



Clinical Indemnity Scheme

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## Cerebral Palsy Claims

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Clinical Claims Manager*



# Clinical Indemnity Scheme

- **National Treasury Management Agency (Delegation of Functions) Order 2003**
  - Specialist Division of State Claims Agency

## Aims

1. Management of clinical claims from 1st July 2002
2. Clinical Risk Management Advisory Services to Enterprises



# Definition

*Cerebral Palsy describes a group of developmental disorders of movement and posture causing activity restriction or disability attributable to disturbances occurring in the fetal or infant brain.*

*Motor impairment may be accompanied by a seizure disorder and by impairment of sensation, cognition, communication and/or behaviour.*



# Nature of Injuries

- Spastic Quadriplegia
- Dyskinetic (+/- spasticity)
- Motor impairment
- Postural and balance problems
- Intellectual and cognitive impairment
- Epilepsy/Seizure disorders
- Hearing & Vision impairment
- Speech impairment
- Reduced life expectancy



# Impact on Child & Family

- Massive/life altering event
- Focus on care of child/needs
- 24/7 care
- Impact on family relations
- Stress/Shock for parents
- Adapt family home to child's special needs
- Cost implications
- Level of care can impact on child's life expectancy



# Support Services

- **Health Services (HSE)**
  - Central Remedial Clinic
  - Medical Card/Long Term Illness Scheme
  - Home Help Service
  - Community health services/providers
- **Voluntary Organisations**
  - Enable Ireland
  - Childrens Sunshine Home
  - St Michaels House



# Problems with Support Services

- Limited resources for provision of services
- Limited finances for aids/appliances
- Budgetary constraints – now more prevalent
- Absence of services in area
- Location of services
- Waiting period
- Availability according to priority



# Problems with Support Services contd/..

## Area of Contention

The plaintiff's lawyers will argue that all the requirements of the child should be paid in full. They maintain that even though this is an entitlement, there is no guarantee that the child will obtain all the services or equipment when required under the public health system.

They will further argue that even if these were there and available that they should still be paid by the defendants.



# Legal Remedy

- Only alternative to public services
- Not the perfect forum
  - Not all neurologically impaired infants due to birth injury
  - Need to establish the injury was birth related
  - Must prove the the injury was due to negligence
  - Cost in bringing the action may be prohibitive
  - Risk of losing the case
- Legal arena can be extremely traumatic
- Can take years to conclude



# The Law

- **Ordinary Principles of Negligence**
  - **Breach of the Duty of care/causation**
  
- **Special Principles of Negligence**
  - *Dunne v. National Maternity Hospital (1989)*
    1. Was the doctor guilty of such failure that no other doctor of equal standing and skill would have made if taking ordinary care
    2. Not negligent if deviated from a general and approved practice unless the action was one no other doctor of like specialisation and skill would have taken using ordinary care
    3. No defence to say conduct was in accordance with customary practice especially if it can shown it had inherent and obvious defects
    4. Not negligent if the course taken complied with the careful conduct of a doctor of like skill and expertise



# The Law contd/...

In general the combination of the two sets of principles dictate that a doctor/midwife will not be held negligent if he/she follows customary and approved standard of practice of the profession in the particular circumstances prevailing at the time of the alleged negligence

*and*

having regard to the doctors/midwives knowledge skill and expertise which he/she knew or ought to have known



# Claims Investigations

- **The medical records & CTGs are reviewed**
- **Statements are sought**
- **Relevant expert(s) opinion commissioned (Midwifery/Obstetric)**
- **Solicitors appointed to deal with the legal proceedings**
- **Additional statements or further explanations may be required**
- **Meetings/conference calls, as required**
- **Consultations with solicitors and/or counsel, as required**
- **Pre-trial consultation with full defence team**
- **Settle or Defend!**



# Expert Reports

- **Appropriate medical experts**
- **Nature of the discipline or injury dictates the expert required**
- **Claim will involve many experts from different disciplines**
- **Expert opinion on the standard of care provided**
- **Experts within the jurisdiction**
- **Experts outside the jurisdiction will also be involved**
- **Misconception that Irish experts will not criticise suboptimal care**
- **Lengthy delays before all expert evidence is received**



# Experts on Liability/Causation

- **Obstetric**
  - CTG specialist (Prof. Arulkamaran)
- **Midwifery**
- **Neonatologists**
- **Paediatric neurologists**
- **Neuroradiologists**
- **Paediatricians**



# Condition and Prognosis Experts

- **Paediatricians**
- **Nursing Care**
- **Physiotherapists**
- **Occupational Therapists**
- **Speech & Language Therapists**
- **Orthopaedics**
- **Rehabilitation**



# Experts on Quantum

- **Vocational Rehabilitation Consultant**
- **Actuary**
- **Economists**
- **Investment Strategist**
- **Auctioneer**
- **Architect**
- **Statisticians**



# Life Expectancy

## Why so important?

- **Apart from the human aspect - life expectancy defines the value of the case**
- **The longer the life expectancy – the more expensive the future care**

## The issues?

- **Invariably there will be differences**
  - Defendants experts 15-18 years v. Plaintiffs experts 35-45 years
- **Reality of the situation is that the future is truly uncertain**
  - Cases settled last year with LE of 15-18 years – children died this year



# Life Expectancy contd/...

## Statistical Experts

- ❖ **Pharoah & Hutton** - Mersyside Data 1966-1989 & UK Regional Data 1980-1996
- ❖ **Strauss & Shavelle** - Prof. David Strauss (US)

## Practice

- ✓ **Engage both to enable the best estimate of life expectancy**
- ✓ **Attempt to narrow to as accurate a figure as possible**

## Benefit

- ✓ **Huge statistical data base**
- ✓ **Well respected experts**



# Pharoah & Hutton

## Hospital/Paediatriac records analysed – Grading Criteria:

### 1. Mental Ability (Grade I-IV)

- Grade IV most severe with IQ < 50
- Grade I normal cognitive function with IQ > 85

### 2. Manual Ability (Grade I-IV)

- Grade IV most severe with inability to feed or dress self
- Grade III is child who can feed or dress self with considerable difficulty

### 3. Ambulatory Ability (Grade I-VI)

- Grade VI most severe with child in wheelchair unable to propel self
- Grade IV is child who requires walking aids for everyday activities

### 4. Visual Ability

- Child classified with severe disability if vision in better eye worse than 6/60



# Prof. David Strauss

## Records analysed – factors identified typically:

- **Gender**
- **Age**
- **Epilepsy/Seizure**
- **Feeding**
  - Tube fed or not (PEG inserted)
  - Does not feed self or must be fed completely
- **Head lifting** (in prone or not)
- **Mobility** (does or does not creep, crawl, scoot or walk)
- **Personal Hygiene**
  - Toilet trained or not (or habit trained)
  - Completely dependent for bathing, hygiene and dressing

*\*There may be other factors such as RTIs, hospital admissions, scoliosis, weight, aspiration control etc.*



# Plaintiff's Case

- **Failure to diagnose foetal distress**
  - Electronic foetal monitoring showed late decelerations
  - Non reactive CTG no accelerations &/or ↓ beat-to-beat variability
  - Period where CTG was suspicious &/or pathological
- **Delay in calling for medical assistance**
- **Overuse of syntocinon leading to hyper-stimulation**
- **Use of syntocinon when contra-indicated**
- **Failure to do FBS to ascertain foetal well-being**
- **Failure to proceed to caesarean section sooner**
- **Delay in effecting instrumental delivery**
- **No paediatrician at delivery**
- **Inadequate resuscitation &/or failure to intubate**



# Case #1

## Facts

- **21 y/o began ANC on 2<sup>nd</sup> pregnancy in January 2003**
- **Hx of Em'CS at T<sup>+4</sup> in 2000**
- **Uneventful ANC**
- **Admitted in labour in July 2003**
- **Agreed to proceed to trial of labour (VBAC)**
- **Due to poor progress & FTA labour augmented with syntocinon**
  - Decision taken by M/W without discussion with doctor
  - Stated usual practice to D/W doctor but nothing in records
- **90 minutes before delivery excessive frequency of uterine contractions**
  - Associated with persistent FH decelerations (fleeting variable  $\downarrow$ 80bpm)
  - Syntocinon not reduced
  - Should have called doctor for FBS
- **30 minutes before delivery patient sick - loss of contact on transducer**
- **FSE not applied until 9 minutes before delivery**
- **FH  $\downarrow$ 80bpm – doctor called & arrived 2 minutes later FH  $\downarrow$ 85bpm**
- **Forceps delivery in 7 minutes from arrival**



# Case #1 contd/...

## Outcome

- Infant suctioned at perineum
- APGARS 3<sup>1</sup> 4<sup>5</sup> & 5<sup>10</sup> - Cord pH was 6.7
- Handed to paediatrician
- Bag & masked – HR 80bpm with no respiratory effort
- Registrar called to intubate infant
- To NICU for ventilation
- Subsequently developed early seizures – HIE Grade II
- At 4 years he was assessed at severe end of scale for cerebral Palsy
  - Mental Ability - Grade IV as IQ < 50
  - Manual Ability - Grade IV as unable to feed himself
  - Ambulatory - Grade VI permanently in wheelchair
  - Visual - Severe < 6 /60
- Life expectancy another 16 years i.e. to 20 years
- At trial plaintiffs lawyers sought €6.5 million
- Settled on day 2 of trial for €3.3 million



# Case #2

## Facts

- **Mother uneventful ANC & admitted May 1983 post dates (T<sup>+10</sup>)**
- **On admission FH regular at 180 bpm - grossly abnormal**
- **CTG at 6:25am 140-158 bpm**
- **Next day T/F to LW with contractions 1:10 minutes**
  - VE Cx 3cm & membranes intact - ARM with clear liquor
  - Oxytocin given to augment labour
- **06:00am - FH 174bpm**
- **11:30am - Cx 4cm Vx -1 station B/S liquor noted**
- **4:20pm - Cx 5/6cm Fully effaced Vx at the spines**
- **7:15pm - FH 170 & 180 CTG started**
- **7:45pm - VE 8/9cm B/S liquor Vx -1? Conts 3/4:10**
- **9:00pm - Tachycardia 190-204bpm Cx 8/9cm Vx at 0 station**
- **9:20pm - S/B Doctors FSE applied No other action taken**
- **10:45pm - Mother fully dilated CTG stopped**
- **11:06pm - Vacuum extraction with episiotomy**



# Case #2 contd/...

## Outcome

- APGARs 5<sup>1</sup> 8<sup>5</sup> 10<sup>10</sup>
- Baby intubated & T/F to NICU
- Early onset of seizures
- Developed cerebral palsy of a mixed spastic & dyskinetic kind
- Almost normal life expectancy to 65 years
- Experts critical of care & of failure to take earlier action (9:00/9:20pm)

## Trial

- Plaintiffs lawyers sought €6.5m but would recommend €5.5m
- We argued our figures into the future were fair & offered €3m
- Settled just prior to trial for €3.391m



# Case #3

SETTLEMENT FIGURES		
	<i>Defendant</i>	<i>Plaintiff</i>
	€	€
General Damages	380,000	400,000
Retrospective Care	227,000	250,000
Future Care	2,923,000	3,000,000
LOEs	560,000	650,000
Assistive Technology	500,000	500,000
Aids/Appliances	853,000	1,400,000
Accommodation	309,000	300,000
<b>Total</b>	<b>5,752,000</b>	<b>6,500,000</b>

## Outcome

- 1986 case involving liability and causations issues
- Poor records – little or no entries
- Compromised at €3 million



# Recent CP Settlements

<b>2006</b>	South	DC	€4.65m*
	South	NH	€3.75m
	West	SD	€4m
<b>2007</b>	North	LG	€3.25m*
	West	RH	€3.391m*
	West	CN	€3m
	Dublin	RH	€2.75m
	West	JB	€2.9m*
<b>2008</b>	Dublin	JF	€3.3m*
	Dublin	PF	€4.5m
	North	FL	€3m
	North	AT	€4.35m
	Dublin	SS	€4.25m
	West	JT	€3m*



# A -v- Powys Local Health Board (2007)

- **Infant born at University Hospital of Wales, Cardiff, on 3rd July, 1991**
- **Profound HIE at birth**
- **Diagnosed with Dyskinetic Cerebral Palsy**
  - Unable to walk unaided & unable to feed herself
  - Involuntary movements & severe dysarthria
  - Poor but understandable (with difficulty) speech
  - Achieved grades in 10 exams in her Irish Junior Cert
  - Likely contender for the Irish Paralympics show jumping team
  - Always require 24 hour care
  - No epilepsy & continent
  - Almost normal life expectancy to 70 years of age
- **Awarded £10.7m (€15 million)**



# Case Conclusion

- **Investigate early & make determination upon expert evidence & legal advice**
- **Defence – endeavour to provide viable alternative explanations for child's outcome**
  - **Genetic**
  - **IUGR/microcephally**
  - **Placental insufficiency/disease**
  - **Timing of the injury (MRI vital e.g. diagnosis of PVL)**
- **US rate of CS 1970-1993 went from 5% to 23% - rate of CP remained unchanged**
- **Settlement of the legal action if case cannot be defended**
- **Court Hearing**
  - **If the case is defensible or**
  - **where judge is asked to decide on the level of compensation**
- **The plaintiff discontinues the legal action (recent case where child died)**



# Why claims are settled!

- **No records/missing records (in part of full)**
- **No CTG/s**
- **Poor records**
  - Absent/inadequate entries (sparse note taking)
  - Unclear clinical plan
  - Illegible handwriting or abbreviations
  - Inability to identify signatures
  - Unable to locate doctors/midwives
- **Negligence**
- **Consideration of the probable judicial attitude to Plaintiff's injuries**



# The Future!

- **Awards for catastrophic injuries will increase**
- **Possibility of structured settlements**
- **Increase in the use of mediation to resolve disputes**
- **No fault compensation scheme**



*Thank you*