



Submission on the

Review of the operation of the Personal Injuries Assessment Board Act 2003 and the Injuries Board

Department of Jobs, Enterprise and Innovation
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Key Recommendations

Access to legal advice must be safeguarded. Each claimant has a fundamental right to legal advice and representation. This should be reflected in a more balanced treatment of this issue in the context of the Injuries Board's processes, publications and publicity.

Definition of 'vulnerable claimant' should be developed. The Society recommends that a definition of 'vulnerable claimant' should be developed and applied from the outset of the process, rather than on a discretionary or on a post facto basis. The Central Bank's Consumer Protection Code may be of assistance in this regard.

Consent to assessment provisions should be amended. Section 14(1)(b) of the Act should be amended to provide that a respondent who fails to respond within 90 days is deemed not to consent to the assessment process. This would encourage respondents to be more proactive, to respond in a timely manner and avoid unnecessary and unfair delays in the assessment process.

Admission of liability should be a prerequisite. Section 16 and the policy of the Injuries Board should be amended to ensure that the Board deals, as originally intended, with cases where liability is genuinely admitted. This would avoid unnecessary delays and expense in cases where liability is at issue.

The Board's discretion under section 44 should be formalised by way of guidelines. Guidelines should be developed by way of Statutory Instrument to inform the Board in the application of its discretion under section 44 of the Act.

Clarity on costs and expenses is required It is recommended that the Board's decision-making process be transparent and that reasons for allowing/disallowing expenses be published. Greater clarity and certainty would lead to less claimants being out of pocket and may result in fewer assessments being rejected.

Any increasing of the Board's scope should proceed with caution. Suggestions that the Board's remit might be extended to claims relating to medical injuries give rise to particular concerns, including the likelihood of increased claims and costs for the health system.

PART I – Operation of the Acts and Board

Introduction

The Law Society represents over 9,000 members, the vast majority of them having a practice in civil litigation. This requires our members to deal on a daily basis with the Personal Injuries Assessment Board (“the Injuries Board”) and the statutory framework underpinning the Board. The views contained within this submission are influenced and shaped by their clients’ experiences.

The Law Society meets the Injuries Board on a twice yearly basis and engages in constructive discussions about issues that either party may have with the other’s involvement in the process.

The Law Society continues to make representations as to how the Injuries Board could operate in a fairer and more efficient way protecting the rights of injured parties, improving the speed of processing claims and avoiding unnecessary delays.

The Minister for Jobs, Enterprise and Innovation is now undertaking a review, which is timely. Views are being sought on:

1. How the legislation is operating in practice.
2. Areas relating to the scope, powers or operation of the Act that may require change.

In the interests of clarity we set out below key issues identified together with recommendations.

Respecting each claimant's fundamental right to legal advice and representation

Pursuing a personal injury claim is a serious matter for any person. Claimants have suffered pain, injury and disruption in their lives which may continue for many years. Many have been unable to earn their living. Other claimants have suffered the loss of a close family member through a fatal injury. All of these claimants have a fundamental right to legal advice and representation to help them make their claims.

Claimants need and benefit from legal advice and representation for many reasons. For example:

- claimants cannot be expected to know and understand the law on limitation of actions;
- the technical nature of a fatal injuries claim, including who can make such a claim and who qualifies as a dependant;
- the need to preserve evidence in the event that the claim is ultimately litigated and how to do this;
- even the crucial matter of identifying the correct respondent or respondents can be complicated;
- claimants may also seek the help of a solicitor for personal reasons such as frailty or general illness, worry, fear of dealing with institutions and inexperience.

The Injuries Board does not provide legal advice.

The right of any person to seek legal advice in respect of their claim is specifically recognised and protected by the Act. Section 7(1) expressly states that nothing in the Act is to be read as affecting this right and no rule shall be made under section 46 that affects that right.

Both the High Court and the Supreme Court (O'Brien v PIAB (2008)) have stated that the right to legal advice and representation applies to the procedures before the Injuries Board by reason of their complexity, importance and potential consequences for the claimant. That case arose out of the Injuries Board's policy of refusing to deal directly with a claimant's solicitor despite the claimant's wishes that they do so. The courts found that the Injuries Board's policy interfered with the solicitor/client relationship and breached the fundamental right of claimants' to legal representation. This policy also evinced an unequal approach by the Injuries Board to claimants and respondents, as the Injuries Board did not apply the same policy to respondents but dealt with their agents and insurers.

The reality is that the vast majority of respondents and their insurers have access to legal advice and representation. Insurers have a wealth of experience, information and resources which claimants lack. Therefore it is essential that claimants are aware of their right to be represented by a solicitor and have accurate information that will assist them in deciding whether to seek such advice. As Ms Justice Denham stated in the O'Brien case: "The lawyer places the person on an equal footing".

Assertions by the Injuries Board that legal advice and representation do not provide any benefit to a person making a claim are incorrect and unfair to claimants.

If the Injuries Board is to achieve its mission of being “an independent facilitator for the delivery of compensation in a fair, prompt and transparent manner for the benefit of society” a more balanced approach to this issue is required. The fundamental nature of the right to legal advice and representation reflects the value our society places on equality and fairness. Whether or not to instruct a solicitor is ultimately the claimant’s decision. Such an important decision should be a well-informed one. It is essential that the information provided to each claimant and to the public is fair, balanced and accurate.

LAW SOCIETY RECOMMENDATION

Each claimant has a fundamental right to legal advice and representation. This should be reflected in a more balanced treatment of this issue in the context of the Injuries Board’s processes, publications and publicity.

Ad hoc approach to ‘vulnerable claimant’

The Act contains special provisions for ‘vulnerable parties’. Section 29 provides that the Injuries Board has a duty in respect of such parties including, as it considers appropriate, to advise the party of the desirability of obtaining legal advice. The Board may also allow vulnerable claimants additional fees and expenses, including legal fees, on the assessment of their claims.

Currently, costs are being paid in insufficient sums in cases where claimants are deemed to be vulnerable. However, from the outset of a claim, both claimants and solicitors are also faced with uncertainty as to whether the claimant will be treated as vulnerable. The special provisions only apply where the Board ‘infers’ vulnerability. A clear definition of a vulnerable claimant is essential. The absence of such a definition leads to uncertainty and puts claimants at a disadvantage.

LAW SOCIETY RECOMMENDATION

The Society recommends that a definition of ‘vulnerable claimant’ should be developed and be applied from the outset of the process, rather than on a discretionary or on a post facto basis. The Central Bank’s Consumer Protection Code may be of assistance in this regard.

Unnecessary delays in consent to assessment process

Once a claim is submitted, a respondent has 90 days within which to consent to the process. A respondent who does not respond within 90 days is deemed to have consented to the assessment process. This suits many respondents. As a consequence, the claimant experiences unnecessary delay in the Injuries Board process. In effect, the nine-month assessment period becomes twelve months because of the respondent's inaction.

This 90-day 'hiatus' puts claimants at a disadvantage. Furthermore, it negates the Injuries Board's objective of efficiently responding to claimants' needs.

LAW SOCIETY RECOMMENDATION

Section 14(1)(b) of the Act should be amended to provide that a respondent who fails to respond within 90 days is deemed not to consent to the assessment process. This would encourage respondents to be more proactive, to respond in a timely manner and avoid unnecessary and unfair delays in the assessment process.

Contesting liability after assessment compromises the regard for Injuries Board process

Section 16 of the Act ensures that liability may be contested at any point following the release of a claim from the Injuries Board.

It is inaccurate to claim (as the consultation notice states) that the Injuries Board deals with claims where 'liability is uncontested'. Liability is uncontested *only insofar as* the claim is being considered by the Board. Respondents are permitted to make full denials of liability after assessment.

The negative impact on users of the Injuries Board, including additional long term costs (due to delayed resolution) arise because:

- Users can wait 9 months or more for a final assessment of compensation by the Board and then find that liability is contested following rejection of the award by one of the parties.
- Claimants' cases are prejudiced in the long-term, particularly as they may be reluctant to engage engineers before the completion of the assessment in circumstances where the engineers' fees will not be recovered.

LAW SOCIETY RECOMMENDATION

Section 16 and the overall policy of the Injuries Board should be amended to ensure that the Board deals, as originally intended, with cases where liability is genuinely admitted. This would avoid unnecessary delays and expense in cases where liability is at issue.

Compromising claimant welfare by failure to fully reimburse costs & expenses

Under section 44 of the Act the Board can direct that the respondent shall pay the fees and expenses, in whole or in part, that, in the opinion of the Board, have been reasonably and necessarily incurred by a claimant in the assessment process. However, many expenses incurred legitimately by claimants in pursuit of their claims are often not allowed by the Board. In many cases, the full amount of the cost of a medical report, which the claimant has had to pay to their doctor, is not allowed and in most cases, the cost of second or third medical reports are completely ignored. Legitimate engineering fees are routinely disallowed despite often being a necessary part of the preparation of a claim. The result is that many claimants are not being fully reimbursed for their claim and this can act as an incentive to reject the assessment.

Furthermore, the advice of a solicitor is crucial to redress the inequality of arms that a claimant encounters where respondents and their insurance companies have the resources to engage extensive legal advice. Over 90% of claimants choose to engage a solicitor but have to do so largely at their own expense.

It is a basic tenet of compensation for personal injuries that the claimant should be put back into the position that he was in before the accident. This principle is impugned when claimants are unable to recover their legitimate costs and expenses from the party who caused their injury and put them to the expense of making a claim.

LAW SOCIETY RECOMMENDATION

It is recommended that Guidelines be developed by way of Statutory Instrument to inform the Board in the application of its discretion under section 44 of the Act.

Furthermore it is recommended that the Board's decision-making process be transparent and that reasons for allowing/disallowing expenses be published. Greater clarity and certainty would lead to less claimants being out of pocket and may result in fewer assessments being rejected.

PART II – Increasing scope of Injuries Board

In addition to our comments above, the Law Society is aware of suggestions that medical negligence claims could be included within the Injuries Board remit. The current consultation on the Act is a useful opportunity to convey our preliminary views on the matter.

It is the Society's view that such a step would be inappropriate and compromise the welfare of injured parties. In addition, and for the reasons set out below, it is likely to result in a significant increase in the cost to the State of such claims.

The widening of the scope of the Injuries Board to medical negligence claims would lead to the following:

Increase in Claims

- a. Currently, by way of example, the SCA handles approximately 650 new medical negligence claims per annum. This is a relatively low number, given that there are 85,000 adverse incidents in Irish hospitals per annum.
- b. Unlike medical reports in non-medical personal injury claims, expert reports in medical negligence cases address the important legal tests such as, but not limited to causation, breach of duty and contributory negligence. Application of these tests is essential in order to safeguard the medical profession and health system from spurious or unmeritorious claims.
- c. The Courts have ruled that solicitors of claimants have a positive ethical duty to investigate and advise on the merit of a client's case. In this way the expertise and experience of a solicitor, with the assistance of expert reports, operates as a filter. The absence of this filter for claims made to the Injuries Board would result in an increase in claims, particularly in light of the large the number of adverse incidents in Irish hospitals annually.

Increase in Cost to the State in Investigating/ Managing Claims

- a. Medical indemnity organisations, including the State through the Clinical Indemnity Scheme, will suffer the inevitable consequences of an extension of the Injuries Board - namely more patients seeking and receiving compensation than at present.
- b. The overall cost to the State, insurers and the medical defence organisations, will be higher because medical defendants will be obliged to investigate much higher numbers of claims, many with no merit.
- c. An influx of new claims would require the SCA, in responding to each new claim, to
 - (i) obtain a set of medical records
 - (ii) analyze the medical records
 - (iii) interview the clinicians
 - (iv) commission expert reports
 - (v) respond to the Injuries Board.
- d. This would impose an impossible burden on SCA and over-stretched hospitals, many of which already have difficulty coping with the present workload. Such an increase will simply break the system.

The myth of “small claims”

- a. There is a mistaken view that the Injuries Board process will weed out “small claims” in the area of medical negligence.
- b. The statistics show that the vast majority (91% in 2012) of Injuries Board awards are under €38,000. This contrasts greatly with the SCA’s clinical negligence figures where the vast majority has an estimated liability in excess of this amount, reflecting the greater seriousness and complexity of clinical negligence cases.
- c. Where a high compensation award is required (for continuing care, rehabilitation etc), it is less likely that an applicant would be willing to accept an assessment solely on the basis of a claim’s “nuisance value”. Therefore the Injuries Board will waste valuable resources assessing claims where their determination will almost always be rejected.
- d. The corollary is true: for cases which would not merit a particularly high quantum, the Injuries Board process may be appealing with the result in the generation of claims that are not currently being brought.

Unsuitability of Time Limits

- a. The 90 day time limit to either accept or reject a claim is not appropriate for medical negligence cases.
- b. In medical negligence cases, delays arise in obtaining expert reports (a small number of suitably qualified experts are available) and also inherent delays in obtaining witness statements and records from under-resourced hospitals.
- c. Frequently, the investigation of liability issues necessitates the assistance of medical experts. It can be enormously difficult to obtain expert medical reports from suitably qualified experts in a timely manner because, naturally, their medical commitments take priority.
- d. In the absence of a definitive determination on breach and causation issues, the defendant would have no alternative but to refuse to consent to assessment by Injuries Board.

Inadequacy of compensation alone

- a. Patients seldom focus solely on the value of compensation offered.
- b. The real controversy is often to determine whether the doctor or hospital has been guilty of substandard care in the first place.
- c. Patients normally want to establish what happened and whether there has been substandard care. They need an explanation as to why the care has been poor and for the hospital or doctor to be held accountable. They want steps to be taken to avoid its re-occurrence with injury to others and they want to receive an apology for what has happened.
- d. The Injuries Board cannot deal with issues other than compensation/damages, so most patients would not accept assessments made by the Injuries Board.

Unsuited to Complex Medical Claims

- a. In non-medical personal injuries claims, applications to the Injuries Board are made by submission of an application form together with a medical report. The Board assesses the value of the claim which, if accepted by both parties, puts an end to the case.
- b. In many clinical negligence cases an early admission of liability can be hugely difficult, even where liability is ultimately admitted, because in many cases there are a multiplicity of defendants comprising consultants and other doctors, hospitals and, inevitably, the HSE. The investigation of medical claims takes time and can be quite complex. Many doctors have indemnifiers other than the State Claims Agency.
- c. In a significant majority of clinical negligence cases, liability is unclear at the early stages and often remains in contention throughout. For example, in the case of brain damaged infants, it can be difficult to establish whether the injury arose as a result of lapses in the care provided to the mother/infant or whether the injury arose as a

result of an event beyond the control of the hospital/doctor i.e. an intrauterine event prior to birth. In the cases where breach and causation are clear from the outset (less than 5% of the clinical negligence cases dealt with in the SCA) the SCA already moves to immediately resolve those cases and therefore there is no real advantage to the Injuries Board dealing with these.

- d. Causation is a major issue in a significant proportion of such cases.
- e. Even where breach of duty is established or acknowledged, it is frequently the case that there are issues as to whether the injury complained of is attributable to the breach of duty as opposed, for example, to being attributable to the condition being treated.

Pragmatic reforms currently being advanced

The Society supports other changes in the manner in which medical negligence actions are processed.

The Society urges urgent implementation of long overdue changes which have been recommended by the appropriate Expert Working Groups, in which the key stakeholders on all sides are represented. It is important to note that the stakeholders include representatives of medical indemnity organisations who have expert knowledge and experience in this specialist area.

The changes required include:

- a. The enactment of the proposed Civil Liability (Amendment) Bill to implement the recommendations contained in the High Court Working Group Report on Periodic Payments Orders in catastrophic personal injury cases.
- b. Introduction of pre-action protocols, as recommended by the Working Group Report.

The pre-action protocols aim to enable parties to settle issues between themselves without the need to commence proceedings and, if proceedings cannot be avoided, to allow for efficient management by the court and by the parties themselves. These aims are achieved by encouraging the parties to:

- (i) exchange sufficient information about the matter to allow each party to understand each other's position and make informed decisions about how to proceed,
 - (ii) make appropriate attempts to resolve the matter before issuing proceedings.
- c. Continuing the development of the HSE's Open Disclosure policy.

Conclusion

The Injuries Board has made a difference to the manner in which personal injury claims are handled. It has brought both benefits and disadvantages to a system that needed streamlining.

While the Law Society continues to have strong reservations about its overall effectiveness, the Injuries Board is now a part of the personal injury claim resolution system and the Society is therefore anxious that it achieves all of its aims. The consultation request states that these aims are to “fairly, promptly and transparently compensate the victims of accidents involving personal injuries in a cost effective manner”. The Society is concerned that compensation is not awarded “fairly, promptly and transparently” in all cases for the reasons set out above.

It is hoped that the Minister will take account of the Society’s recommendations. The Society is available to meet with the Minister to elaborate on any of the issues raised.

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