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The Honourable Mr Justice Charles Meenan
The High Court
Four Courts
Dublin 7

10th October 2018

By post and email: cmeenan@courts.ie

Dear Judge Meenan,

Re: Expert Group on Law of Torts and Management of Clinical Negligence Claims

Thank you for your letter dated 7th September addressed to AvMA's CEO, Peter Walsh which has now been passed to me to deal with. I take this opportunity to apologise for the delay in responding to your letter.

By way of introduction I am a solicitor who specialised in claimant clinical negligence claims before working for AvMA, I am AvMA's Medico-Legal Director.

I have pleasure in enclosing a report on the services required by a child following birth injury, particularly cerebral palsy as requested. As I explain in the report given the broad nature of the brief the report is fairly generic, the services provided are ultimately dictated by what the court considers the child needs.

I have also commented in the report on problems encountered by people bringing clinical negligence claims in England by setting out an overview of the protections provided and then looking at typical problems encountered despite those protections.

Please do not hesitate to contact me if you wish to discuss further or if I can be of further assistance.

Yours sincerely

Lisa O'Dwyer
Director Medico-Legal Services

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RESPONSE TO IRISH EXPERT GROUP REVIEWING THE LAW OF TORT AND CURRENT SYSTEMS FOR MANAGING CLINICAL NEGLIGENCE CLAIMS

10th October 2018

1. Brief Introduction to AvMA:

1.1. Action against Medical Accidents (AvMA) was originally established in 1982. It is the UK patient safety charity specialising in advice and support for patients and their families affected by medical accidents. Since its inception AvMA has provided advice and support to over 100,000 people affected by medical accidents.

1.2. AvMA provides specialist support and advice to around 3,000 people each year who believe they have been affected by substandard care and potential failings in patient safety. Our staff and trustees have considerable experience and knowledge of patient safety and medico-legal matters including clinical negligence.

1.3. AvMA works with government departments, health professionals, the NHS, regulatory bodies, lawyers and other patients' organisations to improve patient safety and the way injured patients and their families are treated following failings in their care.

1.4. AvMA also accredits specialist clinical negligence solicitors so that injured patients or their families have access to the best quality legal advice if they need it.

1.5. AvMA offers specialist services to the public, free of charge. AvMA's specialist services are its Helpline, pro bono inquest service and advice and information services.

1.6. AvMA only assists on inquests where the death occurred in a health care setting or against a background of medical services having been provided mental health and primary care issues.

2. The Irish Expert Group's Request for Information from AvMA:

2.1. The Irish Expert Group reviewing the Law of Tort and Current Systems for Managing Clinical Negligence Claims (the Expert Group) is Chaired by the Honourable Mr Justice Charles Meenan

2.2. In a letter dated 7th September 2018 from the Honourable Mr Justice Charles Meenan to AvMA's CEO, Mr Peter Walsh a request was made for AvMA to provide a report on ***"The services required by a child following birth injury, particularly cerebral palsy, throughout their lifetime."***

2.3. The request has been made within the context of term (c) of the Expert Group's Terms of Reference.

2.4. Term (c) reads that the Expert Group are to: ***"examine the role of the HSE in addressing the problems encountered by persons involved in clinical negligence claims and addressing the health needs of persons affected by clinical negligence, with consideration given to***

whether particular care packages could be made available for persons with specific injuries, e.g. cerebral palsy following birth"

3. AvMA's Response:

3.1. AvMA wishes to draw to the Expert Group's attention that our charitable remit does not extend to us running an in house litigation service. However, members of the organisation do have litigation experience from their previous employment.

3.2. AvMA does have direct contact with members of the public through its services who have experienced injury as a consequence of clinical injury including parents of children who have sustained brain injury at birth and in other medical circumstances.

3.3. AvMA will introduce members of the public who want independent legal advice to specialist claimant clinical negligence solicitors who have been accredited by us. If the Expert Group requires additional information on the services required by a child following catastrophic medical injury AvMA would be pleased to arrange a formal introduction to one of our specialist practitioners.

3.4. The Expert Group's instructions are very broad. The services required by a child who has suffered a birth injury as a result of negligent treatment will depend on the extent of the injury sustained and the child's resulting needs.

3.5. For the avoidance of doubt, given the broad nature of the instructions this response is by neccesity generic in nature.

4. Typical Services Required by a child following birth injury:

4.1. **Care:** A care expert would be expected to set out the costs for caring for the disabled child at the time of assessment as well as in the future – this is particularly relevant as the child's needs will change as they grow.

4.2. Relevant factors will include the extent to which, if at all the child is mobile indoors and outside; is incontinent of bowel and/or bladder; personal care needs (feeding, washing, dressing, toileting). Naturally these factors will have a bearing on the number of carers required to mobilise the child/person as well as the time taken to execute the tasks identified and any statutory requirements such as manual handling regulations and so forth.

4.3. The care report will identify any specialist equipment required such as hoists, wheelchairs, transport needs (specially adapted vehicles to carry the wheelchairs etc).

4.4. The care report may also identify the need for a case manager who is responsible for organising carers to come to the home. It is not unusual for there to be a separate report from a case management company

4.5. **Accommodations Needs:** Typically, these would be evidenced by way of a report from an architect and/or chartered building surveyor and would look at how suitable the current accommodation is for the child's present and future needs. This report might be expected to set out the likely costs of adapting the property if that is a feasible option or it may recommend that alternative accommodation be secured and set out the specification and associated costs for the accommodation required.

4.6. Accommodation costs will consider recommendations made by other specialists such as the need for hoists and other equipment to ensure that the accommodation is suited to adaptations necessary to accommodate those recommendations.

4.7. **Speech and Language Therapy (SALT):** As well as current and likely future speech and communication needs a SALT report will also look at a child's eating, drinking and swallowing needs including their saliva control.

4.8. **Physiotherapy and or Occupational Therapy Report**: This will focus on the child's mobility and range of movement as it affects the upper and lower limbs. An independent expert report should involve an examination of the child to form a view on their passive and active range of movements at the time of the examination as well as the likely prognosis for future movement and improvement.

4.9. For individuals who have suffered a serious cerebral palsy such as a dystonic cerebral palsy which affects the entire body, physiotherapy may be indicated to avoid the increased stiffening of the limbs caused by their immobile condition.

4.10. The increased tightening of limbs that some cerebral palsy children experience may require additional medical interventions, for example surgery to loosen tension that may develop in say the hip. A separate report from a surgeon may be required in such cases to set out the cost of the surgery or alternative medical treatment.

4.11. **Psychological:** This service would be expected to consider the child's cognitive skills and covers areas such as social awareness, including nonverbal communication (eye contact etc), visual awareness, auditory comprehension; vocal communication and play skills. They may also consider issues such as any sleep or feeding difficulties being experienced by the child. These reports are helpful indicators for assessing the individual's potential future development and the implications for the child and their family for the future.

4.12. **Technology and Disability assessments**: This service will assess technological devices that are currently available to assist people with severe disabilities interact with their environment in a meaningful way. A report of this type may look at equipment such as powered wheelchairs equipped with special sensors to enable it to follow certain pathways providing the user with a sense of independence. It might also recommend

items such as simple voice output devices and multisensory facilities as well as computer equipment.

5. **Could particular care packages could be made available for persons with specific injuries, e.g. cerebral palsy following birth?**

5.1. This is a complex question and one the Department Health (DH) in England and Wales has recently tried to grapple with in its Rapid Resolution and Redress (RRR) proposal. That proposal was based on injuries that had occurred as a result of breaching the duty of care owed to patients typically by failing to meet the legal standard expected as set out in the cases of Bolam and Bolitho.

5.2. It also proposed introducing a further class of potential claimants, those whose injuries arose as a result of treatment provided failing to meet the "avoidability test".

5.3. Where it can be demonstrated that an experienced, specialist clinician would have provided care that would have prevented the adverse outcome this will the benchmark for the Avoidability test is

5.4. From AvMA's perspective, in principle the short answer is yes, however one size does not fit all and so it is with care packages. AvMA firmly believes that any care package offered must be fit for purpose and provide the individual with the care they need, as distinct from the care the State wants or feels it can afford to provide.

5.5. Families caring for a child with cerebral palsy or other brain injury need access to services such as carers. However, in England and Wales the funding provided by local authorities for care needs is both variable from one local authority to another and without exception insufficient, therefore the care available is inadequate.

5.6. Families who go through the litigation process are often driven to do so because of need; it is not unusual to find families who have spent several years going through litigation who have been without any sort of care assistance throughout that time.

5.7. The DH consulted on its proposed RRR scheme in May 2017 but to date the scheme has not been introduced. The proposals were thin on detail and it was far from clear how the scheme would work in practice. For example, it was It is not clear that the families would have any earlier access to services through the RRR scheme than through litigation. The scheme did state that the infant's eligibility for compensation under the scheme could take time to determine and there was no certainty that care would even be provided.

5.8. The RRR scheme was intended to be voluntary. It offered a personal budget type approach to families seeking to secure care. However, there was no detail of the type of budget envisaged and how it could work in practice.

5.9. AvMA's position is that if a care package can deliver the care required to put the family back in the position they would have been but for the negligent treatment and resulting injury then we would support this. However, it is imperative that the care required by the family should be based on what the family genuinely needs, that need should not be assessed in the context of what the state can provide, and any package of this type must be administered by a body independent of the State.

5.10. One of the key safeguards to the success of a proposal of this nature is that the scheme offered must be voluntary and cannot avoid the injured person and or their family's right to litigate if they believe it is in their best interest to do so.

5.11. It must also be noted that even if the State were to offer an adequate care package this is only one element of the injured person's needs, other issues such as appropriate accommodation and therapies must also be made available. If this is not addressed, then a stand alone care package is highly unlikely to be enough to avoid litigation.

6. Overview of protection for persons involved in clinical negligence claims in England

6.1. According to a recent public accounts committee report: **"Managing the Cost of Clinical Negligence in Hospital Trusts"** dated 29.11.17 https://publications.parliament.uk/pa/cm201719/cmselect/cmpubacc/397/39706.htm less than 4% of people experiencing a harmful incident will make a claim.[1]

6.2. In our experience the public and in particular people who have experienced injury as a result of negligent medical treatment generally want three key things: First to know and understand what went wrong with their care; second to receive an apology and ensure that lessons have been learned and third to know that steps have been taken to address the failings that resulted in their injury so that it does not happen again to anyone else.

6.3. AvMA takes the view that if the existing safeguards were properly enforced there should be little reason for an individual who has been injured because of clinical negligence to resort to litigation. For many claimants litigation is a last resort when other avenues of redress have broken down or proven to be ineffective.

6.4. In order to explain the problems commonly encountered by persons involved in clinical negligence claims it seems sensible to outline the key existing safeguards which enable patients/claimants to access information. The key safeguards are:

6.5. **NHS Constitution**: The NHS constitution sets out a number of promises and pledges about the standards and service patients can expect to

[1] Managing the Cost of Clinical Negligence in Hospital Trusts, Chapter 1 "Rising costs of clinical negligence" paragraph 12.

receive when things go wrong. All NHS bodies are required by law to take account of the constitution. Under the constitution there is a right to have any complaint made about an NHS service properly investigated. There is also a right to compensation where harm has been caused by negligent treatment. The NHS commits to ensure that when mistakes happen and/or where harm has been caused to a patient whilst receiving health care under the NHS, an appropriate explanation will be given and pledges that lessons will be learned to help avoid a similar incident occurring again.

6.6. **The NHS complaint procedure**: This is rooted in the NHS Constitution and in the **Local Authority Social Services and National Health Service Complaints (England) Regulations 2009** (The Regulations). The NHS is obliged to act, if necessary, in the light of the outcome of any complaint. Where a complaint has been made there is a duty to investigate the complaint in an appropriate manner and resolve it speedily and efficiently. Once the NHS has received a complaint they must investigate the matter complained of

6.7. **Parliamentary Health Service Ombudsman (PHSO):** The PHSO is the second tier of the complaints process and is independent of the NHS. The PHSO may consider the nature of complaint and the way it has been handled. The PHSO exists to help resolve complaints against the NHS, government departments and other public organisations. They make judgments on the complaints and help to put things right if they have gone wrong; they describe themselves as leading the way to make the complaints process better. The PHSO often become involved because the NHS has offered a poor explanation of what went wrong with the care complained of or because they have failed to acknowledge that a mistake or mistakes were made.

6.8. **The Duty of Candour:** The duty of candour applies to healthcare providers in both the public and private sectors. The statutory duty of candour came into force for NHS bodies in November 2014 under Regulation 20 of the ***Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.*** It became a requirement for all other organisations in April 2015 under the ***Health and Social Care Act 2008 (Regulated Activities) (Amendment) Regulations 2015.***

6.9. The duty of candour places a duty on health care providers to ensure that matters are fully identified, investigated and information is provided to the patient. The emphasis is on the quality and quantity of information provided to the patient being as good as possible.

6.10. It has been an important step to ensuring that all health and social care organisations registered with the Care Quality Commission (CQC) are open and honest with patients when something has gone wrong with their care.

6.11. The obligation to be open and transparent is triggered as soon as reasonably practicable after the relevant care provider has become aware that a "notifiable safety incident" has occurred. The obligation is to notify the patient or relevant person about the incident and to provide them with reasonable support.

6.12. A "notifiable safety incident" is one where any unintended or unexpected incident has occurred that in the reasonable opinion of a healthcare professional could result in or appears to have resulted in death or moderate or severe harm to the service user. It also covers the situation where the injury constitutes prolonged psychological harm.

6.13. Under the statutory Duty of Candour not only must the patient or service user be notified of the incident and given a true account of the facts according to the information available at the time but written notification must also be given. The written notification must set out the facts and circumstances of the incident, explain what enquiries are being undertaken, and the results of any enquiries undertaken at the time the letter is written.

6.14. An apology should be given to the patient. The patient must be continually updated on any additional information that comes to light, for example, following completion of any outstanding enquiries.

6.15. **Serious Incident Reports (SIR):** Serious incidents are defined by NHS England as ***"Events in health care where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant, that they warrant using additional resources to mount a comprehensive response"***[2]

6.16. A serious incident **MUST** be declared where acts and/or omissions have occurred as part of NHS-funded healthcare (including in the community) that has resulted in: **Unexpected or avoidable death** of one or more people, this includes suicide/self-inflicted death.

6.17. **Unexpected or avoidable injury** to one or more people that has resulted in serious harm that requires further treatment by a healthcare professional to prevent the death of the service user; There are other triggers for calling a serious incident report, but these are the main ones.

6.18. Serious incidents must be reported without delay and in any event no longer than two working days after the incident is identified. NHS trusts should have effective systems and processes in place to report, investigate and respond to serious incidents in line with national policy and best practice.

6.19. The healthcare providers Chief Executive Officer or equivalent is responsible for identifying a senior manager or clinician or other officer with relevant delegated authority to gather and secure evidence, identify witnesses and ensure safety of patients and staff.

6.20. Healthcare providers should tell families or patients that a serious incident report is underway. The Duty of Candour and the NHS principles of being open and honest envisage families or patients being involved in the process.

6.21. Where an investigation is carried out, it should focus on three key questions: What were the problems? How did the incident happen? – this

[2] https://www.england.nhs.uk/wp-content/uploads/2015/04/serious-incidnt-framwrk-upd.pdf

will involve looking at the factors that contributed to the problem/s. The fundamental question is: why did the incident occur?

6.22. **Data Protection Act 1998, Freedom of Information Act 2000, General Data Protection Regulations (EU) 2016/679)**: It may be possible to clarify the facts around an incident by requesting information under the Data Protection Act 1998 (DPA), the Freedom of Information Act 2000 (FOIA) or under General Data Protection Regulations (GDPR) which were introduced in May 2018

6.23. **The Pre-Action Protocol for the Resolution of Clinical Disputes:** The Pre Action Protocol (PAP) is set out in the Civil Procedure Rules[3] The PAP for clinical disputes aims to resolve as many disputes as possible without the need to resort to litigation. It has long emphasised the need to restore trust and a relationship between patient and healthcare providers, reduce delay and ensure costs are proportionate.

6.24. The Protocol is intended to apply to all claims against hospitals, GPs, dentists and other healthcare providers (both NHS and private) which involve an injury that is alleged to be the result of clinical negligence.

6.25. Critically, the PAP notes the importance of each party to a clinical dispute having enough information and understanding of the other's perspective and case to be able to investigate a claim efficiently and, where appropriate, to resolve it.

6.26. The PAP encourages a cards-on-the-table approach when something has gone wrong with a claimant's treatment or the claimant is dissatisfied with that treatment and/or the outcome.

6.27. **Civil Procedure Rules**: When properly applied play an important part in ensuring that cases in England and Wales are dealt with justly. One of the coroner stones of this is ensuring that there is equality of arms between the parties, this includes looking at the financial position of each party as well as the complexity of the issues and equal access to relevant and pertinent information about the medical treatment provided or not provided.

6.28. The parties are expected to co-operate with each other and identify the issues between them at an early stage to promote early resolution where possible.

6.29. One of the ways the court promotes this approach is to enforce the rules around disclosure of relevant information and documentation; Court Orders will be made where necessary for pre action and/or specific disclosure.

6.30. Pre Action disclosure enables the claimant to have a better idea of their treatment, what if anything went wrong with their treatment, the history of the treating medic and other relevant information.

6.31. Full disclosure is a key part of enabling the claimant to properly plead their case.

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[3] http://www.justice.gov.uk/courts/procedure-rules/civil/protocol/prot_rcd#alternative

6.32. The court has the power to strike out the whole or part of a statement of case which discloses no reasonable grounds for bringing or defending a claim, or which is an abuse of the process of the court or otherwise likely to obstruct the just disposal of the proceedings.

6.33. The court may give summary judgment against a claimant or defendant where that party has no real prospect of succeeding on his claim or defence. This power may be exercised on an application by a party or on the court's own initiative.

7. Typically, what problems are encountered by persons involved in clinical negligence claims?

7.1. Despite the above safeguards, Claimants/patients do still experience difficulties with finding out the truth about their treatment, much of this has to do with the way medical care providers manage the existing processes. Sanctions for non compliance with the available processes are either not available or where they are, they are rarely enforced.

7.2. Complaints are often badly handled by health care providers and do not treat the patient with respect, preferring a paternalistic approach. Responses to complaints can be drafted in overly complicated medical terms which does not communicate with the patient. Although this is increasingly being seen as a poor response it does still happen.

7.3. Equally, serious incident reports or similar investigations are often carried out by individuals who are not independent or impartial to the facts under investigation – perhaps they were involved in the allegations or concern raised and their interests are conflicted. When this happens there is naturally concern that the Healthcare provider may have hidden crucial evidence relevant to what actually happened in their treatment.

7.4. This is deeply damaging to the trust between patients and health professionals. The failure to get to the truth is inconsistent with the NHS Constitution and directly contradictory to the Serious Incident Framework currently applied to local investigations. It is also contrary to the ethos and requirements demanded by the statutory duty of candour.

7.5. AvMA takes the view that for clinical negligence work to be properly carried out and the rights and processes available fully utilised that the patient/claimant must be represented by a lawyer who has demonstrable experience and expertise in clinical negligence work.

7.6. To address this, AvMA was the first organisation to set up an accreditation scheme, the AvMA Panel Membership. Individual lawyers are accepted to the panel, not the firm. Lawyers are accepted if they can show they have:

(a) The requisite knowledge of the law relating to clinical negligence.

(b) An appropriate level of medical knowledge

(c) Client care skills to include handling sensitive information on condition and prognosis; managing client expectation; explaining cost implications

(d) The ability to litigate. We look for lawyers who take a robust approach to litigation but who are pragmatic and sensible only settling claims for appropriate awards and not being afraid to take cases to trial if necessary.

(e) Procedures in place at their firm to ensure adequate supervision especially of more junior members of the team.

7.7. Funding can be problematic. Since April 2013, public funding for clinical negligence has been severely curtailed and is generally only available in cases of severe brain injury acquired at birth. The main source of alternative funding is through a Conditional Fee Agreement (CFA).

7.8. Along with the CFA, After the Event (ATE) insurance can be purchased. ATE insurance will cover the cost of expert reports thereby enabling the claimant to seek independent medico-legal opinion from an appropriate medical expert on whether the treatment received fell below an acceptable standard of care (negligence). If there has been a breach in the standard expected the ATE insurance will cover the cost of a medical expert opinion on what injury, if any was consequent upon the breach (causation).

7.9. Where there have been positive reports on liability and causation, further expert opinion on condition and prognosis may be necessary.

7.10. The process of obtaining independent expert evidence is expensive; the provision of ATE insurance is crucial to enabling individuals to access justice.

7.11. Under the Civil Procedure Rules the court must look at whether the claim is proportionate. There are several factors that must be considered when looking at proportionality but at its most basic there is a need to look at whether the cost of bringing proceedings exceeds what might reasonably be recovered by way of damages. The courts have demonstrated that they will take a fairly robust approach to proportionality and this has made lawyers circumspect about the cases they will take on.

7.12. In practical terms, it can be much harder for a low value claim which might be complex on its facts and issues to be brought because of proportionality issues. The problem with this is that it prevents individuals exercising their right to redress.

7.13. One example of a low value claim is the elderly person who is living a full and active life but who has well managed medical conditions. If that individual goes into hospital and dies because of negligent treatment their widow or widower may have difficulties finding legal representation to enable them to exercise their rights.

7.14. Arguably, death is the worst outcome there can be however a claim of this nature might only be worth say £15,000 - £20,000. The fact the deceased had co-morbidities means that causation is likely to be complex and expensive. The cost of bringing the claim may exceed the value of the award of damage and as a result the surviving spouse may find it difficult to obtain representation.

7.15. Defendant conduct can make these cases difficult to handle. Rather than accept reasonable offers of settlement defendant lawyers can tactically lengthen the time taken to resolve the case. A defendant lawyer may choose to be obstructive and unreasonable in their behaviours which in turn becomes expensive. Issuing proceedings can be expensive and may not be justifiable on proportionality, the claim may end up being dropped without resolution.

7.16. There is a need for trusts and healthcare providers to learn lessons from their mistakes. A failure to allow individuals to access their rights of redress is a missed opportunity by the healthcare provider to learn from their mistakes. If mistakes are not identified and not addressed, they will perpetuate themselves causing continued harm to the public they are meant to serve and so the cycle of negligence continues.

7.17. Patients do not want to litigate; they find the process daunting. Patients litigate when they feel they have no other option because the healthcare provider is not behaving in an open and honest way. Litigation is equally stressful for medics and care providers who may have to give evidence and for whom the knowledge of having caused harm can be damaging to them personally and to their careers. Many patients enter into litigation because they feel it is the only way to find out the truth about their own or a loved ones treatment.

7.18. Litigation should only ever be used as a last resort. Where it is referred to it must offer a level playing field for both parties to ensure fairness. In practice it does not always deliver as it should, lack of expertise of both judges and lawyers with conduct contribute to this.

Lisa O'Dwyer
Director Medico-Legal Services
Action against medical Accidents.

10th October 2018