



THE BAR  
OF IRELAND

*The Law Library*

Submission by Council of The Bar of  
Ireland to the Minister for Justice &  
Equality in response to the Statutory  
Consultation on Pre-Action Protocol for  
Clinical Negligence Actions

21st September 2017

## INTRODUCTION

The Council of The Bar of Ireland (the **Council**) is the accredited representative body of the independent referral Bar in Ireland. The independent referral bar are members of the Law Library and has a current membership of over 2,200 practising barristers.

The Bar of Ireland welcomes the opportunity to share and represent its members' views in response to this consultation. The members who have contributed to this submission represent plaintiffs and defendants in medical negligence actions and, we believe, are in a position to offer practical insight regarding the proposed procedural changes.

A pre-action protocol for clinical negligence actions which reduces costs and increases the efficiency and effectiveness of procedures both pre-commencement and post commencement is welcomed by the Council. However, significant concerns arise from the draft pre-action protocol for clinical negligence actions (the **Draft Protocol**) which was provided to the Bar Council under cover of letter of 1 August 2017 from the Department of Justice, Equality and Law Reform.

## GENERAL OBSERVATIONS

1. In general terms, there is concern that the Draft Protocol as drafted is unworkable particularly within the time constraint of a strict two year limitation period and in the context of the manner in which clinical negligence proceedings are currently funded – plaintiff practitioners predominantly working on the basis of payment made by the defendant following a successful conclusion of the litigation, the so called *'no foal no fee'* approach to funding litigation. We are also of the view that the letter of claim mechanism it is overly detailed appearing to require litigants to set out by way of pre-action correspondence as much, if not more, detail than currently required to be set out by way of pleadings in a medical negligence case. For instance, in addition to requiring a claimant to set out the facts on which the claim is based, particulars of negligence, causal link, injuries arising, condition and prognosis, the template Letter of Claim (Form 5) also requires a claimant to:
  - *"set out what investigations have been carried out to date e.g. information from the claimant and witnesses, any complaint and outcome"*; and
  - *"in more complex cases"* to set out a chronology of the relevant events as well as referencing *"any relevant document"* and to enclose copies of same where possible.
2. The above requirements go well beyond the pleading requirements of the Superior Court Rules which, save in exceptional circumstances, do not require the pleading of evidence. They also go beyond the discovery obligation of litigants which limit the documents to be produced to those which are not only relevant but also necessary.
3. The Draft Protocol suggests a form of trial by correspondence and/or an attempt to introduce a form of litigation that is not in place in this jurisdiction. Even in England and Wales where the

civil procedure rules provide for some reliance on affidavit evidence of oral evidence at trial, it is of note that the equivalent Protocol operating in that jurisdiction does not require claimants to set out or reference either witness evidence or documentary evidence at the pre-issue stage. This submission addresses this further below (sections 8 and 9).

4. Of importance, it seems likely that extremely detailed Letters of Claim followed by equally detailed Letters of Response then reproduced in subsequent proceedings as pleadings will result in increased costs. Given that the intention behind most Pre-Action Protocols is to simplify, not complicate matters, a process limited to an outline or summary of the main points in each parties' case would more effectively meet the intention behind the introduction of pre-action Protocols, namely that the parties might be informed of each other's case prior to the formal commencement of proceedings and that settlement might be promoted.
5. Moreover, clinical negligence cases are often complex and require specialised legal and medical advice to be properly litigated. Often separate expert opinions are needed on each of breach of duty, causation, condition and prognosis and special damage. These reports are expensive and take time to obtain not only because of the limited number of experts available (especially in specialised areas of medicine) but also because they often have to be obtained from an expert outside the jurisdiction. The lack of any legal aid or other funding mechanism for clinical negligence cases in Ireland is a significant hurdle for many potential claimants. It can be extremely difficult to get sufficient information to draft a Personal Injury Summons within the already short two-year limitation period allowed for issuing proceedings and often proceedings are issued with only the minimum information required. This is generally not for a want of trying but rather due to an inability to move the case faster due to on-going injury on the part of the plaintiff, insufficient funds for expert reports and lack of availability of experts to advise or to advise in a timely fashion.
6. The Draft Protocol is silent on how the specialised advice necessary to achieve the detail required by it is to be paid for by plaintiffs. For instance if proceedings do not issue, taxation of costs does not arise. If proceedings do issue, pre-issue matters dealt with by Counsel do not tax (always stated to be 'solicitor/client'). In both cases how is the cost of any work carried out to be measured and payment of same enforced by plaintiffs, the majority of whom in clinical negligence cases have, to date, relied on the taxation of costs to pay their legal and medical advisors.
7. At present plaintiffs have the protection of knowing that once proceedings issue, drafting can be carried out by specialised Counsel whose costs will then form part of the costs of the action to be paid by the defendant whether by agreement or taxation. They also have the protection of knowing that they can receive advices from both Junior and Senior Counsel, the cost of which will also form part of the costs of the action. If the matters which to date have been required to be dealt with post issue are now required to be dealt with pre-issue, it is vital for plaintiffs that arrangements be made with regard to the funding of same and in particular with regard to funding representation equal to that available to the health service providers. Unless specialised counsel (and solicitors) are to be paid fully for the work carried out at this stage (which if a case is to settle will be significant) they will not be involved at this stage which is prejudicial to the

rights of plaintiffs. While settlement is to be encouraged, any settlement must be fair to the rights of plaintiffs and there must be equality of arms in terms of representation. The health service providers have specialised solicitors and insurance firms representing their interests with a panel of specialised barristers and experts available to assist all of whom are or can be paid by the relevant indemnifier (in most cases the State Claims Agency) regardless of taxation. This is not the case with plaintiffs and this is an issue which needs to be addressed before compelling all plaintiffs to comply with a protocol they may be ill equipped to deal with.

## **MORE SPECIFIC OBSERVATIONS**

### **Section 2 – Definitions**

8. The term “health service provider” (hereinafter “HSP”) as defined in section 2 does not include a health care institution/hospital (as opposed to a medical practitioner).<sup>1</sup> The Protocol should be expressly stated to apply to all claims against hospitals, medical practitioners, nursing practitioners, dentists and other health care providers. The definition ascribed to the term HSP is also important when considering the issue of “*third party records*” at section 6 of the Draft Protocol and what in fact constitutes a “*third party*” (see further below).
9. While this section ascribes a definition to the term “*records*” the remainder of the Draft Protocol (including the relevant template forms) refers continuously to “*clinical or medical records*” as opposed to “*records*” within the meaning of the definition section. This requires clarification/amendment as it seems there may be some unintended restriction on the type of records which are to be provided under the exchange of information regime. The fact that “*medical records*” and “*clinical notes*” are individually listed in the definition of “*records*” clearly suggests that there is a restriction on the records to be exchanged or furnished in that the records are to be confined to clinical or medical notes and records. By exclusion this means that administrative records, nursing notes, observations, CTG tracings and all the other documents identified in the definition section are not to be included in the exchange of information protocol. The fact that section 4 (2) (a) provides that the health service provider must provide an estimate in respect of the reasonable cost of “*providing relevant scans and x-rays*” when responding to a request for “*copies of clinical or medical records*” suggests that it is envisaged that the term “*medical and clinical records*” includes all the documents referenced by bullet points under the definition of “*records*”. In addition, assuming the broader definition applies throughout the Draft Protocol, the meaning of the words “*including but not limited to*” when defining the term “*records*” further complicates the issue.
10. In the event that the above is a simple drafting error and that the documents to be exchanged are all the documents listed under the definition of “*records*” then there should be some misgivings as to the type of records which must be exchanged. In particular the category of “*correspondence*” is extremely broad and could conceivably cover correspondence that is

---

<sup>1</sup> Section 32A of the Civil Liability and Courts Act 2004 is inserted by the Legal Services Regulation Act 2015 defines a HSP as “a person whose name is on – (a) the register of medical practitioners, (b) a register maintained by the Dental Council, etc

privileged “for a variety of reasons” or documents which would offend the data protection legislation.

11. Concerns also arise with the breadth of the risk documentation records “to include all investigations, communications, memos, statements, reports.” There is not only a real possibility that documents within that category are privileged but also there may be confidentiality and data protection issues arising. It is assumed that in including in the definition of records investigations “carried out at any stage” and “documentation from risk management to include all investigations, communications, memos, statements, reports” that same does not include any such documents which are covered by litigation privilege. We would suggest putting in a saver in clause 2 to the effect that “save insofar as any such documents are covered by legal professional privilege”.

### **Section 3 – Exchange of Information**

12. We note in respect of section 3 “Exchange of information” that a procedure is set out for the provision of copies of records. In paragraph 3(1) the Draft Protocol refers to “clinical or medical records”. This appears to be a narrower definition than the definition of “records” in the definitions section. It may be that in certain clinical negligence claims, for example, nursing notes are also required as well as medical and clinical records. Regarding section 3 and the request for copies of records, the provision should be made for that request to include a request for any relevant guidelines, protocols or policies.<sup>2</sup> As stated above, clarity is needed on this issue and while the definition of records ought not be limited to medical and clinical records caution needs to be exercised in relation to, for example, risk management records from a privilege, confidentiality and data protection perspective.
13. The category of “person” who may make a request for records to the health service provider under section 3 is strangely restricted. It provides at 3 (1) (a) that “a person” can make a request for records on behalf of “that person” i.e. himself/herself. It also provides at 3 (1) (b) four other categories of “a person” who can make such a request on behalf of “that person”. None of the four categories include a solicitor acting on behalf of “that person”.
14. Separately, there should be a provision within section 3 or indeed section 4 that provides a validation period or process if the request is made by a person other than the patient. For a variety of reasons ranging from confidentiality to data protection, a health service provider should obtain proof from a person who claims to be writing on behalf of a particular patient that the person in question has the appropriate authorisation to do so. The time period for such an enquiry by the health service provider as to the status of the person making a representation on behalf of a patient, the response thereto and subsequent validation by the health service provider should not “eat into” the time period prescribed for the health service provider to respond to the request.

---

<sup>2</sup> These are documents which are referenced in the recently updated corresponding protocol in England and Wales – Pre Action Protocol for the Resolution of Clinical Disputes (effective 6 April 2015)

15. Aside from providing basic factual information such as name, address, date of birth, date of incident (if known) and name of the hospital in which the person was at the material time, the balance of the information required by section 3(2) and in Form 1 is unnecessarily onerous and in some cases not capable of being provided by a layperson in the absence of expert opinion following review of the medical records. For instance in many cases a person will not be able to identify the date or time when "*possible clinical negligence took place*" and will require detailed causation evidence to assist in that regard. It is not clear how a layperson can identify the records that he needs to investigate his claim as required by section 3(2)(b). In most cases a layperson will not be able to identify the clinical or medical records he requires beyond stating that he requires his clinical records held by the hospital to be furnished to him. Similarly Form 1 is unduly lengthy and complicated and places an onus on a layperson to provide information which cannot be given in the absence of medical records and expert opinion – e.g. the requirement that the person set out "*the nature of the claim*" against the hospital that is being considered, something which cannot be answered in the absence of expert medical and legal advice following review of the records which are sought. The level of detail required by the Draft Protocol is to be contrasted with the equivalent Protocol operating in England and Wales which simply requires a person to set out basic details such as name, address and date of incident. That is all that should be required at this stage of a claim. Any subsequent Letter of Notification will provide the necessary information to commence investigation of a possible claim if same is anticipated by the patient after consideration of the records. Prior to consideration of his records a patient may well not be in a position to articulate the nature of his claim and at such an early stage he should not be required to.

#### **Section 4 – Response of HSP**

16. With respect to section 4 "Response of health service provider" sub paragraph (1), other than forwarding the required records within a period of 11 weeks the phrase "*provide a substantive reply*" is not clear. If it is envisaged that other than a cover letter enclosing the relevant records a more fulsome reply of some nature is required within 11 weeks, then that should be stated clearly in section 4(1).
17. Regarding section 4(1), a period of 11 weeks to provide medical records is unduly lengthy particularly in the context of a tight, non-extendable two-year limitation period. In England and Wales the Courts retain a discretion to extend the limitation period and/or same can be done on consent of the parties and this is expressly referenced in their protocol.
18. Regarding section 4(2), an attempt should be made to specify the costs that can apply to any request for records as opposed to leaving it to the HSP to set a "*reasonable*" costs. A limitation in line with the costs provided for in the Data Protection legislation might be appropriate.
19. It seems that section 4 (2) (a) envisages the health service provider furnishing the actual scans and x-rays to the person requesting records. There are some scans and x-rays which may not be capable of being reproduced. Similarly with certain pathology/microbiology records/slides there can be a difficulty with reproduction and either the originals have to be given or inspection

facilities given. In a litigation or pre-litigation setting there would generally be a solicitor's undertaking in relation to the custody and return of such records. A model to develop this aspect of the Draft Protocol may be found in the Freedom of Information process.

20. In addition, section 4(4) (and the corresponding section 5(4)) appear on their face unworkable – if a person cannot locate a record, how can they then indicate when they will be in a position to do so?
21. Insofar as sections 4(5) and 5(5) are concerned the Draft Protocol should set out the lawful reasons upon which the HSP or claimant may rely on for not producing a particular record.
22. The Draft Protocol should provide a mechanism whereby in the event of a failure on the part of the HSP to provide the records or an explanation for any delay within the allocated time period, application can be made to the Court for an Order for pre-action discovery, with necessary cost consequences for not compliance. Medical records are fundamental to any proper consideration of a potential clinical negligence claim and frequently there is an issue with the provision of records or complete records. This is expressly provided for in the UK equivalent protocol.

#### **Section 5 - Request for records by HSP**

23. Section 5 should only apply if and when a Letter of Notification is sent by a claimant and this should be expressly stated in the body of section 5(1). Prior to intimation of a possible claim a HSP can have no right of access to a private citizen's clinical/medical records.
24. There is a fundamental mistake, or so it appears, at section 5 (3). It is assumed that the reference to "health service provider" at the end of that sentence should in fact read "the person". In a similar vein the reference to sub-paragraph 6 at section 5 (4) appears to be in error and should presumably refer to sub-paragraph 1. Form 3 also contains errors with part 1 referring to the HSP as opposed to "*the person*".

#### **Section 6 - Third Party Records**

25. There are some very fundamental difficulties with this section of the Draft Protocol.
26. The mandatory obligation at section 6 (3) of a third party providing records to a patient or a patient's representative, solely by reason of the fact that the health service provider has identified that such documents are in the possession of a third party, is offensive to the rights of that third party. There is no room in the provisions for the third party to challenge the request made and it is all too easy to envisage circumstances where documentation held by a third party, who could be anyone from the State Claims Agency to an employer of a patient to a relative of a patient, being compelled to furnish documentation in breach of that third party's rights. There is also no mechanism within the protocol for that imperative placed on a third party to be enforced. In any event, it would be impossible to impose such an onerous obligation on a party entirely innocent to whatever issue exists between a patient and a health service provider.

27. Separately, it is noted that where the health service provider requires records from a third party that *“in the first instance [the records held by a third party] be requested by or through the person inquiring into possible clinical negligence.”* However, the Draft Protocol does not proceed to permit the health service provider, should the third party not provide the records to the person inquiring into possible clinical negligence, to then request from the third party itself the provision of the records. In that regard, section 6 of the Draft Protocol appears to be incomplete. There could, potentially, arise a situation where a health service provider is prejudiced by not being able to obtain third party records other than via the person inquiring into possible clinical negligence and consideration should be given to permitting an application to Court by the HSP for pre-action discovery from the claimant / Third Party.
28. In addition, arising from the issues regarding the definition of a HSP above, clarification is required as to whether another hospital under the control of e.g. the HSE or within the same hospital group is to be defined as a third party or the HSP.

### **Section 7 – Letter of Notification**

29. With reference to section 7, a number of matters arise:

- With regard to section 7(1) presumably the letter should be sent as soon as practicable after receipt of the medical records **and**, if appropriate, the initial supportive medical report and not simply after receipt of the medical records?
- The reference at section 7 (2) (a) to an *“action”* should presumably refer to a *“contemplated action”*.
- The necessity of section 7(2)(a) and (b) is unclear and appears to conflict with the template Letter of Notification at Form 4. Paragraph 6 of the template requires the claimant to confirm that *“this is a case which is proceeding, but that it is premature for the Claimant to send a Letter of Claim”* whereas section 7(2)(a) states that the Letter of Notification *“must inform the HSP that further investigation is required to determine if the action is proceeding”*. A claimant might well be satisfied from an early stage that an action is proceeding but might not be in possession of the totality of the information required to serve a formal Letter of Claim. If the purpose of the Letter of Notification is to notify the defendant of the possibility of a claim, it is submitted that at this stage the claimant should be required to do no more than advise that initial investigations identify a possible claim in negligence and thereafter invite the defendant to commence their own investigations i.e. section 7(1) should suffice.
- Similarly, with regard to section 7(2)(c) – this is possibly a typographical error, but as drafted there is a mandatory requirement to inform a HSP that the claimant may have reasonable needs that could be met with rehabilitation treatment or otherwise. We assume that what was intended was that **if** the claimant has such needs this can be set



out. Rehabilitation treatment and the needs of claimants are dealt with by way of a standalone section in the UK protocol which might be a more appropriate way to proceed.

- Section 7(3) requires a plaintiff to send the same letter to a number of parties including any “*identified third party*”. Clarification is required as to what parties might be anticipated here but as drafted the necessity for such a requirement is not clear. Why would a Letter of Notification be sent to a third party?
- Section 7(4) suggests that reference might be made in the Letter of Notification to entering into settlements, meetings, negotiation and discussion. While it is noted that this is a discretionary element to the letter, we are of the view that consideration of settlement at such an early stage must be seen as premature and should not be included in this section of the Protocol. The Letter of Notification only comes into play when there is a possibility of a case but prior to a claimant being in a position to say that there are grounds for a claim based on medical and legal advice. If it is the case that a claimant is not in a position to serve a Letter of Claim we cannot see how any plaintiff (or their legal advisors) would be in a position to consider or thereafter enter settlement talks – how can a claimant decide to settle a claim they do not know they have or the extent of which is unknown to them? A lawyer could not (or should not) advise a claimant to settle a case in such circumstances and while an injured person may well be attracted by the concept of an early settlement, to do so in the absence of even the basic information that is required to serve a Letter of Claim would, in our view, be disadvantageous to that person. There are added difficulties dealing with the rarer cases of a litigant in person. A Pre-Action Protocol should not endorse the notion of an injured person being able to settle a claim, the basis and extent of which is unknown to them.
- It is not uncommon in medical negligence cases for issues to arise with regard to the identity of the appropriate defendant to any proceedings. It is submitted that in the Letter of Notification the claimant should identify the party or parties believed to be the correct defendant in respect of the treatment provided and call upon the recipient of the letter to provide additional information regarding the legal identity of the correct defendant if not agreed.
- With reference to section 7(5) and the response by the HSP to a Letter of Notification the following points are made:
  - It is not clear why a response from both the HSP and its indemnifier are required – a single response would simplify matters
  - The Protocol should expressly direct that on receipt of a Letter of Notification the HSP should forward this to their indemnity provider/SCA.
  - The Protocol should also provide that if the letter acknowledging receipt of the Letter of Notification is sent by the HSP as opposed to his indemnity provider, the letter should identify whether the HSP has indemnity cover and identify the provider.
  - The letter acknowledging receipt should identify to whom any Letter of Claim should be sent.

- With regard to section 7(6) and Form 4 – paragraph 9 references a “*subsequent application for an extension of time for the Letter of Response*”. The Draft Protocol makes no reference to requests or applications by defendants for extensions of time to respond, something which is expressly dealt with in the body of the corresponding UK protocol. If extensions of time are contemplated, this should be rectified and expressly referenced in the body of the Protocol.

## Section 8 – Letter of Claim

30. With reference to section 8(2), the Draft Protocol suggests that the detail to be provided in the Letter of Claim is almost identical to that to be provided in any later Personal Injury Summons and the template Letter of Claim at Form 5 appears to go further (see comments above re witness and documentary evidence above). There also appears to be an inconsistency between the body of the Draft Protocol and the Template Letter. The latter requires a claimant to set out “*an outline of the main allegations of negligence*” and “*an outline of the causal link between the allegations and the injuries complained of*” whereas section 8(2) appears to go further requiring the claimant to set out “*the allegations of breach of duty and causal link with injuries*”. We are of the view that the obligation should not be to draft particulars in line with those which would be contained in a Personal Injuries Summons and that if wording is to be used in the Draft Protocol (rather than simply referencing the template letter which would be the more straightforward approach) it should be the same as that used in the template i.e. clarification is required that what should be set out is an outline of the main allegations being advanced as opposed to the full particulars of claim.
31. As in England and Wales, the Draft Protocol should expressly make clear that Letters of Claim are not intended to have the same formal status of particulars of claim (or Personal Injury Summonses) and should expressly state that sanctions should not necessarily apply if the Letter of Claim and any subsequent particulars of claim in the proceedings differ (See paragraph 3.19 of the updated English Protocol)
32. Further issues arising with regard to the Letter of Claim:
  - The reference to “*reasonable costs*” at section 8(2)(i) is unclear – is this treatment costs, legal costs or other costs? If legal costs, the need for an estimation of same at the Letter of Claim stage is unclear and overly cumbersome. It is submitted that this should only become an issue requiring consideration if the parties agree to mediate/or enter into ADR. To require consideration of this issue before any Letter of Claim is sent is unnecessary and further adds to the administrative costs arising to a claimant.
  - Regarding section 8(2)(j) - the need to provide the information (and what that information might be) is unclear but clarification is required as to why plaintiffs should be required to set out in narrative form what investigations have been carried out given that a Letter of Claim can only be sent once appropriate legal and medical advice has been taken. To require more of a plaintiff arguably breaches the principals of legal professional privilege. The template Letter of Claim expressly refers to witness statements etc and appears to contemplate a

narrative account of the evidence proposed to be given being set out in the letter. This is not appropriate and any suggestion that claimants should be required to advise a potential defendant of potential witness evidence should be removed from the Protocol. It is noted that no similar requirement is made of defendants responding to the Letter of Claim and there needs to be parity in this regard. If, contrary to what is set out above, it is considered necessary to require a claimant to set out what investigations have been carried out by him then section 9 (Response to Letter of Claim) should expressly stipulate that in circumstances where a HSP disputes or denies or does not admit the allegations made by the claimant, it too should set out what investigations it has carried out into the allegedly negligent treatment to include reference to witness evidence and documentary evidence and expert evidence. We are, however, of the view that neither party should be required to do this.

- Section 8(4) seems overly cumbersome. It is unclear what “*third parties*” are contemplated as necessary recipients of a Letter of Claim and clarification is required but we are of the view that it should be sufficient to send the Letter of Claim to either the HSP (who can then forward it to his/her indemnifier in the usual way) or to any other entity identified by it in earlier correspondence as the person to whom the Letter of Claim should be sent (e.g. SCA).
- The template Form 5 Letter of Claim has a section entitled “*funding information*”. The relevance of this in an Irish context is unclear and clarification is required.
- Likewise (as set out above) we do not think it necessary to set out costs arising to date unless and until ADR/mediation is entered into.

### **Section 9 – Response to Letter of Claim**

33. With reference to section 9, a number of matters arise. Turning first to section 9(2) the timeframe of four months from receipt of the letter of claim for a health service provider to provide a response is an unduly short time period. The reasons are as follows:

- In respect of subparagraph 3(b) four months is an unduly short time period in order to ascertain whether the events specified in the letter of claim are disputed. This will require a detailed review of all the medical and clinical records as well as interviewing the doctors and nursing staff involved in the alleged events.
- More fundamentally, the requirement in subparagraph 3(e) that there be a “*statement, in clear terms, which alleged breaches of duty and causation are admitted or denied and the reasons for the admission or denial;*” will, in practical terms, be impossible to achieve in a period of four months from receipt of the letter of claim. Admitting or denying breaches of duty requires expert advice. Issues of liability and causation are usually highly complex and require not only reports from one expert but from a number of experts in different fields. Such advices are procured from leading medical practitioners in their particular fields. Often, such practitioners have heavy clinical practice workloads and it can take some time to obtain the relevant expert reports. It is submitted that the period of four months is simply unworkable if what is required is an admission of breach of duty or causation.

- There also appears to be an inconsistency between subparagraph (e) and subparagraph (f) where (f) states that the statement indicating whether a denial of alleged breach of duty and causation is based on independent expert evidence. As matters stand, in delivering a Defence a denial of breach of duty cannot be included without an independent expert verifying same. When reviewing Form 6 it is clear in paragraph 4 that:

*“A bare denial will not be sufficient. Specific responses to the allegations of breach of duty and causation should be given. If the health service provider has other explanations for what happened, these should be set out as fully as possible;”*

Responses to such allegations of breach of duty and causation cannot be given in advance of obtaining independent expert evidence. Therefore, there is a clear inconsistency in paragraph 4 of the draft letter of response where the subsequent bullet point asks the health service provider to confirm whether any denial is based on receipt of independent expert evidence.

- The requirement that an offer to settle the matter by the health service provider when in receipt of a letter of claim “must” be supported by a medical report does not make sense. An offer to settle at the earliest possible opportunity would be in the interests of all parties and to suggest that the health service provider must await a report on condition and prognosis before offering to settle a case not only increases costs but also unnecessarily delays resolution of the matter. It may also be the case that a particular patient will refuse to undergo a medical examination or it may not be in the interest of the patient to have a medical examination performed. In such circumstances it seems that the health service provider is precluded by the regulations from ever offering to settle the case.
- In a similar vein to the above the stipulation at regulation 9 (5) that the health service provider must furnish a schedule of the claimant’s losses is obviously unrealistic as it is incapable of being complied with by a health service provider. This section can therefore be interpreted as meaning that an offer to settle the case cannot be made unless such a schedule is furnished.
- Equally as regards (4) there may be instances where it would be inappropriate to provide an apology in advance of obtaining expert advice as to whether or not a health service provider had been negligent or in breach of duty.
- In general, the stipulation that an admission of liability or an apology must be accompanied by a reason for such an admission or apology is unnecessary and unhelpful. There are many cases where injury occurs due to a number of factors and also many cases where a particular doctor may not accept responsibility even in the face of an unsupportive expert witness report. To insist that the health service provider should specify the reason why it is admitting liability or apologising in such cases may be counterproductive and in fact lead to a reluctance to admit liability or offer an apology.

- With respect to (5) it is not clear how the health service provider could have obtained a medical report on the condition and prognosis of the claimant in a period of four months from the date of receipt of the letter of claim. A condition and prognosis report requires a claimant to be examined by relevant expert or often more than one expert.
- The obligation placed on the health service provider to respond to the letter of claim at section 9 should clarify that the health service provider's insurer or the State Claims Agents can do so on its behalf.
- In clinical negligence cases it can be difficult to ascertain the correct legal entity to name in proceedings e.g. GP practices – practice name v every GP, independent v pure HSE hospital, private v public patients, nominee v hospital name, private practices trading under business names. With regard to section 9(3) detailing the contents of the Response to the Letter of Claim, we are of the view that there should be an express direction to the effect that the Letter in Response should:

- (a) identify the appropriate defendant(s) against whom proceedings should issue; and
- (b) advise the claimant of any other potential defendants to the Claim.

This should also form part of the Template Letter (Form 6)

- There should also be an express provision to the effect that if the claimant has made an offer to settle in his Letter of Claim, the defendant should respond to that offer in the Letter of Response (with reasons).
- Paragraph 1 of the Template Letter (Form 6) refers to the defendant asking for "*further instructions*" – the meaning and import of this is unclear and clarity is required.
- In circumstances where, in accordance with section 13 of the Draft Protocol, noncompliance will be taken into account when determining liability for costs in the event that proceedings are issued, in circumstances where it will be in practical terms impossible for a health service provider to obtain an expert report and admit breach of duty within four months of receipt of a letter of claim it seems unduly prejudicial as against a health service provider.
- There is merit in a direction in the Protocol to the effect that from an early stage there be an agreed set of indexed and paginated medical records for use by the parties and their experts. Parties working off a number different sets of medical records is confusing and inefficient. An agreed set from an early stage would be in ease of all parties, their experts and ultimately the Court (or a mediator). This might perhaps only come into play once a Letter of Response keeping liability in issue is sent.

## **Section 11 – ADR/Mediation**

34. The directions with regard to section 11 are overly prescriptive and do not reflect the reality of what is happening on the ground in relation to the mediating of clinical negligence claims.

35. In the first instance the requirement that a party must respond to an offer of mediation should have a prescribed time period. There is no time period provided at 11 (2) within which the party to whom an offer of mediation has been made must respond to that offer. It must also be recognised, and unfortunately so, that where a mediation is offered at a very early stage it is generally turned down for no valid reason. In the circumstances we suggest that where mediation is declined and as provided for at 11 (2) (b) there should be an obligation on the party declining mediation to set out in detail the reason why the offer is being refused.

36. The matters in respect of which agreement should be reached between the parties and as provided for at 11 (3) ignore the involvement of the mediator. The vast majority of the elements set out are matters that should be agreed in conjunction with the mediator or alternatively should be stipulated by the mediator. There is a real possibility that by providing a check list of matters that should be agreed between the various parties that agreement will not be reached and thus mediation not achieved.

37. The requirement that “*the termination of the mediation*” should be agreed in advance at 11 (3) (f) really undermines a mediation. A mediation should be open-ended and without any time limitation. The mediator decides when to finish the mediation and is generally empowered by his/her mediation agreement to keep the parties engaged until such time as a solution is reached or the mediator, in his/her discretion, believes there is no point in continuing with the matter. Accordingly it would be totally counterproductive to suggest that the parties agree, in advance of going to mediation, a time period within which the mediation should be conducted.

38. Further, the import of section 11(4) is unclear and ought to be clarified.

## **Section 12 – Issuing of proceedings**

39. We have significant concerns that the bar or moratorium on issuing proceedings as envisaged at section 12 may be unconstitutional.

40. Following on from the tight time limits and the non-extendable limitation period operating in this jurisdiction, a claimant may well find himself in a position where he has complied with the detailed requirements of the Protocol only to have to issue proceedings prior to the defendant having delivered a Letter of Response. While Part 15 of the Legal Services Act 2015 inserting a section 32C into the Civil Liability and Courts Act 2004 contemplates application to Court seeking directions that the action shall not proceed further until steps required by the pre-action protocol are complied with, there is no section in the Draft Protocol dealing with this issue. We note that in the UK protocol it is expressly stated (paragraph 3.20) that “*if, for any reason, proceedings are started before the parties have complied, they should seek to agree to apply to the court for an order to stay the proceedings whilst the parties take steps to comply*”. We would not advocate an application to stay the plaintiff’s

proceedings while waiting for a Letter of Response (unfair to plaintiffs) but think there should be some provision in the Protocol which provides that if proceedings have to issue before the parties have complied with the Protocol, the parties should comply with their obligations under the Protocol prior to taking any further steps in the litigation with provision made for applications to Court to compel the parties to comply within the relevant time periods.

41. The exception to the moratorium on issuing proceedings as provided for at 12 (b) is unfair and probably unconstitutional. It provides that proceedings can be issued where to do so “*would be necessary to protect the interests of the Claimant*”. This should be extended to circumstances where such commencement of proceedings were also necessary to protect the interest of the Defendant. There may well be cases where the Defendant requires the matter be proceeded with urgently and the regulations should accommodate such an eventuality. In addition, there is no mechanism whereby the issue as to whether the commencement of the proceedings “was necessary to protect the interests of the claimant” can be determined. The obvious arbiter of that issue is the Court but there is no requirement that a Court be consulted.

### **Section 13**

42. Section 13 (1) appears unduly harsh. It provides that if one party does not comply with any requirement of the protocol then the other party is relieved of all obligations under the protocol. Accordingly if a Claimant or health service provider was a day late in delivering a letter or a record then the other party no longer has to comply with the protocol. The offending party must, however, continue to comply with the protocol which would appear to be impossible if the other side is not obliged to do the same. A better solution would be to stipulate that where one party was in breach of the protocol then the other party was not obliged to comply with the protocol unless and until the other party became compliant. There should be a provision that allows for applications to the Court in respect of alleged non-compliance and obligations on the part of the other party

### **CONCLUDING REMARKS**

While the Council of The Bar of Ireland is of the view that any process which attempts to streamline medical negligence cases is to be welcomed the Council is nonetheless concerned that the Draft Protocol does not reflect the reality of what is happening on the ground when it comes to persons bringing medical negligence cases in this jurisdiction.

Unlike in England and Wales (where a similar although less prescriptive protocol has been in place for some time) Irish plaintiffs are (currently) operating within the confines of a non-extendable two year limitation period. Generally, a plaintiff in a clinical negligence case will not seek advice immediately upon the occurrence of an adverse incident (even if they know of it or suspect it). In general the more serious the injury the more time it takes to recover sufficiently to seek the advice. By the time they do, several months can have passed. Often they seek advice from a non-specialised solicitor who then requires advice from specialised counsel to get the case moving. All of this in the context of no legal aid or other funding mechanisms (both of which apply to clinical negligence cases in England and

Wales) for what are generally complex cases both medically and legally necessitating specialised input from a relatively early stage.

In most cases the legal advice to be given to an injured person in these types of cases is dependant on obtaining an expert report which generally speaking has to be obtained from an expert outside the jurisdiction at a not insignificant cost to the plaintiff. In virtually all cases these reports are paid for up front and before a plaintiff knows whether they are supportive of a case or not. If not supportive, a second opinion might be sought. If supportive a second report is often required, sometimes on breach of duty (e.g. a report from a neo neonatologist is often required to consider the post natal care afforded to a plaintiff injured at birth and in respect of which an obstetric report will generally be the first report obtained) and often on causation (e.g. a neurologist report to assist with timing of any birth injury arising) with additional reports being required for condition and prognosis and thereafter special damage.

Points have been made regarding the period of 4 months being too tight for compliance by a HSP. It is certainly the case that virtually no plaintiff would be in a position to turn around a case in that time period. However, if for arguments sake you give a plaintiff say 12 months to recover sufficiently from the occurrence of an adverse event, go to a solicitor, get advice and then make a request for records etc, allowing 11 weeks (almost 3 months) to the HSP to give him the records, all that is left in reality before proceedings have to issue is 9 months of which the HSP needs more than 4 months to respond to a letter before claim. If 6 months were to be given, working backwards, that would leave only 3 months to the plaintiff to get the letter of claim out which is not going to work. In addition, none of this leave times for the mediation/settlement process envisaged as a central part of the protocol. It also seems to the Council that the level of detail required is overly ambitious and out of keeping with what can realistically be achieved particularly on the part of plaintiffs operating within extremely tight and often difficult financial constraints. Instead of focusing on an exchange of correspondence and the content of that correspondence in this regard it would be better if more emphasis and a focus was placed on early exchange of expert witness reports as it is really only when that happens that both sides are in a position to truly consider their positions

The Draft Protocol serves to activate legal drafting and the seeking of legal opinion at a much earlier stage than when proceedings have been commenced and although this is obviously to be welcomed it may well prove difficult to do so within the various time constraints. This increases the amount of work which will need to be carried out by legal advisors prior to commencement of proceedings. At present, there is no mechanism for measuring the cost of this work as same has not previously been subjected to the taxation system. Any such dramatic increase in workload by legal representatives will ultimately be passed on to the claimant or borne by the health service provider. It is submitted that a mechanism for addressing the costs associated with the Draft Protocol should be devised and sent to stakeholders for comment prior to implementation of the Draft Protocol.

For all of the reasons outlined above, the Council cannot endorse the Draft Pre-Action Protocol in its current form. Representatives of the Council are available to engage in further discussion with the Department on any aspect of this submission.





# THE BAR OF IRELAND

*The Law Library*

Distillery Building  
145-151 Church Street  
Dublin 7 D07 WDX8

Tel: +353 1 817 5000  
Fax: +353 1 817 5150  
Email: [thebarofireland@lawlibrary.ie](mailto:thebarofireland@lawlibrary.ie)  
Twitter: @TheBarofIreland  
[www.lawlibrary.ie](http://www.lawlibrary.ie)