Meeting of the Expert Group on Clinical Negligence Claims
Thursday, 11 July 2019

Presentation by
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On 26 June 2018, the Minister for Health and the Minister for Justice and Equality, in association with the Minister for Finance, announced the establishment of this Expert Group, chaired by Mr Justice Charles Meenan, to consider "an alternative mechanism to the court process for resolving clinical negligence claims". These Terms of Reference define the scope and role of the Group and state at para (d) *examine the role of the State Claims Agency in managing clinical negligence claims on behalf of the HSE to determine whether improvements can be made to the current claims management process.*

This summary outlines the current role of the State Claims Agency ("the Agency").

By way of introduction, the National Treasury Management Agency ("NTMA") is a State body which operates with a commercial remit to provide asset and liability management services to Government. The NTMA is designated as the State Claims Agency when performing the claims and risk management functions delegated to it under the National Treasury Management Agency (Amendment) Act 2000.

The Agency manages personal injury, property damage and clinical negligence claims brought against certain State authorities, including Government ministers, the Attorney General, healthcare enterprises, the Commissioner of An Garda Síochána, prison governors, and community and comprehensive schools amongst others. There are currently in the region of 146 delegated State authorities within the Agency's remit.

Those State authorities whose claims are delegated for management by the Agency do not have conventional insurance cover. Instead, these authorities operate under State indemnity, a self-insurance model whereby the State bears the financial risk associated with the costs of claims on what is referred to as a "pay as you go" basis.

The Clinical Indemnity Scheme ("CIS") was established in 2002 to rationalise pre-existing medical indemnity arrangements by transferring to the State, via the Health Service Executive ("HSE"), hospitals and other healthcare agencies, responsibility for managing clinical negligence claims and associated risks. Under the CIS, the State assumes full responsibility for the indemnification and management of all clinical negligence claims arising in the State's public hospitals, including those which are birth-related. Claims made under the scheme are managed by the team of clinical claims managers within the Agency.
The CIS is the principal scheme under which the Agency manages clinical negligence claims taken against healthcare enterprises, hospitals and clinical, nursing and allied healthcare practitioners covered by the scheme.

For example, the State authorities whose claims are managed by the Agency that are relevant to the work of the Group include:

- All HSE facilities, public hospitals and other agencies providing clinical services;

- Non-consultant hospital doctors, nurses and other clinical staff employed by health agencies whether permanent, locum or temporary;

- Consultant hospital doctors are covered with effect from 1 February 2004 in respect of alleged clinical negligence incidents on or after that date;

- Clinical support staff in pathology and radiology services;

- Public health doctors, nurses and other community-based clinical staff in respect of clinical activities;

- Dentists providing public practice;

- Certain other ancillary healthcare providers. Participating enterprises are specified in Schedule 1, Part 1 of the National Treasury Management Agency (Delegation of Functions) Orders 2003 and 2007 (SI Nos. 63 of 2003 and 628 of 2007);

- The former Mount Carmel Hospital, Dublin with respect to midwifery/obstetrics practices during certain periods.

- Consultant hospital doctors in whole time private practice, or those who have offsite private practice, are covered by the CIS where, depending on the speciality concerned, the relevant limit of indemnity purchased independently from a medical defence organisation is exceeded.

Under and in accordance with the National Treasury Management Agency (Amendment) Act, 2000, the Agency's principal objectives are:

- to ensure that the State's liabilities in relation to personal injury and property damage claims, and the expenses of the Agency in relation to their management, are contained at "the lowest achievable level"; and,

- to implement targeted personal injury and property damage risk work programmes to mitigate litigation risk, in State authorities and healthcare.

The Agency's approach to managing complex clinical negligence claims is guided by a straightforward principle – where it is just and proper, people who have suffered a personal injury as a result of a clinical negligence event must be compensated appropriately and as quickly as the circumstances of their cases permit.

Clinical negligence litigation is complex. The Agency deals with plaintiffs and their families who, in many instances, have suffered enormous trauma and pain and it wishes to act fairly, ethically and with compassion in all its dealings.

The Agency must ensure that no one is under-compensated but, in accordance with its statutory mandate, it must also ensure that no one is over-compensated. It is all too common for persons familiar with, involved in, or reporting individual cases to make public remarks critical of the management of claims by the Agency, suggesting there has been unacceptable delay in conceding liability or agreeing quantum. This kind of criticism is routinely not deserved. Although personally frustrating for the persons involved in the defence of those claims, it is rarely appropriate for the Agency to respond to such criticism and it is mostly prohibited from doing so. It is therefore rare for the full unvarnished facts to be disclosed in these matters.

For example, in a recent high profile and sensitive case, the Agency has been criticised in the media and other forums for its management of the case and, in particular, for imposing obstacles to settlement. Nothing could have been further from the truth. All of the criticism ignored the fact that the presiding judge, Mr Justice Kevin Cross, praised the manner in which the case had been managed by the Agency. While some cases can take up to between two to three years to be concluded, that particular case was settled within ten weeks of the summons being lodged. Mr Justice Cross said the case was handled in an efficient and humane manner, with all sides pulling out the stops to get the matter ready for hearing quickly.

Nonetheless, people express concern that, in some cases, parents of children who have been catastrophically injured as a result of clinical negligence have had to undergo the additional trauma of giving evidence in Court and being cross-examined on their evidence. So why does it happen?

Sometimes, it happens because the case is so complex that breach of duty or causation have been difficult to determine or are in dispute. But it mostly happens in cases where the settlement demands made by plaintiffs' lawyers are significantly overstated.

The Agency has direct experience of cases where solicitors acting on behalf of plaintiffs have originally demanded a multiple of two or even three times the figure that they were eventually prepared to settle for. One striking example is a case where a plaintiff's lawyer firm initially sought €26,000,000.00 in compensation. The firm refused to settle for a lesser figure before the case went to Court but then settled for a sum of €12,000,000.00 following a number of days of High Court hearing. Had the Agency settled at the figure originally claimed, it simply would not have been doing its job on behalf of the taxpayer.

As part of its remit, the Agency has certain obligations that it must fulfil. Among these is an obligation to practitioners in public hospitals to defend their professional reputations and vindicate the exercise of those practitioners' duty of care to patients.

Given that many clinical negligence cases involve multi-million settlements, the Agency also has an obligation to the tax payer to verify the scientific and expert medical evidence put forward by plaintiffs in proof of the cases. An additional obligation is to verify the actuarial figures constituting the measurement of special damages in any individual case. Catastrophic injury cases arising in a clinical setting invariably involve complex issues of breach of duty and causation. Multiple independent experts are engaged by both sides

to explore the issues of breach of duty, causation, condition and prognosis and the calculation of special damages. This inevitably takes time and is understandably frustrating for plaintiffs and their families.

The Agency is acutely conscious of the ordeal that individuals and their families have suffered and it takes every step it can to ensure the litigation is handled sensitively and that, wherever possible, such litigation does not add to the considerable distress already suffered by the affected individuals and their families.

However, the Agency cannot ignore the fact that it has a statutory mandate that it must carry out. If it does not investigate claims and manage litigation conscientiously and professionally, that would constitute a failure on its part to do what it has been tasked to do by the Oireachtas.

There are occasions where, faced with any individual plaintiff's lawyer firm presenting a case with settlement demands that are excessively high, the only way the SCA can discharge its duty to the taxpayer is to very reluctantly proceed with allowing that case to go to a formal Court hearing. This can result in the Agency facing criticism for the way it manages these cases but it is criticism that the Agency believes is unwarranted.

The Agency recognises that the current system would benefit from reform and that is why it has taken a number of important steps in an effort to shorten the time required to settle cases for plaintiffs and their families.

The Agency recognises the need to mitigate the more adversarial aspects of the Tort system as it applies to clinical negligence cases. These cases, by their very nature, frequently involve considerable trauma to the injured party and their family, trauma which is worsened by the uncomfortable journey afforded by the Tort system before the plaintiff receives compensation. Mediation affords the parties in clinical negligence cases a calmer, less adversarial environment within which to resolve such cases.

Despite this, the number of mediations in clinical negligence cases remains lower than hoped. Some plaintiffs' lawyers – and, it must be stressed, a minority of them – remain implacably opposed to mediation in these cases. It is difficult to understand why this is so. The Agency genuinely feels that mediation is in the best interests of plaintiffs and yet some plaintiffs' lawyers disagree.

The policy of the Agency is to admit liability as soon as the expert medical evidence becomes available to indicate there has been a breach of duty. The Agency takes every step it can to ensure that litigation is handled sensitively to ensure no additional distress is caused to the person who has made the claim or to his or her family. The Agency is required, of course, to operate in accordance with its statutory mandate to investigate claims thoroughly and to manage litigation in a professional manner. It is not always an easy task to get this balance right when carrying out this statutory role, knowing the often devastating personal consequences for persons who have suffered injury.

The Agency has been to the forefront of attempted reforms in clinical negligence litigation. It was represented on the Medical Negligence Working Group which recommended the introduction of Pre-Action Protocols. The Legal Services Regulation Act, 2016 provides for the making of regulations to introduce the Pre-Action Protocols. The Agency has no doubt that when the Protocols are introduced, they will lead to much-needed improvement and reform of clinical negligence litigation by reducing the current unacceptable delays. The effect of the Protocols is to ensure that the parties meaningfully engage each other without the necessity to issue and serve legal proceedings thereby reducing the lifecycle, significantly, of any individual claim. This should lead to a much less adversarial system with significantly reduced timelines to resolve clinical negligence cases. In advance of the introduction of the Pre-Action Protocols, the Agency has partnered with the Medical Protection Society to roll out a pilot Pre-Action Protocol with certain lawyer firms who represent plaintiffs in clinical negligence actions.

The Agency believes that the implementation of the Pre-Action Protocol will transform the way clinical negligence cases are managed. The idea is that the parties can quickly narrow the issues to those that are really disputed and, if necessary, mediate them. It provides a meaningful opportunity for resolution without recourse to the Court process.

Of course, the Agency must take care when recommending alternatives to the Court process, as the merest suggestion of alternative dispute resolution ("ADR") is sometimes criticised by plaintiff solicitors as an attempt to deprive their client of the Constitutional right of access to the Courts.

The most notable exception to this has been where the Agency suggests ADR in relation to claims for costs, where plaintiff solicitors have been pleased to avoid delays in the taxation of costs by the Office of the Taxing Master.

For some plaintiffs, the prospect of a confidential process for resolution of their clinical negligence claim is offensive. They would much prefer to highlight the wrong done, whether to advocate for change or otherwise.

Notwithstanding this context, the Agency does regularly employ creative options for resolving clinical claims.

The Agency resolves the majority of claims by negotiating a settlement, either directly with plaintiffs' legal advisors or through a process of mediation: 98% of clinical negligence cases handled by the Agency are resolved without the necessity for a contested court hearing.

The Agency is a vocal advocate for mediation. The Agency has offered this method for resolving clinical negligence litigation for almost ten years. For some, mediation is a particularly suitable method for resolving clinical negligence claims in that it allows for the patient and clinician to be heard and can assist not just with compensating the plaintiff for their injuries but can also serve to repair frayed relationships which is often necessary in the context of ongoing treatment.

The State Claims Agency has used mediation primarily in birth injury litigation, alleged missed or delayed cancer diagnosis and fatal injuries.

The Pre-Action Protocol will require each party to set out their position at an earlier stage and will lend itself to early and fruitful mediation.

However, the Agency's experience of mediation is not without its difficulties. Plaintiff teams are often not well prepared. Often, the Agency is given a large schedule of special damages on the eve of, or certainly very proximate in time to, the mediation which can then frustrate any meaningful prospect of useful mediation. Also, there is sometimes unwillingness for the mediator and the plaintiff to communicate directly. Some solicitors will not allow the mediator to speak directly with their client and as a result the mediator cannot be sure what information is being given to the plaintiff.

It would be useful if, in cases which fail to settle at mediation, the mediator was to prepare a report detailing whether or not both parties were sufficiently prepared in advance of the mediation and whether or not both parties fully engaged in the process. Costs implications for failure to meaningfully engage would assist, for example, if the party who failed to fully engage was responsible for the mediator's fee. Alternatively, the mediator's report could be furnished to the trial judge at the end of hearing when the judge is addressing the issue of costs after a contested hearing.

The Agency regularly expedites cases for plaintiffs with terminal diagnosis.

This occurs most frequently in the context of alleged missed diagnosis of cancer cases. In a recent case, the plaintiff notified the claim to the Agency in mid-February 2018. A Defence was delivered by mid-March 2018 and the case was settled in April 2018.

In cases where there is no dispute as to liability from the outset, the Agency moves to settle these claims early and often, in the case of the more experienced claims managers, directly with the plaintiff's solicitors, thereby keeping costs to a minimum.

The Agency, entirely on its own initiative, also pioneered the introduction of interim payments to compensate catastrophically injured victims in order to alleviate their families' worries relating to the guaranteed payment of their future care and other requirements throughout their lifetime. Since 2010, the SCA put in place Periodic Payment Orders in 83 cases, involving catastrophic injury, for plaintiffs and their families. Unfortunately, approximately 19 plaintiffs, subsequently, did not renew their Periodic Payment Orders, opting instead for lump-sum payments in frustration at the delay in the introduction of the Legislation to underpin a Periodic Payment Order regime. However the Agency continues to offer families settlement of their cases in the form of Periodic Payment Orders now under the provisions of the Civil Liability (Amendment) Act 2017. This is not without its own difficulties as there is concern among plaintiff representatives around the indexation of payments as provided for in the Act.

For certain injuries, there remains the option for Government to set up a redress scheme. Two notable examples with relevance for clinical negligence are the Lourdes Hospital Redress Scheme and the Surgical Symphisiotomy Scheme.

The Lourdes Hospital Redress Scheme was established in 2007 to compensate former patients of Dr Neary who underwent unnecessary gynaelogical procedures in Our Lady of Lourdes Hospital, Drogheda. It had 155 applicants, 119 of whom were successful, with total awards paid out at just over €18 million.

The Surgical Symphisiotomy Scheme was established in 2014 to compensate patients who had undergone surgical Symphisiotomy in the years from 1940-1970. The operation, for the majority of women, created lifelong pain and suffering. There were 600 applicants to the scheme, of whom 399 were successful, with total awards paid out at €29.8 million.
The Agency notes that both schemes addressed a limited and defined class of persons that was not capable of expanding further and addressed a specific class of injury for which a quantum of damages could be calculated by reference to common features and without substantial differences in special damages.

It is worth recalling that the Agency resolves the majority of claims by negotiating a settlement, either directly with plaintiffs legal advisors or through a process of mediation: 98% of clinical negligence cases handled by the Agency are resolved without the necessity for a contested court hearing.

At December 2018, the Agency managed 10,658 total active claims with estimated outstanding liability of €3.15 billion (clinical and non-clinical). Of these, 3,196 were active clinical claims, with an estimated liability of €2.33 billion (clinical only).

The total estimated outstanding liability takes account of the Court of Appeal decision in *Russell (a minor) v. Health Service Executive*. The Court of Appeal concluded that the so-called Real Rate of Return ("RRR") in respect of the calculation of future care-related special damages should be 1%. It also held that the RRR in respect of all pecuniary losses should be 1.5%. Prior to this judgment, the RRR used to calculate estimated outstanding liability was 3%. The change has significantly increased the cost of claims.

Arising from the Court of Appeal decision, the Agency has paid "catch up" payments totalling €33 million. These payments were made in respect of catastrophic injury cases, not fully resolved, where settlement had originally been agreed on a lump sum basis or by way of interim payment order for a defined period of time at the prevailing 3% RRR prior to the Court of Appeal decision. These cases, therefore, required to be adjusted for the effect of the lower rate by the payment of additional compensation.

At December 2018, maternity services claims comprised 74% of the total estimated outstanding clinical claims liability. This high estimated liability associated with maternity series claims principally relates to the high cost of settling catastrophic brain injury cases.

The Agency welcomes scrutiny of the way it conducts clinical negligence litigation. Such scrutiny is an essential aspect of reassuring both taxpayers and people who make clinical negligence claims that the Agency does its job properly, ethically and fairly. The Agency is

the subject of regular audits by various independent State and non-State bodies. On an annual basis, the Agency is audited by a large accountancy firm, who conduct a file process audit and, separately, an audit on reserving policy. The Agency is also examined by the Comptroller and Auditor General in relation to the conduct of litigation and the NTMA Compliance and Risk business unit, which reports to the NTMA's Agency Risk Committee. Within the CIS a formal annual peer audit of claim files is conducted. The Agency is proud of feedback from these audits, which routinely compliments the Agency for the work it does and compares the Agency favourably with international best practices. The Agency also appears regularly for detailed scrutiny before the Oireachtas Public Accounts Committee.

In addition, in August 2017, the Board of the NTMA established a Strategy Committee for the Agency comprising two Board members, three outside medical, legal and risk professionals and a representative from the Department of Public Expenditure and Reform.

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