 2015, which was a year of consolidation for the Agency during which the number of employees exceeded 100 for the first time since its inception. It was also a year when the National Incident Management System (NIMS) was rolled out right across the public sector, to include multiple health enterprises and hospitals. NIMS, of course, enables all State authorities and health enterprises to comply with their Statutory obligation to report their adverse events to the Agency.

Significantly, the NIMS project received the prestigious accolade of winning the international "Excellence Award Programme" at the Marsh ClearSight Conference held in California. Clients of Marsh ClearSight include many Fortune 500 companies and public bodies worldwide.

The Agency warmly welcomed Dr. Varadkar, Minister for Health, when he visited the Agency in August 2015 and received an update on the NIMS project and met Agency personnel.

On the 20th October 2015, the Agency launched a report entitled "Clinical Incidents and Claims Reports in Maternity and Gynaecology Services". The Report, which was well received by many media outlets, comprised a five year review of data relative to the years 2010 to 2014.

In early November 2015, the Agency received Judgment from the Court of Appeal in the case of **Gill Russell v HSE.** The Court held that in cases involving catastrophic injuries, a claim for the cost of future care should be calculated at a Real Rate of Return (RRR) of 1% and all other claims for pecuniary loss at 1.5%. The High Court had previously reduced the RRR from 3% to 1% for the purposes of calculating all future losses in catastrophic injury cases. The outcome of the Court of Appeals' decision was to grossly

increase the levels of special damages to be awarded and/or agreed in catastrophic injury cases. Based on actuarial projections, the Agency estimates that the State's annual cost of compensation in clinical negligence cases could increase by as much as €100m.

The year ended with the more positive news that the Agency's Legal Costs Unit received its formal Statutory underpinning to receive and negotiate Bills of Costs on behalf of State authorities arising from litigation generally and not just personal injury litigation. The Legal Costs Unit has achieved considerable success, to date, in reducing Tribunal of Inquiry related Bills of Costs by as much as 50% on an average basis.

Looking ahead into 2016, the Agency hopes that the long-awaited Periodic Payment Order (PPO) legislation will be finally promulgated. The Agency has been a long-term, firm advocate that families of catastrophically injured victims should not have to worry about the investment risk associated with those victims' awards/payments and the worry associated with the cost of funding their future care. The promulgation of PPO legislation, together with the Statutory underpinning and introduction of pre-action protocols, should mitigate against the more adversarial elements of, and delays associated with, the current Tort system as it applies to clinical negligence cases.

Finally, it will be the intention of the Agency to use this medium to publish relevant National data, gathered through NIMS, which should be of interest to our readers and this data will cover a number of separate topics.

Ciarán Breen,
Director, State Claims Agency

In photo from left to right: Dr. Dubhfeasa Slattery (Head of Clinical Risk, SCA), Ciarán Breen (Director, SCA)

Clinical incidents and claims report in Maternity and Gynaecology services: a five year review, 2010-2014

October 2015: A dedicated, national report, "Clinical incidents and claims report in Maternity and Gynaecology services, a 5 year review: 2010-2014", was published by the State Claims Agency (SCA) in October 2015. **The aim of this report is to help improve patient safety, quality of care and the patient experience by outlining detailed, national, clinical data on patient safety incidents, claims and cost, tracked over a 5 year period.** This report provides an in depth review of the most common clinical incidents and most common and costly claims, adjusted for activity and contextualised, where possible, with international data from peer reviewed scientific journals

and national reports. Total expenditure paid was reviewed in detail over a 5 year period. The 19 public maternity hospitals were compared in an anonymised manner from a patient safety incident and claims' rate perspective. A detailed analysis of 10 years of closed claims pertaining to retained foreign bodies in maternity and gynaecology services was performed and results presented. Results of a national survey carried out in 2015 of the modes and patterns of incident reporting by acute hospitals nationally to the SCA were shared.[1]

General Results

Variation and lack of standardisation in patient safety incident reporting and quality or reporting was identified. Lack of uniformity exists across the 19 maternity hospitals in relation to the reporting of severity of injury, particularly in relation to incidents rated as extreme. While the quality of the data reported to the SCA is often good, at times, it is suboptimal. Some mis-categorisation of incidents was identified where incidents were rated by services as extreme, but "no harm/injury" had been sustained. Overall, this variation and lack of standardisation regarding incident reporting makes comparisons between maternity and gynaecology services nationally inaccurate.

> **"Variation and lack of standardisation in patient safety incident reporting and quality of reporting was identified**

Maternity Services

Out of a total of 9,787 incidents, which occurred in maternity services in 2014, reported to SCA, 9,397 (96%) were clinical.[1] Seventy five were rated extreme by the maternity services, but detailed clinical and manual analysis revealed that the true number of extreme incidents was less than 75. The most common incidents which occurred between 2010-2014, in decreasing frequency, is "other" (the category used when none of the known categories applied to the incident), followed by post partum haemorrhage, 3rd and 4th degree perineal tear, apgar score < 5 at 1 minute, 7 at 5 minutes, cord base excess < 12 and pH< 7.2, unexpected transfer to the special care baby unit (SCBU) or neonatal intensive care unit (NICU), unplanned re-attendance and shoulder dystocia. Between 2010-2014, post partum haemorrhage and unplanned re-attendance have increased in number while perineal tear, unexpected transfer to the SCBU/ NICU have remained relatively stable and infants with low apgar score and low cord pH have almost halved.[1]

In 2014, 140 claims were created in maternity services of which 137 (98%) were clinical. The most common claims in maternity services between 2010-2014 were "other", perineal tear and shoulder dystocia (all 3 of which are decreasing over this time period), still birth, unexpected neonatal death and cerebral irritability.

Total expenditure paid on clinical claims in maternity services was 54% (€57.3 million)* of all clinical care related claims in the year 2014 (€106 million).[1] Cerebral palsy accounted for €47 million paid in 2014.[1]

IN 2014

140

MATERNITY SERVICES CLAIMS

98% = CLINICAL

TOTAL PAID

€57.3 MILLION

33

GYNAECOLOGY CLAIMS

100% = CLINICAL

TOTAL PAID

€4 MILLION

Gynaecology Services

Out of a total of 1,403 incidents reported, 11 (0.8%) were rated extreme. The most common incidents which occurred between 2010-2014, included: unplanned re-attendance, delayed or cancelled surgery and failure/faulty medical equipment, all 3 of which have increased, while patient falls (unsupervised), missing healthcare records/misplaced incomplete/incorrect data and the category "other" have decreased. In 2014, 33 gynaecology claims were created, all of which were clinical.

The most common claims between 2010-2014 (excluding mass actions), included: unexpected complications following an operation/procedure, unintentional laceration to an organ, delayed diagnosis and retained or missing swab/needle/device. Total expenditure paid on gynaecology claims in 2014 was €4 million.

Closed Claims

Medico legal claims closed between 2004-2014 related to retained foreign bodies in maternity and gynaecology services were analysed in detail.[1] Despite multiple interventions, retention of foreign bodies remains both a national and international opportunity for improvement.[1]

Reporting to the SCA

Variation was identified regarding the modes and patterns of incident reporting by acute hospitals nationally to the SCA including: the percentage of incidents reported (range 10% to 75-100%), the backlog of incidents (<100 to >1,000 incidents), and time delay in reporting to the SCA (range 1 week to 6 months). Surprisingly, five hospitals were unaware of the statutory obligation to report adverse events to the SCA. *Figures rounded

The findings in this five year review were presented to Minister Varadkar at the NTMA in August 2015 and the report was published on October 20th 2015 and disseminated to all stakeholders.

Reference

1. Clinical incidents and claims report in Maternity and Gynaecology services: a five year review 2010-2014. Slattery D., October 2015, State Claims Agency. Available from www.stateclaims.ie

Article by: Dr Dubhfeasa Slattery, MB BCH, MRCPI(Paeds), FCPI, M Med Sci, PhD
Head of Clinical Risk, State Claims Agency

Symphysiotomy Claim

In 2015, the State Claims Agency successfully defended a case involving a symphysiotomy performed in 1963. The 74 year old **plaintiff claimed that she suffered lifelong pain and difficulties after undergoing a "prophylactic" symphysiotomy procedure 12 days before the birth of her baby, in a Dublin Maternity Hospital.** The plaintiff claimed there was no justification for the procedure.

The case was heard over 15 days by Mr Justice Cross in the High Court. This case was accepted by the Judge to be a test case for other similar claims.

The Court heard submissions in relation to two preliminary issues:

Submissions were heard in relation to two preliminary issues:

1. Prejudice

The Court thereby held that **although some fifty years had passed since the symphysiotomy, there was no prejudice to the defence.** This was on the basis that the plaintiff had narrowed her case down to one plea – that there was no justification for the procedure. The defence therefore did not need to rebut any allegations as to the manner in which the procedure was carried out.

2. Statute of Limitations

The Court held that the time to initiate legal proceedings ran from the plaintiff's 'date of knowledge'.

The Court accepted the plaintiff's evidence that her date of knowledge was in August 2011, when she received a copy of her 1963 medical records from the hospital. She gave evidence that she had asked for the medical records following a TV program on symphysiotomies. She instituted legal proceedings in 2012.

These preliminary issues dealt with, the Court went on to hear from a wide range of expert witnesses.

Judgment

Mr Justice Cross found that "the practice of a prophylactic symphysiotomy in 1963 was not a practice without justification". He said it was indeed a controversial practice but it was strongly defended and the strength of the defence made it impossible for the plaintiff to prove her case.

The Court accepted that medical practice evolves and that, where any practice is a general one, a defendant cannot escape liability if it is established that the practice has inherent defects which ought to be obvious to any person giving the matter due consideration. The Court was satisfied that prophylactic symphysiotomy was a general and approved practice in 1963 within the meaning of the third Dunne principle.

The hospital notes in relation to this plaintiff's care indicated that the treating doctors were convinced a vaginal delivery would not be possible. Accordingly, they proceeded on a course of symphysiotomy, which, at the time, they had reason to believe was not generally adverse in its effect to the mother and it was safer as far as the child was concerned.

Mr Justice Cross concluded that, given the real fears of multiple Caesarean Sections at that time and the perceived benign effects of symphysiotomy and given the wide acceptance of this practice among the leading consultants in the Coombe Women's Hospital and the National Maternity Hospital, **the plaintiff failed to establish this practice was one with such inherent defects that ought to have been obvious to any person giving the matter due consideration.** Therefore, she could not prove her case against the Defendant. The case is currently under Appeal. The Court of Appeal hearing date is the 12th April 2016.

> **"the practice of a prophylactic symphysiotomy in 1963 was not a practice without justification**

Article by: Claire Foley, Solicitor/Clinical Claims Manager, State Claims Agency

Lessons learned from claims finalised nationally in 2014 in Emergency Medicine

Aim

To review all medico-legal claims finalised nationally pertaining to Emergency Medicine during 2014 and identify learning opportunities. A finalised claim is one in which all the financials have been agreed, but not necessarily paid.

Method

A retrospective one year review of all claims finalised nationally in Emergency Medicine in 2014, pertaining to adults, was conducted. This list was obtained using the NIMS (National Incident Management System) and a data search performed using the term 'Emergency Medicine'.

Results

Fifty six finalised claims were identified, of which 23 (41.1%) were excluded: 10 were statute barred, 6 were withdrawn by the claimant, 3 pertained to paediatric emergency medicine and 4 were miscategorised. Of the **33 (58.9%) finalised claims**, 20 (60.6%) related to male patients.

Two claims (6.1%) resulted in fatalities. One pertained to a patient with no known drug allergies, who developed anaphylaxis: adrenaline was not administered. The second related to a patient who was discharged from the Emergency Department (ED) with gastritis and collapsed at home. Despite resuscitative efforts, the patient died secondary to a perforated duodenal ulcer.

With regard to the non-fatal claims (Figure 1), multiple specialities were identified, of which orthopaedics (n=17, 54.8%) was the most common, followed by surgery (n=5, 16.2%) and cardiology (n=3, 9.7%). There was one (3.2%) claim each in the specialities of infectious diseases, gastroenterology, urology, neurology, gynaecology and dentistry.

Regarding orthopaedics (n=17), delayed diagnosis of fracture (n=9), was the most common claim; followed by unexpected complication after treatment (n=3) which included infection (n=2) and nerve damage (n=1). The remaining orthopaedic claims involved missed septic arthritis (n=2), cauda equina (n=1), finger injury (n=1) and wrong limb x-rayed (n=1).

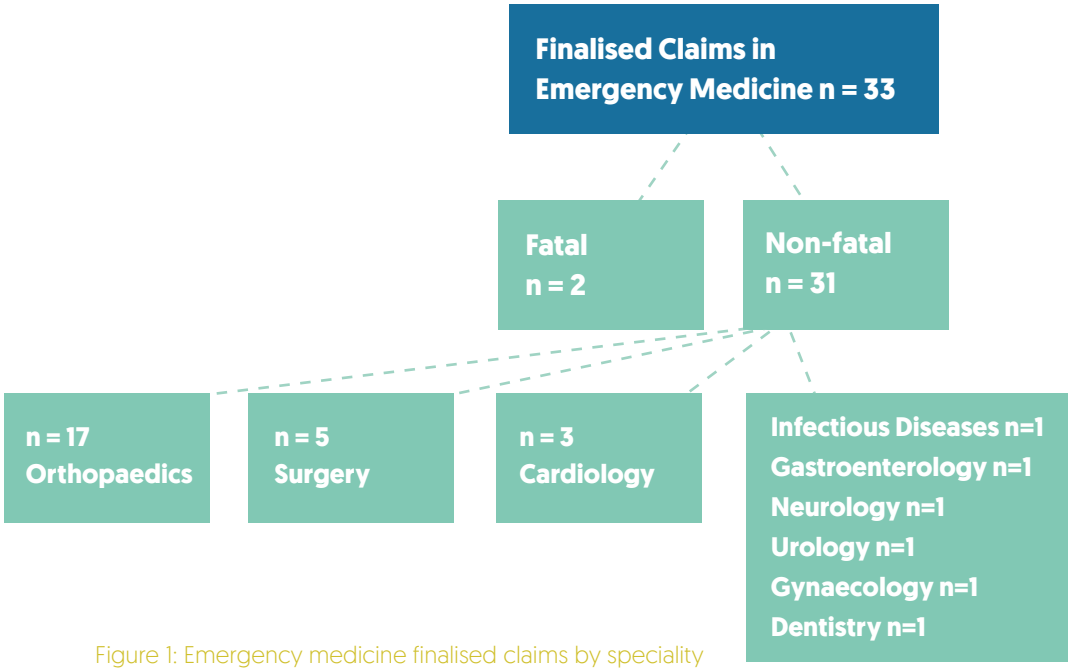


Figure 1: Emergency medicine finalised claims by speciality

Surgery accounted for five claims, of which three related to delayed diagnosis of appendicitis. An emergency laparotomy for acute peritonitis secondary to a perforated and gangrenous appendix was required in one case. The patient had presented two days earlier with abdominal pain, vomiting and diarrhoea and a diagnosis of gastritis had been made.

Cardiology claims (n=3) pertained to a delayed diagnosis of non-ST elevation myocardial infarction; a retro-peritoneal clot post angiogram and a suboptimal cardiopulmonary resuscitation where defibrillation was repeatedly impeded due to excessive chest hair.

The single Infectious Disease claim resulted from a high risk patient who presented with varicella infection on a background of immunosuppression secondary to an organ transplant. A delay in commencement of treatment resulted in acute renal failure and and a cerebrovascular accident.

A breakdown of claims by incident type identified that "delay in diagnosis" was the most common (n=23, 69.7%), followed by "delay in treatment" (n=4, 12.1%) and "unexpected complication of treatment" (n=6, 18.1%).

69.7%

OF CLAIMS DUE TO DELAY OF DIAGNOSIS

12.1%

OF CLAIMS DUE TO DELAY IN TREATMENT

Lessons Learned:

- **Implement specific Education and Training** in clinical and radiological presentations of orthopaedic cases, prior to commencement of ED rotation.

- Recognition of **high risk patients** with appropriate referral and escalation to senior decision makers.

- Importance of clear, accurate and timely **documentation**. Poor quality documentation is a criticism in many expert reports and HSE and HIQA investigations (HSE, 2014; HIQA, 2013).

Article by: Fiona Culkin and Deirdre Walsh, Clinical Risk Advisers, State Claims Agency

*Data validated as of the 13/05/2015

References

- Holohan, T. (2014) HSE Midland Regional Hospital, Portlaoise Perinatal Deaths (2006-date).

- Health Information and Quality Authority (2013). Investigation into the safety, quality and standards of services provided by the Health Service Executive to patients, including pregnant women, at risk of clinical deterioration, including those provided in University Hospital, Galway, as reflected in the care and treatment provided to Savita Halappanavar. Health Information and Quality Authority, Dublin.

Open Disclosure

Article by: Ann Duffy, Clinical Risk Adviser, State Claims Agency

Background

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. In her foreword to the report, Chairperson, Dr. Deirdre Madden, states: "When such adverse events occur there must be a system in place that ensures that all those affected are informed and cared for, and that there is analysis and learning from the error to try and prevent the recurrence of such an event."

One of the key recommendations of the report is the development and support of a culture of Open Disclosure to patients and their relatives. Open Disclosure (OD) 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."

Pilot

In October 2010 the SCA and HSE commenced an Open Disclosure 2 year Pilot project at two sites, the Mater Misericordiae University Hospital (MMUH) Dublin and Cork University Hospital (CUH). The leads in the SCA (Ann Duffy) and HSE (Angela Tysall) developed a 4 hour accredited workshop on open disclosure. Disclosure guidance and national policy were developed by incorporating the learning from the pilot programme while also integrating international learning and best practice guidelines.

An external researcher undertook an evaluation of the pilots between 2014 and 2015. Face-to-face or telephone interviews were held with nineteen managers and healthcare professionals involved in open disclosure in the two pilot sites. One patient representative and thirteen national managers (including the two open disclosure leads in the HSE and SCA) were also interviewed. Three focus groups were held with staff at CUH. An on-line survey was distributed to staff working in CUH and MMUH There were a total of 339 responses to the on-line survey, of which 211 were from CUH and 128 were from MMUH. The chart on the right represents the respondents by discipline.

Progress to Date

1. On 12th November 2013, Dr James Reilly, Minister for Health, launched the State Claims Agency and HSE national policy and guidelines on open disclosure.

2. Both OD leads have been working with 47 hospitals and in 3 CHOs as part of a change management programme to deliver open disclosure sessions.

3. Over 400 briefing sessions (approx. 4,000) for all staff and 270 workshops were delivered (approx. 3,000).

4. Seven "train the trainer" workshops (2 day workshops) with 140 senior staff trained to deliver training within their organisations were delivered.

5. The external evaluation report will be published in the near future.

The Future

The SCA remains committed with the HSE in ensuring that open disclosure remains a pivotal part of good business within our health services. A strategic approach is now being taken by both Agencies to ensure that OD and the learning opportunities to date influence the healthcare landscape by continuing to inform national policy, under and post graduate education and relevant healthcare organisations.

Breakdown of occupations of respondents to the survey

- Nursing & Midwifery - **122**
- Consultants & Physicians - **58**
- Allied Health Professionals - **37**
- Administration - **64**
- Hospital Managers - **10**
- Medical Scientists - **23**
- Other - **23**

Indemnifiers, regulators, healthcare professionals and academics collaborate to address clinical risks in care transitions

A collaborative study was conducted between Medisec and the University of Limerick Hospitals (UL) Group with healthcare professionals from primary care sites (GP practices and pharmacies) and secondary care sites as well as patients in both sectors.

The Steering Group included representatives from the State Claims Agency (SCA), Health Information and Quality Authority (HIQA), Irish College of General Practitioners (ICGP), School of Pharmacy Trinity College Dublin, Schools of Medicine: University of Limerick (UL) and University College Dublin (UCD), Medical Council, World Health Organisation (WHO) Patients For Patients' Safety, Health Service Executive (HSE), UL Hospitals. The project was managed by an independent healthcare consultant.

The main aim of this study was to investigate the experiences of clinical incidents in healthcare settings from the perspectives of both healthcare professionals and patients and determine key strategies for improving healthcare services and transitions in care.

Semi-structured interviews were conducted with healthcare professionals including GPs, pharmacists, consultants, hospital doctors, nurses and administration staff and a focus group with patients from primary and secondary care.

> **"Investigate the experiences of clinical incidents in healthcare settings from the perspectives of both healthcare professionals and patients**

The report identified the following:

- Medication error was the most predominant risk highlighted among healthcare professionals.
- Current referral pathways to hospital are complex. Conflicting views among healthcare professionals on appropriate referral routes were identified.
- While most GPs are utilising IT based systems in their practices, paper based systems are still creating barriers in communication between primary and secondary care, and healthcare

professionals in both sectors are receiving handwritten referral and discharge letters with limited and, in some cases, illegible patient information.

- Healthcare professionals requested expansion of the role of the hospital pharmacist and increasing the number of hospital pharmacists at ward level.

- Patients want to be empowered with access to their medical notes.

- A long-term solution would involve synchronising IT systems across primary and secondary care and greater use of electronic communication, including the usage of "healthmail" which allows all hospitals to communicate clinical information securely to GPs.

- Where possible, promote patient access to their own healthcare records, to promote patient inclusion in their own healthcare and to facilitate better patient communication, education and awareness.

Project Recommendations

The report recommends the following:

- In order to decrease the risk of medication error, electronic information sharing practices need to be synchronised across primary and secondary care.

- The expansion of the role of the hospital pharmacist, increasing the number of hospital pharmacists at ward level and encouraging more collaboration with other healthcare professionals from primary and secondary care which could reduce the risk of medication error.

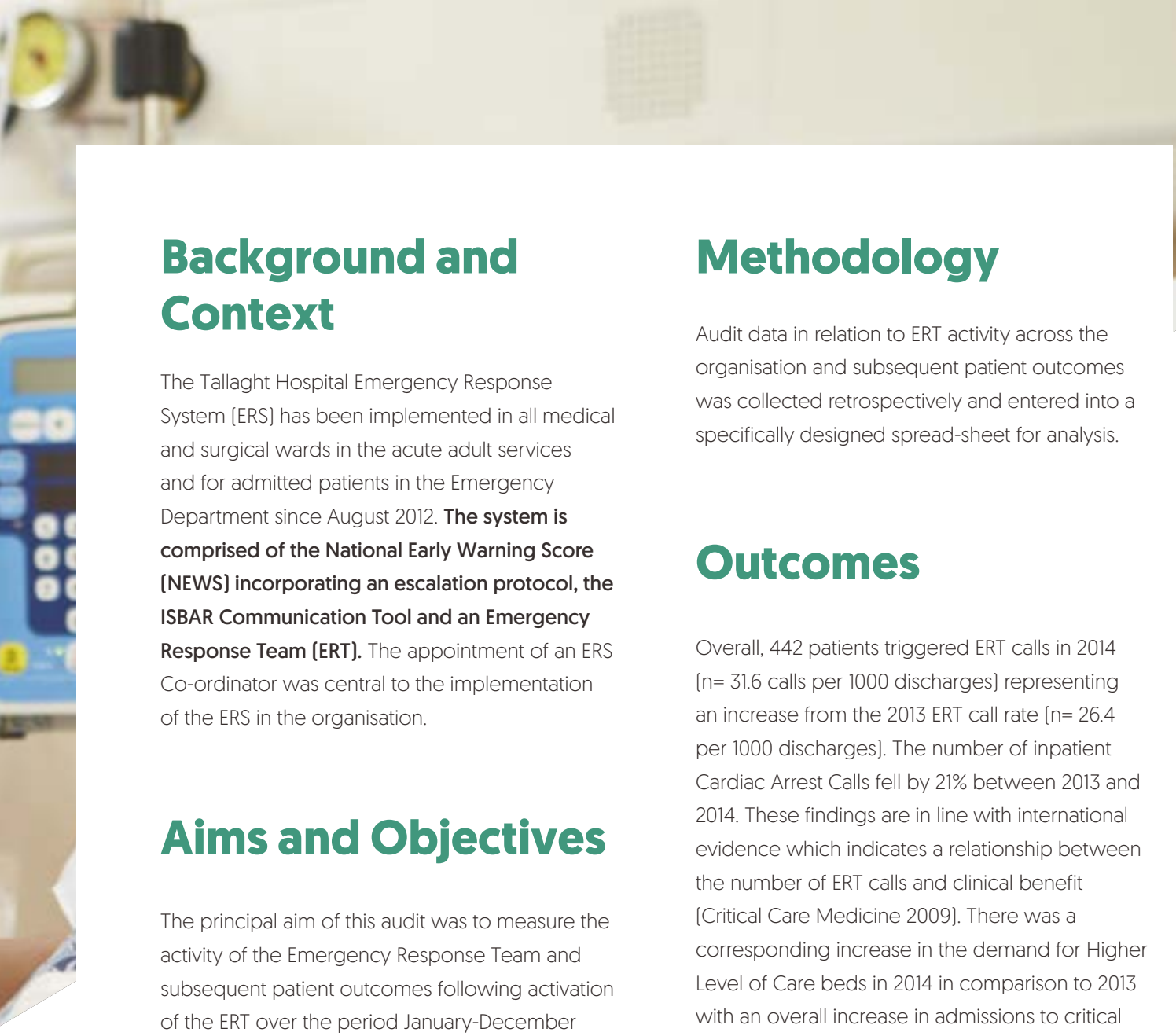
- The need for clearer referral and discharge pathways and support for healthcare professionals in transitioning patients from primary and secondary care in terms of providing more resources in units such as the Acute Medical Assessment Unit (AMAU), Medical Assessment Unit (MAU) and the Local Injuries Unit (LIU).

The objective of the steering group is to use the findings of the report to initiate improvements in the communication between primary and secondary healthcare sectors. There is continued collaboration of the agencies involved to action the recommendations identified.

Article by: Ruth Shipsey, CEO Medisec Ireland and Claire O'Regan, Clinical Risk Adviser, State Claims Agency

An Audit of the Emergency Response System in Tallaght Hospital 2014

Article by: Shauna Ennis, Nurse Practice Development Adviser, Tallaght Hospital



Background and Context

The Tallaght Hospital Emergency Response System (ERS) has been implemented in all medical and surgical wards in the acute adult services and for admitted patients in the Emergency Department since August 2012. **The system is comprised of the National Early Warning Score (NEWS) incorporating an escalation protocol, the ISBAR Communication Tool and an Emergency Response Team (ERT).** The appointment of an ERS Co-ordinator was central to the implementation of the ERS in the organisation.

Aims and Objectives

The principal aim of this audit was to measure the activity of the Emergency Response Team and subsequent patient outcomes following activation of the ERT over the period January-December 2014. In doing so, areas for further development of the ERS in the organisation can be identified and addressed.

Audit Aim

To measure the activity of the Emergency Response Team and subsequent patient outcomes following activation of the ERT over the period January-December 2014.

Methodology

Audit data in relation to ERT activity across the organisation and subsequent patient outcomes was collected retrospectively and entered into a specifically designed spread-sheet for analysis.

Outcomes

Overall, 442 patients triggered ERT calls in 2014 (n= 31.6 calls per 1000 discharges) representing an increase from the 2013 ERT call rate (n= 26.4 per 1000 discharges). The number of inpatient Cardiac Arrest Calls fell by 21% between 2013 and 2014. These findings are in line with international evidence which indicates a relationship between the number of ERT calls and clinical benefit (Critical Care Medicine 2009). There was a corresponding increase in the demand for Higher Level of Care beds in 2014 in comparison to 2013 with an overall increase in admissions to critical care areas of 31%.

Of the 442 patients who triggered ERT calls in 2014, 63% recovered and were discharged home and 31% did not survive to discharge. The remaining 6% were still inpatients at the end of the year. Older patients were associated with increased numbers of ERT calls with the 71-80 year old age group triggering the highest number of calls. This finding is consistent with an increase in admissions to the hospital of older patients (61-90 years) since 2012 and a corresponding decrease in admissions of younger patients (16-60 years). This trend supports the 'morbidity expansion' model which will see an increasing number of elderly patients with multiple comorbidities requiring hospital admission (Journal of Public Health 2010).

Of the 144 patients who triggered an ERT call and did not survive to discharge, 78% had an End of Life (EOL) decision in place. These EOL decisions were, in many cases, prompted by the Emergency Response Team review. The ERT assisted primary teams in identifying those patients who required consideration with regard to the escalation of treatment and planning end of life care.

Conclusion

This audit data demonstrates that the recognition of deteriorating patients is improving where the Emergency Response System is active in Tallaght Hospital. There has been a significant increase in Emergency Response Team activity between 2013 and 2014. Increasing numbers of ERT calls presents significant challenges to existing critical care nursing and anaesthetic services to provide critical care expertise to areas external to the Intensive Care Unit (ICU). The following key areas for development in 2015 were identified with regard to the Emergency Response System:

1. A Critical Care Outreach Nursing Service commenced in May 2015. The aim of this service is to provide a critical care consultative, educational and direct clinical intervention approach to support nursing staff and junior non-consultant hospital doctors caring for deteriorating patients in ward areas.

2. A Quality Improvement Project was undertaken with a view to improving clarity and communication regarding resuscitation decisions and treatment escalation plans. This work was based on the data demonstrating that older patients triggered the highest number of ERT calls and the EOL decisions prompted by Emergency Response Team reviews. A "Resuscitation Decision and Record of Treatment Escalation Plan" has been developed and is currently being piloted in the hospital.

3. An education programme - "Recognition and Management of the Acutely Ill Adult" has been developed for Registered General Nurses and has commenced in January 2016. The aim of the programme is to further enhance the requisite knowledge, skills and competence of registered nurses in recognising and responding appropriately to the acutely ill adult in clinical ward settings.

KEY STATS

442
PATIENTS TRIGGERED ERT CALLS IN 2014

21%
DECREASE IN CARDIAC ARREST CALLS FROM 2013-14

63%
OF PATIENTS THAT TRIGGERED ERT CALLS RECOVERED & WERE DISCHARGED HOME

Areas for Development

1. **A Critical Care Outreach Nursing Service**
2. **Piloting of a "Resuscitation Decision and Record of Treatment Escalation Plan"**
3. **Commencement of the "Recognition and Management of the Acutely Ill Adult" education programme**

Future Developments of the Emergency Response System

In 2014, data collection in relation to the ERS was expanded to include the age profiles of all patients admitted to the hospital. This has provided valuable data in terms of the needs of older age groups with multiple co-morbidities. This data will further inform the hospital's strategy going forward. **It is envisaged that the role of the Critical Care Outreach Nurse will evolve over the coming months to ensure that the service is meeting the requirements of a dynamic clinical environment.** This will be informed by ongoing data collection and stakeholder engagement in partnership with the Emergency Response System Steering Group.

Community of Practice

The concept of Community of Practice (CoP) has been around since the 1990's and was defined in 1998 by Etienne Wenger as **"a group of people who share a concern or a passion for something they do, and learn how to do it better as they interact regularly."** It is through this process of sharing information and experiences within the CoP that members learn from each other, and have an opportunity to develop themselves personally and professionally. CoPs have the ability to influence theory and practice in many domains, have become the basis of knowledge and learning in many organisations and have been embraced in St Mary's Hospital, Phoenix Park.

Bone Health CoP

Falls and falls related injuries are costing our health service and economy in excess of €500 million a year and are set to rise with our ageing population (HSE, DoH, 2008). Health and Social Care staff are becoming proactive in addressing this major problem but need a more collaborative approach. In 2011 and 2012 St Mary's developed and implemented a suite of elearning tools on bone health, osteoporosis, falls prevention and falls management. Both feature under Bone Health in the Park and can be viewed at our website www.bonehealth.co. Due to the response to both these programmes from a local and national perspective across the care continuum for older adults, we have recognised the need for a resource for health and social care staff on an ongoing basis, to network, offer support, guidance and continued education from experts in this area of practice. By developing a CoP online across the community, hospital, residential, palliative care and intellectual disability care settings this was achieved. **There are currently 75 members of the CoP including nurses, doctors, occupational therapists, physiotherapists, radiographers, pharmacists, dieticians and healthcare assistants** all with a common interest in bone health and falls prevention in an ageing population.

FALLS & FALLS RELATED MEASURES COST THE HEALTH SERVICE & ECONOMY

> €500 MILLION PER YEAR

CoP Objective & Aim

The objective of the CoP is to provide a collaborative network for health and social care staff working with older adults. The aim of this network is to provide informal and formal support, guidance and continued education on falls reduction, prevention and management. Through gathering information from the membership body and sharing what is working well, identifying areas for improvement and identifying areas for development around falls reduction, prevention and management in each of the identified areas of practice this can be realised. The CoP communicates online www.foreverautumn.co and has a face to face meeting annually while also hosting group meetings where work is under development.

Through the CoP an education resource was developed for people with intellectual disabilities, as none previously existed, using the expertise within the CoP membership. It was afforded its own website www.happybones.ie and is accessed regularly by people with an intellectual disability, their families and carers. Our websites have had over 36,000 visits since 2011.

CoP Hosts First Conference

In September 2015 the CoP hosted its first conference in Cappagh Hospital and had 135 delegates attend all with a specialist interest in the area. The ebonehealth education resource developed by Daragh Rodger and Anne Spencer was officially launched by Professor Moira O'Brien and the conference also provided an opportunity to share information on what is happening nationally in relation to falls prevention and bone health. We had the honour of Professor Moira O Brien presenting on the history of Osteoporosis care in Ireland which highlighted her tremendous dedication, expertise and enthusiasm in the field of osteoporosis diagnosis, treatment and management.

The long term objective is to provide a CoP that is accessible to all health and social care professionals, carers, families, service users and the public who require information on any aspect of bone health, falls reduction, management and prevention.

A CoP that is accessible to all health and social care professionals, carers, families, service users and the public who require information on any aspect of bone health, falls reduction, management and prevention.

Authors & Project Leads

The project leads for Forever Autumn Community of practice are Daragh Rodger, Advanced Nurse Practitioner (daragh.rodger@hse.ie) and Anne Spencer, Educational Technologist (aspencer@petal.ie)

2015/16 SCA CIS Risk Key Facts & Figures

NATIONAL

46
HOSPITAL SITE VISITS

17
MATERNITY SERVICES VISITS

4
NEW CLINICAL RISK FORUM MEETINGS WITH THE HSE

TRAINING AND EDUCATION FACE TO FACE WORKSHOPS ON HOSPITAL / COMMUNITY SITES:

TRAINING/EDUCATION	NO. OF SESSIONS	PEOPLE TRAINED APPROX
Incident Management & Reporting inc. NIRFs	16	1,230
Open Disclosure (OD): - Briefing sessions - Workshops - 4 hours - Train The Trainer - 2 day course Total trained in OD in 2015:	 83 35 7	 2,300 625 143 3,068
Documentation and recording in clinical practice	12	287
Other topics e.g. consent, management of clinical risk, systems analysis investigation and medication incidents	7	150

LECTURE SERIES

University lecture series: UCD, TCD, UL, RCSI.

- Higher Diploma in Midwifery
- BSc in Nursing
- Surgical training programme for NCHDs
- MSc in healthcare management
- MSc in quality and safety in healthcare
- Graduate Diploma in healthcare risk management and quality

Invited national speaker at:

- Irish Hospital Consultant Association (IHCA) annual conference
- Irish College of General Practitioners Trainers annual conference
- MBA Executive Programme: Auburn University USA

MEDICAL EDUCATION NEW CLINICAL RISK COURSES UNDER GRADUATE AND POST GRADUATE:

- University of Dublin Trinity (TCD)
- Royal College of Physicians of Ireland (RCPI)

No query too small or large
Monday to Friday email, phone or visit us

PUBLICATIONS & DATA ANALYSIS

INTERNATIONAL

Presentations at Medical Scientific Conferences

11th Congress of European Society of Gynaecology, Prague

- An analysis of ten years of closed claims of retained foreign bodies in maternity services.
- An analysis of ten years of closed claims and retained foreign bodies in gynaecology services.

NATIONAL

Poster Presentations

National Emergency Medicine Programme Conference, Dublin

- National clinical incidents and claims in emergency medicine 2010-2014.
- Lessons learned from claims finalised nationally in 2014 in emergency medicine.

DATA ANALYSIS

Clinical Closed Claims in:

1. Retained Foreign Bodies in Maternity Services
2. Retained Foreign Bodies in Gynaecology Services
3. Mental health
4. Paediatrics
5. Emergency medicine

PUBLICATIONS

NATIONAL REPORT

Clinical Incidents and Claims Report in Maternity and Gynaecology Services: a five year review 2010 – 2014. Published October 20th 2015. Available on **www.stateclaims.ie**

PUBLICATIONS IN PEER REVIEWED MEDICAL JOURNALS

- IMJ: Towards improved and safer care for patients and doctors IMJ.108 (7): 198-199 invited editorial
- IMJ: Patient safety incident reporting in the who, what, where, when and why (IMJ in press)

PUBLICATIONS IN NON-PEER REVIEWED JOURNALS

- The Soaring Cost of Maternity and Gynaecology Services Claims: The Consultant: 2015; Winter Edition 34-35
- Communicating with patients following adverse events. Open Disclosure: the professional and ethical response: Irish College of Ophthalmologists Journal: 2016; Spring Edition (accepted).

AFFINITY

http://www.affinityfallsbonehealth.ie – web repository

1. Foundation education resource
2. Measure and monitor framework developed
3. Update regarding HSE Affinity Commitment within European Innovation Partnership on Active and Healthy Ageing (EIPAHA)
4. Assisted HSE in KPI development

CLINICAL RISK TEAM 2016

1. Ongoing identification of trends and patterns in Irish health and social care and ongoing clinical risk management recommendations.
2. Continuing hospital site visits.
3. NIMS: incident reporting and management train the trainer programme available for CHO and hospital groups. Contact your division for details.
4. Open Disclosure: ongoing collaboration with the HSE. Ongoing train the trainer courses.
5. Affinity: develop an integrated approach to reducing falls and promoting bone health clinical risk teams HSE national service plan 2016.
6. Ongoing team expansion.

For more information on any of the above or if you have a query, please email stateclaims@ntma.ie

NIMS Update

Article by: Mike Sweeney, Programme Manager, State Claims Agency

ROLLOUT TO DATE

Phase I of the National Incident Management System (NIMS) implementation was completed in June 2015 with the successful training and migration of approximately 700 existing STARSWEB users nationally, along with a significant number of new users, onto the new NIMS platform.

In addition, in 2015 there was a number of significant developments including, a new national complaints module, rebranding of the system to the NIMS, a proof of concept for a national recommendations' tracking tool, an E-Learning tool, and enhancements around the capture and classification of incidents, including serious and reportable events and updates to the location hierarchies.

2016 AND BEYOND

In 2016 we plan to continue to improve the NIMS, with enhancements in the capture of radiation incidents, blood products, medication incidents, clinical procedures and many more. In addition, the system will be updated to reflect the new community health care organisation structure and divisional reporting.

Key deliverables of Phase II of the NIMS Implementation include training and rollout of the NIMS reporting suite, developing a communications and engagement strategy with all stakeholders, encouraging adoption of the incident investigation screens and further rollout of the complaints' and recommendations' modules.

It is our joint goal to learn from incidents through the collection and analysis of incident related data. To achieve this, we must ensure that both the culture and tools effectively support this effort and we are committed to developing and enhancing the NIMS through 2016 and beyond, to ensure it continues to perform a key role in achieving this goal.

'EXCELLENCE IN INNOVATION' AWARD

The NIMS was developed on the Marsh ClearSight Risk and Claims management platform, STARS Enterprise.

Marsh is the world's second largest Insurance Broker and is a world leader in the area of Risk and Claims Management. Marsh has developed the 'Excellence Award Program' which seeks to recognise the compelling and innovative ways in which their clients have used technology to support their risk management strategies and programs.

In 2015, from a client base of circa 1000 clients, the NIMS won the 'Excellence in Innovation' Award in recognition of the scale, flexibility and breadth of functionality of the solution delivered to such a broad and diverse client base nationally, and in delivering positive business results to solve risk management, safety and claims operations challenges.

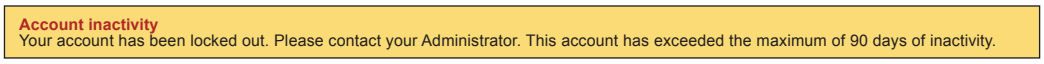
In photo from left to right: Mike Sweeney (Programme Manager, SCA), Conor O'Kelly (CEO, NTMA), Pat Kirwan (NIMS Project Sponsor, Deputy Director, SCA)

KEY FACTS AND FIGURES FOR 2015

2015	GIS	CIS	TOTAL
Incidents Reported	97,317	43,301	140,618
Claims Received	2,278	665	2,943
Claims Resolved	1,381	482	1,863
Active Claims (end of 2015)	5,275	3,000	8,275
Transactional Spend	€32m	€189m	€221m

FAQ – FREQUENTLY ASKED QUESTIONS

1. **My account has been locked out, how do I access NIMS?**



This message appears when you do not access the system for over 90 days. If this should appear you will need to contact the helpdesk at NIMSHelpdesk@ntma.ie or 01 2384240 to get your account reactivated.

2. **I am getting 'Page Cannot be Displayed' when I try to access NIMS, what do I do?**

Possible Causes:

- Incorrect web address.
- Changes were made to the PC recently.

Possible Solutions:

- Check that web address is as follows: https://www.nims.ie
- Ask your IT department to check the settings on the PC and relate to the NIMS helpdesk exactly what, if any, changes were made. The NIMS Helpdesk can provide a troubleshooting guide to IT personnel of areas that they can check.

3. **What are "CLAIMS PREVIOUSLY REPORTED AS INCIDENTS" (CPRI) and why are these important?**

These are claims which have been previously reported as incidents to the SCA. It is recognised that there are a number of incidents which are extremely difficult to report if organisations have not been informed e.g. member of public incidents in your facilities. The SCA represent the numbers of CPRI as a percentage of the total number of claims received in a period. In 2016 we will be focusing on this percentage with a view to developing a baseline with your organisation. Those CPRI will be analysed and we will support organisations in improving this figure over an incremental period.

In addition to supporting the SCA in performing its functions, this figure is a key performance indicator (KPI) for incident reporting in your organisation. Incident numbers alone are not the sole indicator of good reporting. CPRI is a powerful figure that not only indicates the quality of reporting, it also targets those incidents which pose a significant risk to your organisation.

SCA GIS Risk Key Facts & Figures

2015

The Enterprise Risk Management Section provides risk advice and assistance to the 129 Delegated State Authorities (DSA) covered by the General Indemnity Scheme. The Enterprise Risk Management Section welcomed four new members to the Section in 2015, bringing the current head count to 17 people. The team consist of engineering, science/ social science and legal professionals. The following is a summary of the key project achievements for the Section in 2015.

NETWORK

2
MEETINGS

200
ATTENDEES

6
SIGs (State Indemnity Guidance)

- State Indemnity as operated by the SCA
- Motor Guidance Document
  - *Delegated State Authority vehicles*
  - *Use of employee vehicles for work*
  - *Business and personal use of State vehicles*
- State Indemnity in polling station and count centres
- Community and Comprehensive Schools Work Placement Guidance

4
RANs (Risk Advisory Notice)

- Adverse Weather Conditions
- Sustainable Use of Pesticides Regulations
- Use of Electrical Adaptors/Extension Leads
- Inspection and Maintenance of School Equipment

All SIGs & RANs available from stateclaims@ntma.ie

REVIEWS

NSAI

QUALITY ISO 9001:2008 NSAI Certified

49
LOCATIONS

6
CLIENT REVIEWS

23
AUDIT REPORTS

QUERIES

1,300
QUERIES ANSWERED

CISM

2,300
CISM WORK POSITIVE ONLINE SURVEYS COMPLETED

http://www.cismnetworkireland.ie/

VSCG

36
ORGANISATIONS ACROSS THE UK AND IRELAND

http://vscg.org/

DELEGATION ORDER

16
NEW AUTHORITIES DELEGATED IN JUNE

SCA GIS Risk Key Facts & Figures

2016

In 2016 the team hope to continue to support clients through risk initiatives. In particular, the Enterprise Risk Management Section will focus on more Network events and guidance documents to support DSAs with everyday application of State indemnity.

NETWORK

2
MEETINGS

129
SIGNED CHARTERS

SECTOR FOCUS GROUPS TO BE EST.

- *Health & Safety Management Systems*
- *Guidance on Contractors & Insurance levels*
- *eZine*

REPORTING

10%↑
IMPROVEMENT

Focus on Claims Previously Reported as Incidents (CPRI)

QUERIES

20%↓

REDUCTION IN QUERIES DUE TO SHARED TRAINING AND THE LAUNCH OF MORE STATE INDEMNITY GUIDANCE (SIGs)

REVIEWS

30%↑
EXPANSION OF CLIENT REVIEWS

DELEGATION ORDER

DEPARTMENT OF HEALTH DELEGATION ORDER EXPECTED IN 2016

http://stateclaims.ie/about-our-work/

KEY SECTOR PROJECTS

- Accommodation Management Review & Guidance – Role of Occupier versus Facilities/Estates
- VSCG – Information signage
- CISM – Tool available to all
- Health and Safety Risk Management Structure and Training Guidance in conjunction with the OGP

For more information on any of the above or if you have a query, please email **stateclaims@ntma.ie**

Is incident reporting, in itself, of much value?

Article by: Pat Kirwan, NIMS Project Sponsor, Deputy Director, State Claims Agency

One of the interesting behaviours that I noted during the implementation of the NIMS was the emphasis on the incident capture stage of the process. Of course it's important, and for as long as incidents are reported and recorded there will be debate about methods of incident capture, paper forms vs. electronic point of occurrence, what data that needs to be captured, reporting picklists etc. However, I wonder whether for some people, reporting has become the beginning and the end and that they have lost sight that, in truth, it is only the starting point of the incident management process.

Yes, incident capture is important in itself. It fulfils a statutory requirement to report incidents to the SCA. It can be the important record in the event of a statutory investigation or a claim for compensation. We know that organisations that have higher levels of reporting are also likely to have improved levels of risk management.

Also, there is some use in analysing aggregated incident data. It can show trends and hotspots. Incident counts can provide initial but sometimes useful key performance indicators. However, there is a limit to the value and impact of these counts. **We can produce all the statistics and counts of this type but, on its own, does it have any real impact – does it prevent these incidents from happening again?**

> **"We need... to put investigation at the centre of our incident management process**

What we need to do is to put investigation at the centre of our incident management process. **Investigation tells us what went wrong and why. It reveals what we need to do to prevent recurrence.** Incident investigation is the challenging and time consuming part of the incident management process but will provide the greatest rewards.

The NIMS workflow design has certain features which makes it a very powerful tool in all stages of incident management but, in particular, for the incident investigation stage. It supports you in prioritising, assigning, tracking, and managing investigations. More importantly you can record the conclusions and recommendation of your investigations. Using the NIMS, you can assign and track your recommendations at a local, regional, organisational or national level, to a close.

This data captured in the investigation, conclusion and recommendation screens in the aggregate for one location, multiple locations in an organisation or for the State as a whole will be a rich vein of information which will provide lessons learned that will steer us in a direction that will lead to real change and improvement.

With the NIMS, you can:

- Prioritise investigations
- Track investigations
- Assign investigations
- Manage investigations
- Record conclusions & recommendations

Unfortunately, like people who have iPhones and use them primarily for texting and phone calls, most organisations are currently using the NIMS data entry functionality. We have a number of pioneers who are using the incident investigation screens and the feedback is very positive. As part of the Phase II Implementation of the **NIMS across the healthcare, civil service and public sectors, we want to encourage and champion the use of the Incident Investigation screens.**

Over 2016, we, in conjunction with our stakeholders, will be launching training, seminars and guidance material to encourage your organisation in using the NIMS tool to support incident investigation. The SCA is completing a suite of reports for senior management and subject matter experts in all our clients' organisations which will give key management information on the end to end incident management process, including those incidents that result in claims. Part of this report will focus on the incident investigation records and, in some cases, we hope to have one to one follow up with your organisation. We are looking forward to working in conjunction with you to get the best out of the NIMS tool and assist you in reducing risk and claims against your organisation and the State.

NIMS
National Incident Management System

Bail Crime Liability

Article by: Ben Mannering, Claims Manager, State Claims Agency

A recent judgment of the President of the High Court, Mr Justice Nicholas Kearns in Lorcan Roche Kelly v the Commissioner of An Garda Síochána, the Minister for Justice, Equality and Law Reform and the Attorney General **reviewed the liability for the Commissioner and Minister where crimes are committed by a person on bail for other offences.**

The plaintiff was the husband of Sylvia Roche Kelly who was murdered by Gerry McGrath on December 8th, 2007. The plaintiff claimed the failure and inaction of the defendants, in the context of a bail application, to inform the court of other offences in which McGrath had been charged, caused or contributed to the fact he was out on bail when he should not have been.

Mr Justice Nicholas Kearns considered the case law to date on such matters.

Lockwood v Ireland & Others [2011]

In Lockwood v Ireland and Others [2011], the court dismissed a claim made against the Garda by a rape claimant after a rape trial collapsed on account of a mistake in the arrest of the accused. The court took the view there was no duty of care such as would create an entitlement to damages arising from the manner in which the Garda conducted its investigation and the claimant would have to establish mal fides on the part of the Garda in order to maintain a claim for damages.

Case Details

- **Lorcan Kelly (Plaintiff) v the Commissioner of An Garda Síochána, the Minister for Justice, Equality and Law Reform and the Attorney General (Defendants)**
- **Mr Justice Nicholas Kearns, President of the High Court**

LM v the Commissioner of An Garda Síochána and Others [2011]

In LM v the Commissioner of An Garda Síochána and Others [2011], Mr Justice John Hedigan, in the High Court, dismissed an action by a plaintiff who complained Gardaí failed to properly investigate and prosecute a rape allegation. The complaint was made in May 1990 when the plaintiff was a child and no steps were taken between December 1990 and September 1996, until the English Child Protection Agency contacted Gardaí.

The UK police interviewed the alleged perpetrator in April 1997 and he was extradited back to Ireland in October 1998 and convicted. The Court of Criminal Appeal quashed the conviction in 2001 and an order prohibiting a retrial was later granted. The plaintiff's mental health deteriorated thereafter and she sued the Garda for the delay in prosecuting the claim. "The key issue in this case is whether it would be contrary to public policy to impose a duty of care on the Gardaí," Mr Justice Hedigan held. "The imposition of liability might lead to the investigated operations of the police being exercised in the defensive frame of mind ... The result would be a significant diversion of policy manpower and attention from their most important function, that of the suppression of crime."

AG v JK and Others [2011]

Mr Justice Hedigan was asked a similar question in AG v JK and Others [2011]. The plaintiff's case was that Gardaí had asked her to provide accommodation for the husband of her murdered friend when he could no longer live in his house, as it was a murder scene. The plaintiff alleged the man, who had a previous rape conviction, later raped her. The judge ruled that, "on the basis of the now well established law outlined ... no duty of care arises in the circumstances herein".

Smyth and Another v the Commissioner of An Garda Síochána and Others

The President, in the case under discussion, set out the arguments as considered in Smyth and Another v the Commissioner of An Garda Síochána and Others. The High Court had refused to dismiss the plaintiff's claims, at interlocutory stage, in circumstances where such a matter might have been expected to be dismissed on public policy grounds. The principle enunciated did not confer a blanket immunity in all circumstances but rather a principle which admitted exceptions in special circumstances. The plaintiff argued the public policy reasons which might be in favour of exclusion were outweighed by the public policy in favour of applying ordinary liability principles because the entire bail system attempts to avoid bail being granted to a person who may go on to commit a serious offence.

Maiorano v Italy

The plaintiff further advanced that Article 2(1) of the European Convention on Human Rights imposes upon the State an obligation to protect the life of individuals against the acts of third parties which may be taken as including victims identifiable in advance as potential targets of lethal acts and also those not so identifiable. In Maiorano v Italy, the Italian state was found to be responsible in respect of a double murder committed by an offender out on day release. Whilst it had not been possible to identify in advance the victims as potential victims, Article 2 required the protection of a society against the potential danger from a person convicted of a violent crime. The court emphasised Article 2 enjoined the state not only to refrain from the intentional and unlawful taking of life, but also the appropriate steps to safeguard the lives of those within its jurisdiction.

Mr Justice Kearns distinguished the Maiorano case on the basis it was a different criminal in a judicial structure and was one where the offender had previously been convicted of similar offences. He was freed under a day release system against the backdrop where the authorities had failed to act on specific warnings of his declared intention to commit further crimes and was clearly distinguishable from the incident case.

He dismissed the plaintiff's claim, not on the basis of some supposed "blanket immunity" but because long established common law principles, whereby a duty of care is deemed to arise, were not present on the facts of this case.

Case Law Considered

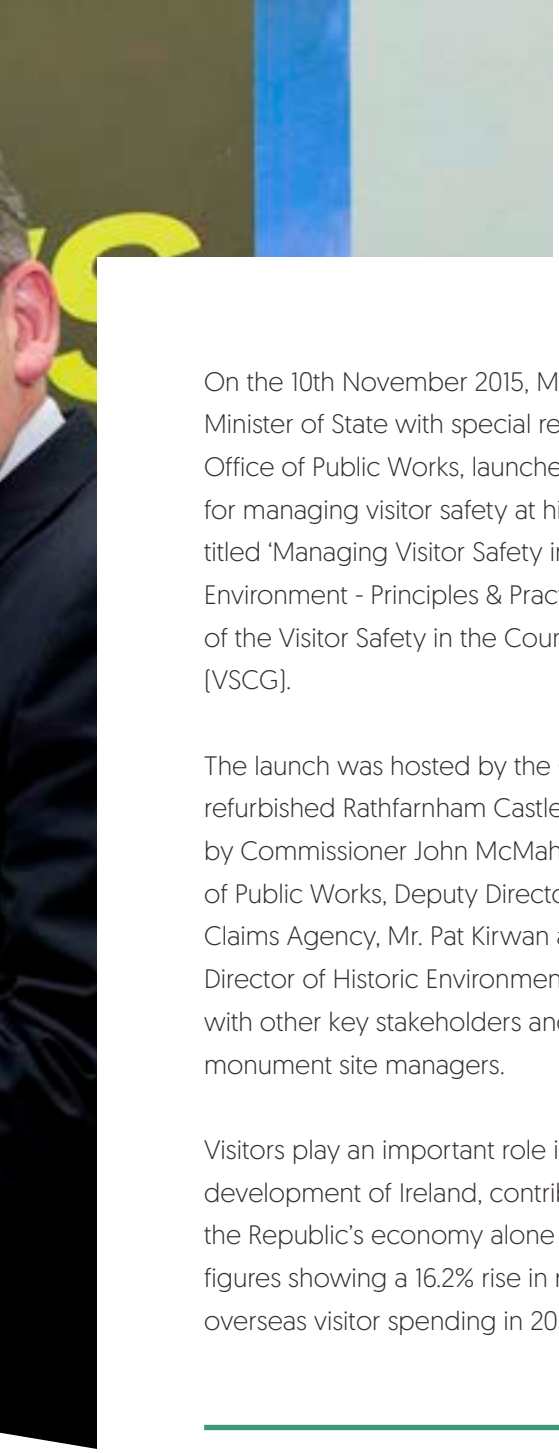
- **Lockwood v Ireland & Others [2011]**
- **LM v the Commissioner of An Garda Síochána and Others [2011]**
- **AG v JK and Others [2011]**
- **Smyth and Another v the Commissioner of An Garda Síochána and Others**
- **Maiorano v Italy**

"Dismissed the plaintiff's claim... because long established common law principles, whereby a duty of care is deemed to arise, were not present on the facts of this case

In photo from left to right: Karl Fox (Enterprise Risk Manager, SCA), Fiona Kearns (Senior Enterprise Risk Manager, SCA), Minister Simon Harris, Pat Kirwan (Deputy Director, SCA)

Minister Simon Harris joins the SCA to launch new visitor safety guidelines

Article by: Karl Fox, Enterprise Risk Manager, State Claims Agency



On the 10th November 2015, Minister Simon Harris, Minister of State with special responsibility for the Office of Public Works, launched new guidelines for managing visitor safety at historical attractions titled 'Managing Visitor Safety in the Historic Built Environment - Principles & Practice' on behalf of the Visitor Safety in the Countryside Group (VSCG).

The launch was hosted by the OPW in the newly refurbished Rathfarnham Castle and attended by Commissioner John McMahon of the Office of Public Works, Deputy Director of the State Claims Agency, Mr. Pat Kirwan and David Mitchell, Director of Historic Environment Scotland along with other key stakeholders and historical monument site managers.

Visitors play an important role in the economic development of Ireland, contributing €3.6bn to the Republic's economy alone in 2014, with recent figures showing a 16.2% rise in revenue from overseas visitor spending in 2015.

16.2%

RISE IN REVENUE FROM OVERSEAS VISITOR SPENDING IN

2015

Managing Visitor Safety

There are however, particular challenges in managing visitor safety which these new guidelines aim to assist with. The opening section of the book lays out the guiding principles that give managers the confidence to make decisions and includes the latest thinking about balancing risk and benefit and include planning and organising for visitor safety, assessing and managing risk, incident reporting and investigation as well as emergency planning and evacuation procedures. The publication draws on the experience of the VSCG members to offer practitioners a methodology to enforce an ethos of 'No Nasty Surprises' on their sites.

Speaking at the launch Minister Harris said:

"The issue of visitor safety management is of critical importance to my Office. I am delighted, therefore, that the guiding principles and risk management techniques included in this publication I am launching today are the perfect match to my Office's core principles of conserving our heritage and improving public access.

I have also no doubt that the other State agencies and Government Departments that form the VSCG will also greatly benefit from the shared knowledge and practical methodology that these guidelines offer for visitor safety, assessing and managing risk and other essential procedures to ensure that all visitors enjoy the benefit of our built environment". Minister Simon Harris, Minister of State with special responsibility for the Office of Public Works.

> **Core principles of conserving our heritage and improving public access.**

The organisations that form the Ireland Branch of the VSCG are responsible for the management of approximately 900 national monuments, parks, historic houses, recreation sites and 1,000km of inland navigable waterways across the island of Ireland, as well as for policy development.

To purchase the new Visitor Safety in the Historic Built Environment guidelines publication, please visit http://vscg.org/publications/managing_visitor_safety_in_the_historic_built_environment.

About the VSCG

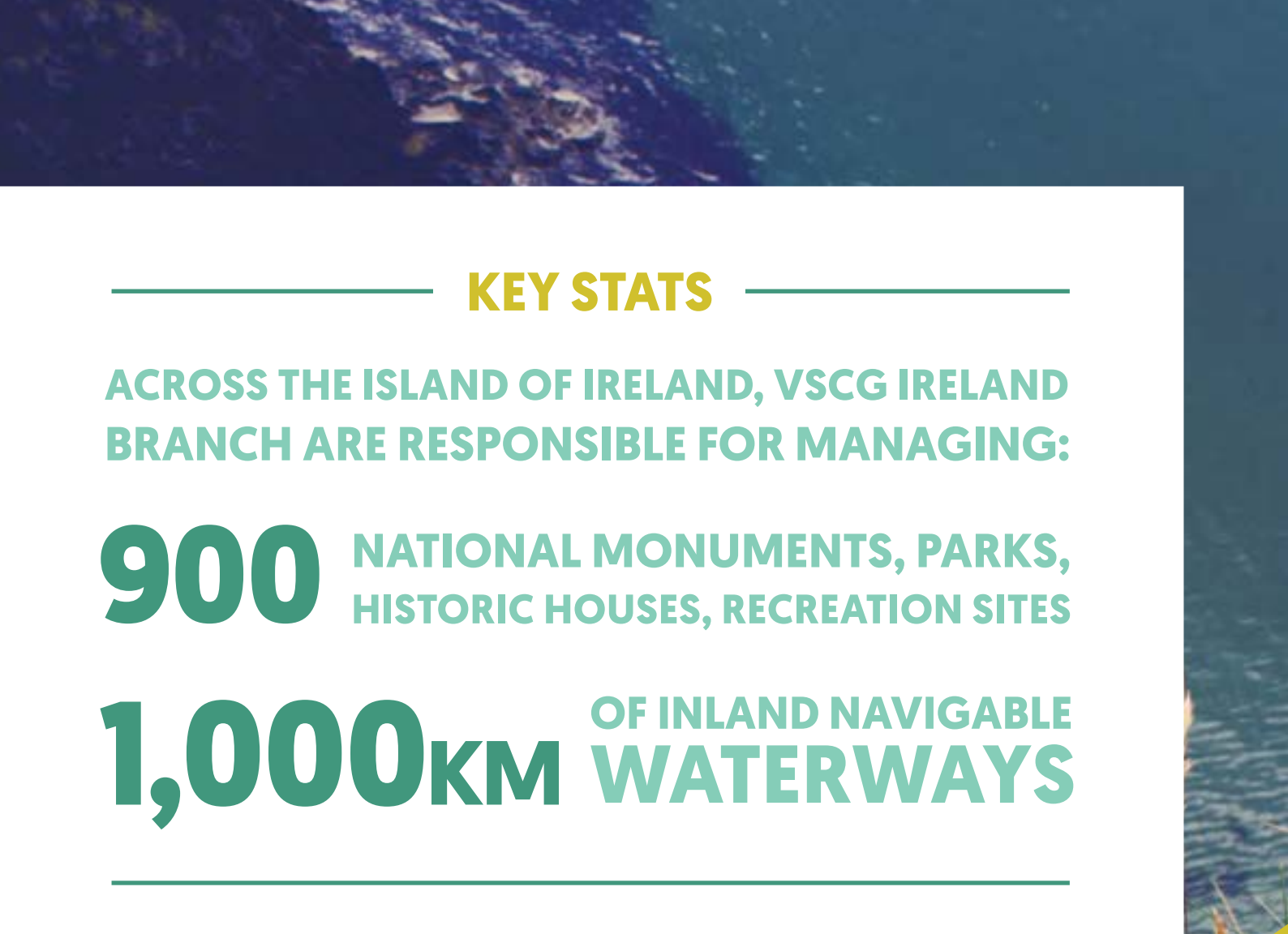
The VSCG was founded in May 1997 and currently has 36 member organisations across the UK and Ireland, most of which own and manage extensive land and property. Members are committed to protecting and enhancing the environment while encouraging public access, and as part of their membership agreement have signed up to a set of guiding principles.

The Ireland Branch of the VSCG was formed in 2013 and is focused on the issues facing the Irish members such as the visitor risk assessment process and a common approach to information provision and signage. A number of Irish organisations have been members of the VSCG since the 2013 launch and this continues to grow year on year.

The current Irish members include:

- State Claims Agency (acting as secretariat)
- Office of Public Works
- Department of Agriculture, Food and the Marine
- Department of Arts, Heritage and the Gaeltacht
- Department of Environment, Community and Local Government
- Waterways Ireland
- Coillte
- The Commissioners of Irish Lights

For more information visit http://vscg.org/ or contact the SCA directly by email at stateclaims@ntma.ie



KEY STATS

ACROSS THE ISLAND OF IRELAND, VSCG IRELAND BRANCH ARE RESPONSIBLE FOR MANAGING:

900 NATIONAL MONUMENTS, PARKS, HISTORIC HOUSES, RECREATION SITES

1,000KM OF INLAND NAVIGABLE WATERWAYS

The Enterprise Risk Management Network 2015

Article by: Myles Tynan, Enterprise Risk Manager, State Claims Agency

The State Claims Agency (SCA) has a mandate to provide information, instruction and training to enable Delegated State Authorities (DSAs) ascertain the extent of risk present and furthermore to provide advices on the appropriate measures to counter and control those risks identified. **One of the greatest challenges faced by the Agency is the communication of our advices to mitigate litigation risk to the appropriate target audience within each client State authority and healthcare enterprise.**

Since its launch in 2007, the Enterprise Risk Management Network (ERMN/The Network) has not only proven to be an effective vehicle for disseminating advices but also in acting as a knowledge sharing forum, where individual Network members can share their knowledge and experience or seek the advices of others who are operating under the public sector umbrella. Recent delegation of claims management orders in 2014 and 2015 more than doubled the number of DSAs availing of State indemnity, bringing to 129 the number of State bodies and agencies indemnified with respect to the General Indemnity Scheme. Consequently, this has led to a greatly increased membership of the Network. To facilitate this expansion, a decision was taken to relaunch the Network in July 2015 in order to welcome each body formally and to introduce the newly delegated Authorities to the concept of State indemnity.

Network Relaunch

The July relaunch was facilitated by one of the founder members of the Network, the Office of Public Works, who kindly offered the auditorium of the National Botanic Gardens in Glasnevin as a venue. As all DSAs have vehicles on the road, be they part of a fleet or employees using their own private vehicles for work, the topic of motor guidance was chosen. The seminar was opened by Ciarán Breen, Director and Pat Kirwan, Deputy Director then provided some background on the Network and introduced the topics for the day. Pat also spoke briefly about the new **Network Charter which the SCA has requested that each DSA have signed by a management representative at senior level.** The Charter outlines the risk management roles and responsibilities of all parties concerned and reiterates our commitment to engage in a positive manner.

Fiona Kearns, Senior Enterprise Risk Manager addressed the audience on the State Indemnity & Driving for Work - Motor Guidance document. The SCA has a query response service, which is available to DSAs for queries in relation to State indemnity and also provides risk management advices. This was the first specific motor insurance guidance document published by the SCA. The motor guidance was developed from the advices provided through this service, along with best practice and departmental policy.

GENERAL INDEMNITY INCREASED BY 60 DSAs OVER 2014/2015

National Gallery of Ireland Event

The second Network event of the year took place in the National Gallery of Ireland on the 24th November. The programme of work for the Health and Safety Authority (HSA) over 2015/16 includes a review of safety management systems within the public sector. Having completed some inspections on Network authorities beforehand, they felt they had garnered enough information to present generally on their findings to date and also on what public sector authorities might expect from such an inspection. HSA inspectors, Anna Maria O'Connor and Thomas Doyle provided interesting and informative presentations on what they would expect from a safety management system generally and also on the HSA's approach to safety management in the context of the public sector.

Anna Maria reported a number of positive findings on those Authorities inspected to date, namely evidence of sufficient safety management system documentation, operational controls, training provision, reporting of accidents and emergency planning, to name a few. However, there were also some areas for improvement, concerning issues such as the appointment of competent persons, lack of evidence of a legal register, key performance indicators or a top management review.

Following this, the SCA's Theresa Doyle, Enterprise Risk Manager, offered some tips to the attendees on being prepared for an inspection from the auditee's point of view and also outlined how the SCA's Enterprise Risk Management Section is available to provide advice should the attendees require it. Following on with our State indemnity guidance series, the latest instalment on "Business and personal use of State vehicles" outlines the State's position in relation to indemnity provisions for this issue.

Topics covered at recent Network Events

1. **Expectations of a Safety Management System**
2. **HSA's approach to safety management in the public sector**
3. **Findings of Health & Safety Authority inspections**
4. **Tips on how to prepare for an inspection**
5. **State Indemnity & Driving for Work – Motor Guidance**

The feedback received indicated that the attendees found both seminars to be a valuable and worthwhile proposition and it is hoped that we will see many of you at the next Network meeting in Q2 2016. If you are interested in finding out more about the Network, please email the ERMS at **stateclaims@ntma.ie**

Our July Network meeting took place in the beautiful environs of the OPW's National Botanic Gardens of Ireland. For further information please visit their website: **http://www.botanicgardens.ie/**

The ERMS second Network event of 2015, took place in the National Gallery of Ireland in November. The National Gallery of Ireland is located in the heart of Dublin, and holds the national collection of European and Irish fine art. For more information on the National Gallery of Ireland please visit **http://www.nationalgallery.ie/**

The SCA's State Indemnity & Driving for Work - Motor Guidance is available for download from **http://stateclaims.ie/resources/**

European Communities (Sustainable Use of Pesticides) Regulations

As you may be aware, the European Communities (Sustainable Use of Pesticides) Regulations came into effect in 2012. **The Regulations were introduced to reduce the risks and impacts of pesticide use on human health and the environment.**

Under these Regulations, from the 26th of November 2015, only registered professional users can apply pesticides (herbicides, fungicides, insecticides, seed dressings, certain rodenticides etc.) which are supplied for professional use. **The Regulations affect any person (e.g. Caretakers, Maintenance Staff, Farmers, Landscapers etc.) who applies professional products, regardless of the quantity of product used or the method of application employed.** It is therefore important that your Delegated State Authority (DSA) ensures that any individual who is deemed a professional user is trained and registered with the Department of Agriculture, Food and the Marine (DAFM).

Further Information

For further information on the requirements of the Regulations, please refer to our risk advisory notice which is available on the SCA website.

CISM "Work Positive" Project Update

The "CISM Work Positive" Framework, the multistage risk assessment which measures workplace stressors, is now in the middle of the pilot stage with participating Delegated State Authorities (see State Claims Agency Newsletter, January 2015 for background information on the project).

The SCA CISM Team and the Project Co-ordinator are actively engaging with the pilot participants in respect of each stage of the risk assessment framework. **"CISM Work Positive", has been received very positively to date with organisations recognising the need for a psychosocial policy framework and risk assessment tool for 'at risk' occupational groups.**

The validation exercise, which will be completed by Ulster University, is expected to be finalised in Q2 2016.

> **"'CISM Work Positive', has been received very positively to date with organisations recognising the need for a psychosocial policy framework and risk assessment tool.**

Further Information

For project queries please email cism@ntma.ie

In photo from left to right: David Dunning (Senior Legal Costs Accountant, SCA), Anna Giles (Trainee Legal Costs Accountant, SCA), Ciarán Breen (Director, SCA), Evelyn Higgins (Adminstrator, SCA), David Mack (Head of Legal Costs). Absent from photo: Marie Hutton (Senior Costs Solicitor, SCA).

Inside the State Claims Agency: The Legal Costs Unit

Article by: David Mack
Head of Legal Costs, State Claims Agency

Established in February 2013 and with a current headcount of five staff, the Legal Costs Unit continues to manage third party costs claims arising from the Mahon, Moriarty and Smithwick Tribunals of Inquiry. These costs form the main heading of expenditure for each of the tribunals. They are awarded by the Tribunal and agreed or adjudicated upon in retrospect. Approximately 450 third party costs orders have been made in total and half of these claims have now been resolved and discharged with substantial savings effected in the order of 50%. The NTMA Amendment Act 2014 provided a legislative framework expanding the Unit's remit to manage third party costs claims against State entities generally and delegation orders have been completed by a wide and diverse section of Governmental Authorities and Agencies, with 74 falling under the remit of the Legal Costs Unit. To view the Act, please visit stateclaims.ie/about-us/legislation/

Assessment of Solicitor's Professional Fees - An Update

Article by: David Mack
Head of Legal Costs, State Claims Agency

The President of the High Court delivered a reserved judgment in the case of Isabelle Sheehan, A Minor –v- David Corr on the 27th February 2015 following a three day High Court Hearing challenging the Taxing Masters decision to reduce the plaintiff solicitor's general instructions fee from €485,000.00 to €276,000.00. **This was a claim for damages arising out of alleged negligence in the management of the ante natal care of the plaintiff's mother.** The plaintiff developed Cerebral Palsy and the case ran for five days in the High Court before being settled on an interim basis pending the enactment of legislation governing periodic payment orders. The State Claims Agency represented the paying party.

The following core principles going to the assessment of solicitors professional fees may be extrapolated from a comprehensive judgment of the President of the High Court who expressly approved earlier case law in this area:

- Section 27 of the Court and Court Officers Act 1995 imposed a duty on the Taxing Master of the High Court to examine the nature and extent of the work done
- Objectively examine each of the separate items in the bill of costs comprising the general instructions fee
- Ascertain precisely what work was done by the Solicitors for the costs
- Whether it involved exercise of some special skill on the part of the doer, what that skill was and why it was necessary
- Indicate what amount of time he considered should have been devoted to the work involved
- Whether the doer of the work bore any special responsibility, identifying what he considered that to be and how it arose
- The extent to which the work was proper and necessary for the attainment of justice as to be allowable as between party and party
- The fact that a condition is rare and unusual does not necessarily render the case more complex in terms of work or preparation
- The "no foal no fee" retainer under which the case was taken did not alter or increase the nature and extent of the work done and in any event the paying party should not be required to subsidise the plaintiff's solicitors business model or indemnify them against risks entered into on a voluntary basis.

The Judgment, which is now under appeal to the Court of Appeal, is a very useful guide to the assessment of solicitors professional fees emphasising the need to keep proper and accurate records and also clarifying the Taxing Masters' duties and obligations on a taxation of costs.

REDUCTION IN PLAINTIFF SOLICITOR'S FEES BY 209,000 EURO

SCA Newsletter is 10 years in circulation

2006


Clinical Indemnity Scheme
Newsletter

This is us - the CIS Team at the State Claims Agency!

Contents this issue

Newsletter launched by the Clinical Indemnity Scheme (CIS) Risk Team

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27 Editions of the Newsletter in 10 years

2011

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Newsletter extended to full SCA publication CIS & GIS (General Indemnity Scheme)

2014

2015

2016

CEO of the NTMA, Conor O'Kelly and Director of the SCA Ciarán Breen launch SCA eZine

2016: Over 2,000 recipients of the eZine across the 129 Delegated State Authorities and other relevant stakeholders

News & Events

The NTMA Choir

Anne Doherty, SCA Office Manager and Aideen Murphy, from NTMA HR volunteering at the 'Singing for Simon' carol service.

The NTMA choir 'Singing for Simon'. Organised by Mairéad Hughes, NTMA, singers include Irene O'Byrne Maguire, Mary Godfrey, Orla Cassin, Tony Diviney, Nicola McGuinness, Lesley Deane, Neasa Seoighe, Margaret O'Meara, Bernadette Maher, Cliona Kenny and Barbara Brennan from the State Claims Agency.

Thanks to generous donations, in excess of €1,700 was raised for the Simon Community.

In photo from left to right: David O' Donovan (Enterprise Risk Officer, SCA), Antoinette NicGearailt, (President, ACCS), Pat Kirwan (Deputy Director, SCA), Eileen Salmon (General Secretary, ACCS), Simon Watchorn (Head of General Indemnity Claims, SCA), Gemma D'Arcy (Senior Enterprise Risk Manager, SCA), Paul Burke (Enterprise Risk Manager, SCA).

School Seminars

In January 2016, the Enterprise Risk Management Section in conjunction with the Association of Community and Comprehensive Schools hosted a series of risk management seminars for Community and Comprehensive Schools. The seminars took place in Dublin, Limerick and Sligo and were well attended by School Principals, Deputy Principals and Safety Representatives. The seminars were designed to re-engage with Community and Comprehensive Schools on risk and claims management matters, demonstrating effective risk management strategies, shared learning in accordance with statutory requirements and best practice standards. A new Work Placement Guidance Document was also launched which will better assist schools with the management of student work placements. The seminars provided a great opportunity to meet with school staff and the interaction and participation from the attendees contributed to the success of the seminars.

Professor Colm Bergin, Dean of Post Graduate Training at the Royal College of Physicians, Ireland (RCPI) who attended the clinical risk course at the RCPI with Dr Dubhfeasa Slattery, Head of Clinical Risk, State Claims Agency.

New clinical risk course in Medical Education: Postgraduate and Undergraduate

The clinical risk team wrote and delivered a clinical risk, postgraduate course for doctors at the Royal College of Physicians of Ireland (RCPI), September 10th 2015, which will be delivered again in the first quarter of 2016. This course reviewed national data on clinical incidents, claims and costs over a 5 year period and employed specific closed medico legal claims to highlight important teaching points and tools for doctors to avoid incidents, injury and litigation.

In parallel, the clinical risk team wrote and delivered an undergraduate clinical risk course for 4th year medical students at the University of Dublin, Trinity College (30th November 2015). This outlined the national data on analysis of 10 years of closed claims in specific high risk areas of medicine, the journey from incident reporting to settlement of claim or court appearance, the lessons learned from national incidents and claims in addition to international literature review of recommended tools to prevent clinical incidents and promote patient safety. A clinical risk course will be run again in 2016 at TCD.

Bursary Award

Presentation of the bursary prize, funded by the State Claims Agency (SCA) to the student scoring the highest in the Professional Dissertation Module, Ms Gillian Nuttall at the graduation ceremony of the Graduate Diploma in Health Care (Risk Management and Quality), UCD, 2015. Ms Nuttall's project was entitled: "Medication Review - a Multidisciplinary Approach in a Nursing Home".

Meet the SCA Director Ciarán Breen

Q: How did you get to your present role as Director?

Well, I joined the State Claims Agency in 2001 and I was the first claims professional to join the Agency at that time. Prior to that, I had been Managing Director of a nationwide firm of liability adjustors with a staff of about 100, and that company carried out functions quite similar to the Agency's, indemnity/insurance functions concerning claims and litigation.

As I said, I joined the Agency in 2001 when I was appointed Head of Claims. A year later, I was appointed Deputy Director and in early 2007, I was appointed Director.

Q: Describe your typical day?

Typical day is out of bed at roughly 5.15 a.m. I read every morning for at least three quarters of an hour before anything else and then I do the usual things, like getting breakfast and showering before heading for work and I am normally behind my desk at about 7.00 a.m. I can have many different work commitments during the day such as attending internal meetings, external meetings, Court and so on and I normally finish up at around 7.00p.m, drive home and then begin the process all over again. Some days it's a bit later when I leave the office but that is generally the average working day.

Q: What is it about your job that gets you out of bed in the morning?

A number of things. Public service is very important to me and the role of Director of the Agency is a very important role because you get to do a huge variety of things. Some involve policy issues where you are advising Government Departments concerning legislation and other matters. It is one of the most interesting jobs in the country in my view. There is no other job in the claims and litigation world quite like being Director of the State Claims Agency. I love coming to work most days but there are some frustrating days as well, as you can imagine.

Q: What is the best advice you have ever been given?

The best advice I was ever given was that your intelligence will carry you a certain way along the road of life and career but hard work will guarantee you success. So, if you work really hard it will take you that extra distance that you need to go if you are ambitious and if you want to achieve the best that you possibly can. That advice was given to me by my late father.

Q: Who or what inspires you?

The position of Director of the State Claims Agency really inspires me. I am not sure that there is any particular person in the world that I would say is an inspirational person for me. I think there are very many inspirational people in the world. What I really like is the job and the people I work with. I work with a terrific group of people, who are all dedicated professionals, who provide excellent public services to our State Authorities and Health Enterprises. Working with those colleagues and being supported by those colleagues is a terrific everyday experience and sometimes I get praise for what the SCA does well but actually that praise properly is attributable to the SCA team because it is the team that accomplishes much more than I do. Ultimately, the Agency is the sum of its parts.

Q: What are your passions outside of work?

Outside of work my big passion is sport; particularly Gaelic football and rugby. I am mad about both and that includes hurling, going to Croke Park and to the Aviva and, of course, supporting my home county, Leitrim. I am constantly of the view that Leitrim will win an All-Ireland quite soon! My other big passion is poetry and attending poetry readings and listening to poets read their work.

Q: Who is your favourite poet?

My favourite poet is Derek Mahon, a Northern Irish poet.

Q: What is your favourite poem?

My favourite poem is probably a poem by Seamus Heaney called the Conway Stewart and it's a poem about a fountain pen and his leaving his community and going elsewhere. The poem is filled with tremendous symbolism.

Q: If you could tell your 20-year old self something, what would it be?

That's a really difficult question. I think I would probably advise that 20-year old to try and get a greater work/life balance. Hard work is a powerful thing but sometimes work can become something other than it might be in terms of that work/life balance. So that is what I would tell myself, probably work a little less hard and play a little bit more!

Noticeboard

SCA Guidance on Contractors & Insurance levels

The SCA have recently published a State Indemnity Guidance document on determining insurance requirements for goods and service RFTs and contracts. This provides risk management advice on engaging contractors including insurance requirements when entering into contracts. Register your interest in receiving a copy of this document and attending an information session on this by emailing stateclaims@ntma.ie

1916 Rising

The Easter Rising commemoration is upon us comprising thousands of events in Ireland and overseas being held throughout the year. The Ireland 2016 programme is the outcome of a lengthy period of consultation and spans the entire year with a particular focus on the events of Easter Week with local events celebrated in many towns and cities throughout the country.

The SCA's Delegated State Authorities, the Department of the Taoiseach and the Office of Public Works, are the main event organisers on behalf of the State. The SCA's Enterprise Risk Management Section have been providing risk, indemnity and insurance advice for these events. For more information on the events, please go to http://www.ireland.ie

New eZine

Want to receive an electronic copy of our new 'eZine'? Subscribe on our website today!

stateclaims.ie/ezine

Comments & Queries

Can be forwarded to stateclaims@ntma.ie

We're Social

The NTMA is now on social media! Follow the NTMA on Twitter @NTMA_IE and LinkedIn National Treasury Management Agency

Reminder!

Ensure all contractors dealing with your CCTV maintenance, installation etc. are licensed with the Private Security Authority. If contractors are not registered, it could lead to CCTV evidence being challenged in litigation. For more information visit: http://www.psa.gov.ie

Date for the Diary!

September 12th 2016 – Clinical Risk, Quality and Patient Safety Conference, Dublin Castle

Gníomhaireacht Bainistíochta an Chisteáin Náisiúnta
National Treasury Management Agency

An Ghníomhaireacht Stáit um Éilimh
State Claims Agency

State Claims Agency, Treasury Building,
Grand Canal Street, Dublin 2

For the latest news and guidance visit *stateclaims.ie*