Children's Hospital Group Office
Herberton
St James's Walk
Dublin 8

THE HIGH COURT

FOUR COURTS

Dublin 7

7 Aug 2018

**Re: Expert Group - law of torts and current systems for management of clinical negligence claims**

Dear Honourable Justice Meenan

I write to you in response to your request for submissions in relation to the Expert Group examining the Law of Torts, and the management of clinical negligence claims. I am the Chief Executive of the Children's Hospital Group, which encompasses the three existing children's hospitals at Crumlin, Temple Street and Tallaght, and which will merge into a single new legal entity in Jan 2019 before the physical move to the new children's hospital in 2022, which will serve as the centre of a national children's healthcare network. These three hospitals currently provide and will continue up to 2022 to provide a great deal of the secondary and tertiary specialist care to new-borns and children who suffer serious harm, whether avoidable or unavoidable. Hence, we have a unique perspective on the burden of such events on the children themselves, their families, caregivers, staff and the wider healthcare system.

We believe any proposed changes to legislation and the accompanying clinical and administrative system should align around a number of fundamental principles.

1. Firstly, any changes should ensure that the system is as child and family focussed as possible. The process should ensure that there is as little stress as possible to the families involved. In cases where there is no disagreement regarding liability, there needs to be a mechanism whereby fault is acknowledged and apologies offered, with an assurance that any relevant lessons will be disseminated and implemented across the system. Whether this is a "no-fault" system is beyond our expertise to comment.
2. How can we best determine the total medical, social and other requirements for children and families, whilst accepting the reality that future technological developments ensure it is impossible to estimate the total costs in advance? It is likely that an expert group comprising clinical and financial expertise may be required to evaluate ongoing and future needs and make recommendations.
3. Whilst it is important to identify and ring fence the total costs of care, there remains a risk that even if money is not an issue, the systems they access may remain un-coordinated; inability or delays to access services further frustrate families and add to stress. Any recommended changes should ensure that pathways focusing on the most common needs of these children are developed, implemented and monitored.
4. What systems and supports are needed for staff to ensure optimal mandatory open disclosure is used consistently and reliably? It is likely that this will require training aimed

specifically at consultants which most likely should be led by the respective post-graduate training bodies.

5. Whilst it is critical to ensure any recommendations ensure fairness to affected patients, the ultimate goal for all of us should be to continually improve safety. How can changes in law drive improvements in safety and ensure lessons are spread. A common observation on all health systems is that the rate of error (10%) and avoidable error (5%) are broadly similar suggesting there are common system causes the world over.[1] Data from Ireland is broadly similar.[2] How many health systems take a pro-active approach to learning from the best performers nationally and internationally to reduce the rate of adverse events? Therefore, any recommendations should also address the need to take different evidence based approaches to enhancing safety.
6. Can hospital performance around safety be linked to insurance payments so that hospitals that are objectively safer or that are taking a pro-active approach to safety pay lower premia, accepting that currently hospitals do not pay premia for liability insurance?
7. It should be recognised that our systems for investigating adverse events and learning from them internationally are less than perfect. As a recent expert review stated, "Root Cause Analysis (RCA) is a promising approach with considerable face validity as a way of producing learning from things that have gone wrong. But it has consistently failed to deliver benefits on the scale or quality needed."[3] Consideration should be given to a recent approach taken the UK government whereby an expert multi-disciplinary group is charged with investigating a small number of serious incidents nationally "purpose is to improve safety through effective and independent investigations that don't apportion blame or liability."[4]

Thank you for the opportunity to make a submission and I wish you well in your endeavours. If you need further information or engagement, I'm contactable on ceo@nchg.ie if required.

Yours sincerely

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Ms Eilísh Hardiman
Group Chief Executive
Children's Hospital Group

[1] Rafter, Natshsha, et al. "Adverse events in healthcare: learning from mistakes." *QJM: An International Journal of Medicine* 108.4 (2014): 273-277.

[2] Rafter, Natasha, et al. "The Irish National Adverse Events Study (INAES): the frequency and nature of adverse events in Irish hospitals—a retrospective record review study." *BMJ Qual Saf* 26.2 (2017): 111-119.

[3] Peerally MF, Carr S, Waring J, et al. The problem with root cause analysis. BMJ Qual Saf 2017;26:417-422

[4] https://www.hsib.org.uk/