sage advocacy

Submission to the Expert Group to review the law of torts and the current systems for the management of clinical negligence claims

21st August 2018

Area b) consider whether there may be an alternative mechanism to the court process for resolving clinical negligence claims, or particular categories of claims, particularly from the perspective of the person who has made the claim. To do this, the Group will examine whether a mechanism could be established which would deal more sensitively and in a more timely fashion with catastrophic birth injuries, certain vaccine damage claims, or with claims where there is no dispute about liability from the outset. It will also examine whether an alternative dispute resolution mechanism or a no-fault system would be effective in some cases.

Area e) consider the impact of current tort legislation on the overall patient safety culture, including reporting on open disclosure.

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Background: Sage Advocacy

The right to have your voice heard and to participate in making decisions which affect you is a fundamental principle in a democratic society. It is a principle simply stated as "Nothing about you /without you". Many people face challenges to their independence due to physical or mental illness, intellectual, physical or sensory disability, lack of family and community supports or an inability to access public services that meet their needs. Some people communicate differently and with difficulty and some people slowly lose their ability to make and communicate decisions as a condition, such as dementia, develops over time. Some are abused and exploited because of their vulnerability. Others feel disregarded or let down by healthcare services while some are harmed through adverse events or clinical negligence. In circumstances where people may be vulnerable, or have to depend on others, there is a need to ensure that their rights, freedoms and dignity are promoted and protected. Through support and advocacy the will and preference of a person can be heard and acted on; independently of family, service provider or systems interests.

The development of Sage Advocacy has been influenced by the scandals of Leas Cross in 2005, and Arás Attracta and Portlaoise Hospital in 2014. First established in June 2014 as a support and advocacy service for older people by the HSE, The Atlantic Philanthropies and Third Age, it was in 2016 asked to explore how it might address some of the more systemic issues relating to people with intellectual disabilities in the South-East. Sage Advocacy clg was established in September 2017 and on March 1st 2018 it assumed full responsibility for the governance and future development of the service. On July 1st 2018 the patient advocacy services, previously provided by Patient Focus, moved to Sage Advocacy which is now a support and advocacy service for vulnerable adults, older people and healthcare patients.

Experience from Patient Advocacy Services

1. The Patient Advocacy Service was established in 1999 to provide a free, confidential and compassionate service to patients and/or their families who have been damaged or feel they have been let down by the Healthcare system. The patient advocacy service assists people to try and resolve difficulties as early as possible after they arise. It aims to ensure the preservation and enhancement of patient rights in all healthcare settings. By a variety of different means the patient advocacy service supports people in their attempt to express their concerns, to tell their stories and to contribute to the discussion about patient safety in a constructive and thoughtful way.

2. Since the establishment of the service almost 20 years ago it has supported people by providing information, to understand and navigate the complaints mechanisms when an incident has occurred, to seek independent reviews of clinical cases, to seek redress through State established schemes and supporting individuals through a legal process to seek justice for failures on the part of the healthcare system. In our experience the majority of people contacting the service regarding incidents of

suspected clinical negligence are seeking access to their relevant medical records, an explanation where an incident has occurred, an apology where an incident has occurred and assurances that action will be taken to ensure a similar incident will not happen again to another person. From our vast experience in providing a patient advocacy service it is our view that for the majority of people the process of seeking redress through the legal system is a last resort, and a decision taken at a time when the person feels they have no other option as the other avenues through the established complaints and review process have been exhausted without receiving a satisfactory response. The decision to pursue a case through the Court system is taken with careful consideration and primarily in an effort to establish the facts and to be given an explanation by the healthcare system and the healthcare personnel involved in their care or their loved ones care.

3. Each year the service supports numerous people who are taking up a legal process with a healthcare provider. We have recently been involved in three cases which were resolved through an open disclosure process, in two of these cases the people affected who were seeking an explanation did not pursue a legal route as the healthcare provider engaged on an equal basis with the person, acted in a transparent manner, provided the facts and an explanation, and provided an apology. In the third case the patient had already engaged with a solicitor prior to the open disclosure meeting taking place. In this case the family had to request a meeting with the hospital to try to get explanations as to what happened. The process of open disclosure enables a trust to be established between the person and the provider, creates an experience of both parties engaging equally where the facts of the incident can be made known and discussed, and both parties trust a true record of the incident is given. In our experience a person is accepting of the facts, and accepting that an incident had an adverse result if they believe a true record is being provided to them, and are less likely to pursue legal proceedings if the process is transparent, truthful and effective. It is our view that an effective open disclosure process would greatly reduce the number of legal cases taken against healthcare providers, and would more greatly benefit all parties involved particularly the person affected by the incident.

4. Sage Advocacy acknowledges that the commencement of Part 4 of the Civil Liability (Amendment) Act 2017 regarding voluntary open disclosure of patient safety incidents, and the proposed Patient Safety Bill 2018 setting out requirements for mandatory open disclosure of patient safety incidents by healthcare providers, will present opportunities to develop a transparent and responsive system to respond to people affected by adverse patient safety incidents in healthcare settings.

Limitations of existing systems and processes in adverse incidents

Based on the experience of providing patient advocacy services the following are limitations within the current systems

5. The current mechanism of making a personal injury claim due to clinical negligence and the Statute of Limitations of 24 months which applies impacts on all parties

involved and limits all parties' ability to meaningfully engage in an alternative resolution process such as an open disclosure process, or an admission of liability and subsequent apology and redress if applicable.

6. Significant delays in accessing personal medical records exist when engaging with healthcare providers. In our experience a healthcare provider may delay the release of medical records up to six months, despite obligations under Data Protection legislation and Freedom of Information Acts. A person making a complaint may be forced to pursue legal proceedings in order to have medical records released during the discovery process.

7. While an indicative timeframe exists for processing a complaint to a healthcare provider under the relevant Complaints Policy, the healthcare provider may delay the processing of a complaint and the initiation of a formal investigation for complaints submitted to the formal complaint mechanism.

8. While a timeframe may be set for the process of a review of a decision from a formal complaints mechanism, these timeframes are not always adhered to. The healthcare provider may delay the processing of a review, and it is our experience that the most significant time delays are experienced at this third stage. Depending on the procedure under which the review is processed timeframes can be from four to 24 months. We have been involved in cases where review processes have taken over two years with no satisfactory explanation for this time delay.

9. It is our experience that a review process is delayed or there is a delay in the issuing of the outcome of a review in cases where there is also an inquest by the Coroner. Considering the current time delays for a Coroner's inquest across the country, with delays of up to two years in the Dublin area, the process of a healthcare provider refusing to issue the outcome of a review until the outcome of the inquest is known has a direct impact on the complainant's ability to engage in a legal process due to the Statute of Limitations should there be a case of clinical negligence.

10. The review of medical records by an independent medical expert is required to establish what may have occurred in a person's clinical treatment and care, and if an incident of clinical negligence has occurred. In order to ensure this is an independent medical expert, medical experts from another jurisdiction are engaged in this review which can add further delays to the process. It is our experience that obtaining an independent medical expert review within Ireland is a challenge, there is potential conflict of interest for medical experts employed by the main healthcare providers to provide an independent expert review.

11. Due to the Statute of Limitations on clinical negligence claims, and the impact of potential delays in the process as outlined above, a complainant finds that they have to engage a legal representative at an early stage in their complaint process. The complainant has to act and prepare for the potential of making a clinical

negligence claim early in the complaint process, as a failure to do this may result in the Statute of Limitations expiring while they are attempting to establish the facts of their case through the Complaints and Review Process, or while awaiting the results of an Inquest in the case of death of a family member. While the complainant's initial motivation in making a complaint is to establish the facts of what happened and to seek an explanation, the complainant will find themselves having to engage a legal representative in order to force a timely and satisfactory response from the healthcare provider, and to ensure they are not disadvantaged should it emerge that there is a potential claim of clinical negligence.

12. In our experience, if a complainant engages a legal representative in the initial complaint process this can result in delays on the part of the healthcare provider, potentially as this may be interpreted by the healthcare provider that the complainant is seeking to make a legal claim for clinical negligence. While an explanation for delays is not always forthcoming from a healthcare provider, the result is a process that lacks transparency and prohibits the opportunity for resolution in a manner that is not adversarial, but is cooperative, effective and satisfactory for all parties.

13. Where a person pursues a legal route, the resources of the healthcare provider are much greater than the individual complainant, the legal process is weighted against the person as the plaintiff, which does not enable a fair procedure.

14. Delays often have a hugely negative impact on patients and/or their families. Waiting long periods of time to get explanations further compounds their hurt. It also results in them losing trust in the healthcare provider. In circumstances where a person is left physically damaged due to clinical negligence the delay can also have a further negative impact on their physical health as until the service provider accepts that there was negligence the patient often does not receive the appropriate and necessary treatment, interventions or rehabilitation etc. Denying a person the truth can also be very psychologically damaging to them. People often start to blame themselves and their life is put on hold until they get answers.

Recommendations

15. Access to independent advocacy should be available to a person at the earliest stage in the complaints process, through the provision of information about advocacy and the provision of an independent advocate if the person wishes to engage an advocate to support them throughout the process.

16. Consideration should be given to enabling parties involved in an incident to engage in mediation as an alternative dispute resolution mechanism at all stages of a complaint, review and open disclosure process, and as an alternative to engaging in Court proceedings. By engaging in a mediation process this should not affect the individual's right to take legal proceedings if there are grounds to do so.

17. In order to enable the complainant, and all parties, to engage effectively in a complaints process, review process, open disclosure process or mediated process a mechanism should be in place to enable a person who is actively engaging in a process to be allowed a stay/pause on initiating legal proceedings to ensure the person's ability to engage in these processes is enabled without affecting their right to take legal proceedings if there are grounds to do so. This is currently impacted by the Statute of Limitations on making a personal injury claim for clinical negligence. A mechanism could be developed which is similar to that which is enabled under Insolvency legislation, which provides for a Protective Certificate to be issued for a period of time preventing legal proceedings being taken against a party.

18. In the interests of ensuring a transparent and fair process a person, or a third party pursuing a complaint on their behalf or after death, should not be unduly delayed and prevented from accessing the relevant medical records. If there is an administrative delay on the part of the healthcare provider in releasing medical records the individual complainant should not be disadvantaged by this in terms of pursuing legal proceedings within the Statute of Limitations period.

19. Time frames in place for processing complaints, and timeframes agreed during a review process should be strictly adhered to. Similarly indicative timeframes proposed for processes relating to open disclosure under the Civil Liability (Amendment) Act 2018 should be provided on a Regulatory or policy basis to ensure open disclosure of incidents occurs in a reasonable time to be effective.

20. Consideration should be given to the introduction of a case management approach by the Courts regarding the introduction of protocols prior to legal action being taken in order to create a more efficient and streamlined system in the Courts to process legal cases regarding clinical negligence.

21. Consideration should be given to the development of a process whereby failures in the practice, policy and procedures of a healthcare provider that are identified through a complaints, open disclosure and dispute resolution mechanism are addressed at a systemic and organisational level.

22. With consideration of the significant personal impact on an individual, and their personal circle of support, who has experienced harm or injury due to clinical negligence, the introduction of any resolution mechanism should operate with respect for the rights of the individual, and ensure their right to fair procedure and right to redress are upheld.