Department of Health

A Rapid Resolution and Redress Scheme for Severe Avoidable Birth Injury: A Consultation

A response by the Association of Personal Injury Lawyers
May 2017

The Association of Personal Injury Lawyers (APIL) is a not-for-profit organisation with a 25-year history of working to help injured people gain access to justice they need and deserve. We have over 3,000 members, committed to supporting the association's aims and all of whom sign up to APIL's code of conduct and consumer charter. Membership comprises mostly solicitors, along with barristers, legal executives and academics.

APIL has a long history of liaison with other stakeholders, consumer representatives, Governments and devolved assemblies across the UK with a view to achieving the association's aims, which are:

- To promote full and just compensation for all types of personal injury;
- To promote and develop expertise in the practice of personal injury law;
- To promote wider redress for personal injury in the legal system;
- To campaign for improvements in personal injury law;
- To promote safety and alert the public to hazards wherever they arise;
- To provide a communication network for members.

Any enquiries in respect of this response should be addressed, in the first instance, to:

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Introduction

We welcome the opportunity to respond to the Department of Health's consultation on the introduction of a rapid resolution and redress scheme for severe avoidable birth injuries. While we believe that a learning culture should be encouraged throughout the NHS, large parts of the proposed scheme are a cause for concern. As proposed, the scheme will not achieve its aims, and will not provide the injured child and their families with the funds required to meet their needs.

General comments

We welcome the idea of early investigation, and a mechanism for guaranteeing early upfront payments for families. However, "stage two" of the scheme appears ill-thought out, and will not improve the experience of families when harm has occurred. The "stage two" compensation package would mean children, catastrophically injured through the failure of the NHS to take reasonable care, not receiving the funds which they and their families need and which the law recognises they are entitled to.

APIL is disappointed that, having met with the Department of Health in the early stages of these proposals, it has not taken on board our concerns, namely:

- The importance of having independent advice at an early stage to enable families to make an informed choice. In the proposed scheme, legal advice will only be available from stage two onwards. Families will be expected to attend meetings about the investigations surrounding their baby's injuries in stage one, at a time when they are likely to be particularly vulnerable, without any support from an independent solicitor.
- APIL also raised at the early meeting that 100 per cent compensation is what the family need – what motivates people to claim is ensuring that a child is cared for for the rest of his or her life. We are extremely disappointed to note that the compensation awarded at stage two will be based on 90 per cent of the average current court award.
- APIL also raised concerns that the scheme lacks provision for any award under the scheme to be approved by the court and for there to be a deputy to manage the injured child's funds and ensure their needs are met. The Department of Health had agreed that this would need to be looked at, and we are disappointed that it appears not to have been taken further. We explain below the reasons why court approval and the role of the deputy are vital.

We are concerned that this scheme will ultimately be litigation's poor relative. If the threshold for compensation is the same as that for a claim in negligence, it is difficult to see how, if given proper independent advice to make an informed choice, a family would choose the rapid redress scheme over litigation. The scheme has been modelled on the Swedish system, and reduces costs by largely relying on state funded care for the claimant[1]. In Sweden, the state welfare system is much more well-funded, and of far higher quality than that available in England and Wales. According to data published by the Organisation for Economic Co-operation and Development, Swedish per head public spending on benefits

[1] Paragraph 4.24 of the consultation, for example, states that the "90%" compensation figure was reached by exploring which elements of care and support are available through state funded services and which require additional funding.

and services for sick, injured and disabled people is more than double that of the UK. To compare the two systems is not comparing like for like. If the scheme only offers access to state care, it will fail to attract those who are considering litigation to choose this route instead. Pursuing litigation will be the only way to ensure that there is access to private care where needed. The consultation itself admits at paragraph 2.3 that for those who have similar care needs but were not negligently harmed, state services are available but sometimes markedly less than what can be procured following a typical court award.

The disparity between the treatment received by families who choose this route as an alternative to litigation, and those who litigate, will be further exacerbated by the DoH simply not having the resources in place to ensure that the scheme works properly. Unless there is dedicated funding put aside, and investment in the specific roles required to make the scheme work – such as investigators, and the "case managers" mentioned at stage two, it will not deliver on its aims.

The Case for Change

We query the suggestion within the executive summary that the average length of time between an incident occurring and an award for compensation being made is 11.5 years. Members report that while there are some cases where there is a court order staying the case for several years, this is only where for example the child might have behavioural issues and it is necessary to see how they develop in their early teens. For even the most profoundly injured children, cases tend to settle by the time the child is aged 6.

We query the statistics at paragraph 2.4 of the consultation stating that the annual cost of claims has risen from £1.2bn in 2014/2015 to £1.5bn in 2015/2016. An analysis of freedom of information responses provided by the NHSLA[2] shows that the cost of clinical negligence claims being closed by the NHSLA has, in fact, been falling. In 2012/2013, the NHSLA closed 9,190 clinical negligence claims – the average cost of these claims was £79,379[3]. By 2015/2016, the number of clinical negligence claims closed by the NHSLA had risen to 10,778, with the average cost dropping to £68,071 – a fall of 14% on 2012/13.

Policy Objectives

We welcome any proposals which include open and transparent dialogue between clinicians and families. We do not, however, see how this aim would sit with the Department of Health's recent proposals to introduce "safe space" across the NHS. "Safe spaces", which are to be introduced for investigations carried out by the Healthcare Safety Investigation Board, would permit and encourage hospitals to hide information from patients and their families[4].. This is directly contradictory to the aims of the RRR scheme.

[2] For the purposes of this response, "NHSLA" means NHS Resolution.

[3] This cost includes NHSLA spend on damages, defendant (i.e. NHSLA) legal costs, and claimant legal costs

[4] In response to its consultation on introducing safe spaces for NHS investigations, the DoH states that HSIB will be expected to conduct its investigations using the safe space principles set out in the NHS Trust Development Authority (Healthcare Safety Investigation Branch) Directions 2016, which require that "unless there is an overriding public interest or legal compulsion, disclosures for purposes other than making recommendations as described in paragraph (b) of material gathered by the Investigation Branch should accordingly be avoided…"

We also welcome the objective of encouraging learning. We disagree, however, with the assertion that it is litigation that leads to a lack of shared learning at present. Paragraph 3.9 of the consultation, for example, states that "the label of "negligence" may impart the suggestion of blame on individual practitioners, which may inhibit total candour or mask potential opportunities for shared learning and improvements at system level". As is evident from the Department of Health's consultation on introducing "safe spaces" in NHS healthcare investigations, the absence of a learning culture is driven by fear of repercussions from whistleblowing, not the threat of litigation. This is highlighted by the safe space consultation paper at 3.11, where it is stated that a 2015 NHS staff survey revealed that only 43 per cent of respondents agreed or strongly agreed that their organisation "treats staff who are involved in an error, near miss or incident fairly". Litigation and learning are not mutually exclusive, and until the NHS becomes more open and transparent, litigation is often the only way for a family to receive the answers they need, and to be assured that lessons will be learnt.

Q1) Do you agree that the scheme should include early investigations, conducted by professionals independent from the trust involved, potentially including at least one obstetrician and one midwife?

We would welcome stage one of the scheme, subject to the concerns we highlight below.

We agree that there should be early investigations. This is likely to go some way to encouraging compliance with the duty of candour and ensuring appropriate early admissions of liability. The earlier an investigation is carried out, the earlier suitable rehabilitation can be put in place.

It may also be worth considering the involvement of people from a non clinical background in stage one, who have experience of conducting investigations into systemic failures and the need to disseminate information widely – such as those from the Air Accidents Investigation Branch.

Q1a) If yes, how independent would the investigating team need to be in order for families to have confidence in the findings? Would investigations need to be conducted;

- **By clinicials in the trust, that were not involved in the incident being investigated nor have had direct management of those involved**
- **Outside the trust involved, for examples through the proposed regional Maternity Clinical Networks (proposed by Better Births)?**
- **With oversight from the Royal Colleges or other independent bodies?**

We believe that independence is vital. In order to ensure independence, investigations must be conducted outside of the trust involved.

We are concerned that there does not appear to be any mention of how these "Stage One" investigations will sit alongside the Healthcare Safety and Investigation Branch (HSIB). The HSIB is designed to deal with system level failures and to carry out an investigation to learn from the incident. The HSIB also has an expert advisory panel, with experts who can be co-opted on to panels if the investigation is in a specialist area, such as maternity care. At the outset therefore, HSIB and stage one of the RRR scheme appear to overlap considerably.

Having a focused approach under stage one of the rapid redress scheme may be beneficial, and may supplement the work of the HSIB, but it has to be considered how the two separate groups will work together. They must complement each other, without duplication of work.

Q2) We are aiming to launch an investigation into the incident within 90 days. Do you agree with this approach, or have comment on the feasibility?

Launching an investigation within 90 days is a sensible approach. Within the 90 day timeframe there should also be a set timescale for an early apology to be delivered. The NHS should also seek to get the family involved in the investigation as a matter of urgency. If the family is not in a position to meet or does not wish to meet within the 90 day timeframe, it is for them to decline the invitation but the onus should be on the NHS to seek to meet with the family at an early stage. This will be an extremely anxious time for the family, and in the majority of cases, they will be looking for answers.

According to research carried out by Ipsos Mori, families can often feel isolated, with a lack of information about what has happened forthcoming. The Ipsos Mori report accompanying the consultation details that parents who had experienced brain injury during birth described feeling distanced from staff. Some parents spoke of staff not wanting to look at them when they were in the room or answer their questions. One parent said that "when [the family] tried to ask questions about what happened, [they] were pushed away…[they] were just so isolated". The research revealed that for parents and stakeholders alike, one of the primary things most people who have traumatic births want is an explanation or to be able to discuss their concerns. Early meetings with family must, therefore, be a priority.

It is also a priority that the family has access to independent legal advice during these early meetings with the NHS. The whole process will be completely new and daunting for the family, and they should have access to an independent solicitor to support them through this difficult time at a stage when they are likely to be particularly vulnerable.

There should also be a timeframe for reporting the outcome of the investigation – families should be told when they can expect to receive the findings of the investigation.

Q3) How can we ensure alignment with, and avoid duplication of, other investigative processes, such as the Serious Incident Framework and the role of Regulators?

As above, there is no mention of the Healthcare Safety and Investigation Branch in this consultation, and given that there is likely to be cross over between the work of HSIB and the stage one investigations, how the two processes interact must be thought out very carefully.

Q4) Do you agree that the scheme should include an early apology to families, in the form of an early expression of regret?

We strongly agree that there should be an early apology to families. As above, it is important that families do not feel ignored. The NHS should strive to be open and honest with patients and their families when something has gone wrong. We welcome revised NHS Resolution guidance on "saying sorry"[5]. We particularly welcome that the guidance is clear that NHS staff should provide an apology as soon as possible after becoming aware that something

[5] http://www.nhsla.com/Claims/Documents/Saying%20Sorry%20-%20leaflet.pdf

has gone wrong, acknowledging what has happened and telling the family and that he/she will find out more. The guidance stresses that the apology should be heartfelt and sincere, and that the patient should be provided with a key contact wherever possible. The guidance also recognises that saying sorry can support learning and improve patient safety.

In addition the apology must be sure to express regret, and must not be evasive. It should comply with the duty of candour. While the duty of candour provisions do not confer legal liability, the rigorous enforcement of this duty by NHS trusts will, we believe, ensure greater transparency and openness and lead to an increasing number of claims investigated with the benefit of clear admissions of breach of duty from the NHS Trust from the outset.

Q4a) Do you agree that the investigations should offer families the opportunity to be involved in the investigation process, with the option for a face-to-face meeting to discuss the findings?

We strongly agree that families should be provided with the opportunity to be involved in the investigation process. It is extremely important also, that the family is able to access legal advice at the earliest possible opportunity, to guide them through this meeting – not just at stage two.

Families will need an advocate when meeting with the NHS to discuss the investigation. The inequality of arms is very stark, right from the start - the process is completely new to these families but the NHS will be a repeat player.

There is no rationale as to why the access to counselling, legal advice and help in accessing state services is not offered in stage one. It is crucial that all of these must be offered at the earliest stage. These services should not be dependent on a finding that the NHS was negligent or the harm was avoidable.

Q5) Do you agree that the scheme design should ensure learning is disseminated locally, regionally and nationally, building upon existing systems where possible?

Yes.

Q5a) Do you agree with the use of a central learning database to collate findings from investigations, which will then feedback nationally to trusts?

Yes.We agree that there should be a central learning database, and welcome NHS Resolution's plans to introduce a Faculty of Learning, which will allow the NHS to "share expertise and solutions under one easy access umbrella"[6].

Q6) How could we best ensure that learning is implemented?

We agree that learning would be best implemented if eligible incidents are thoroughly investigated and that learning is disseminated. There must be a change in the culture of the NHS to transparency and openness, and this will further encourage learning. As stated in our safe space response, there is no quick fix to addressing the problems in the NHS culture, but a focus on openness, transparency and the duty of candour is the way to

[6] http://www.nhsla.com/AboutUs/Documents/NHS%20Resolution%20-%20%20Business%20Plan%202017-18.pdf

achieve it. We welcome the aims of the Faculty of Learning, to learn from inquests, effectively deliver candour, and to support trust boards with the "governance and management of performance concerns".This first stage is not about allocating blame but ensuring proper care for patients and full investigation when things go wrong, to avoid the repetition of mistakes that needlessly cause injury.[7]

Q7) Do you think there are additional potential barriers to learning that are not addressed by the current design of the policy? If so, do you have suggestions about how these can be addressed?

As above, we believe that whistleblowing and fear of repercussions from the NHS are a barrier to the development of a learning culture in the NHS generally. There are mechanisms already in place to increase openness and transparency, such as the duty of candour, but other NHS proposals such as the introduction of "safe spaces" for HSIB investigations, and eventually for all NHS investigations, would allow further secrecy and concealing of information from families.

We foresee a potential barrier being a lack of resources. In stage one, it does not appear that there will be specific recruitment of investigators. In stage two (aside from the other issues we highlight with this section) the consultation does not suggest that there will be specific recruitment of case managers. Both investigators and case managers will already be working as healthcare professionals, with the challenges and responsibilities that come along with that. Any work undertaken as part of the rapid resolution and redress scheme will have to be balanced with the other pressures on their time. In order for the scheme to work, there must be separate recruitment and subsequent empowerment of those who take on the roles within the scheme.

Q8) What improved support could be provided to practitioners following these tragic events?

We are unable to provide comment on this section, but question why there is no specific question on providing support to families following the tragic events. The consultation only states that families will be eligible for access to counselling once they get to stage two. This is unacceptable.

Stage 2

General comments

Paragraph 4.15 of the consultation states that access to legal advice will be available "if required". It is not even, therefore, a pre-requisite for stage two that there is legal advice. As above, access to an independent solicitor from the outset of stage one is vital. These cases involve protected parties – and families must seek legal advice to decide whether to choose the rapid resolution route, or litigation, to ensure that their child's needs are met.

Q9) Do you agree that families should be provided with an early upfront payment, likely to be in the average range of £50 – 100k, when avoidability can be established?

We would welcome guaranteed early upfront payments by the NHS. However, we fail to see why these payments will only average £50,000 – £100,000, and will only be available when the child is 4.

The early upfront payment suggested in the scheme is tokenistic, and not based on what the individual child's needs are. The consultation states that the early payment would support families with any up-front costs required to care for their child, such as adaptations to accommodation. A payment of even £100,000, however, would not cover standard alterations to a home. Further, the existing home may be completely unsuitable for adaptations, and the family may be required to move out to a new house. This would be impossible to do with just £50,000 – 100,000.

The justification for providing a smaller amount of money is that it is an "early" upfront payment. We disagree with the consultation that the lump sum and any periodical payments will be provided on average a year earlier than they would via the court route. Our members report that in litigated cases at present, claimants often get substantial payments at around 4, and in some cases, even earlier. Some members report that compliance with the duty of candour has led to a change in behaviour, with some trusts admitting liability more promptly. There needs to be focus on a trust-wide compliance with the duty of candour, early communication between the parties and working on a collaborative basis. When these factors are all in place, and the family seeks legal advice soon after the injury, an initial payment can be made to the families on account as early as within 12 months of the injury. In one instance, a birth injured occurred on 12 July 2014, solicitors were approached on 22nd July and full liability was admitted and a voluntary interim payment was offered on 24 March 2015. The interim payment was made on 22nd July 2015, just over a year after the incident. We suggest that rather than trying to implement a flawed redress scheme which will result in families not getting the amount of compensation at the time they require it to meet their child's needs, that there should be a focus on improving openness and transparency with complete compliance with the duty of candour.

We query why the child needs to be aged 4 before a payment is made under this scheme. If the family has been through the stage one investigation of the scheme and has been deemed eligible for stage two, then it will be clear that something seriously wrong has happened. Why is a payment not made immediately when the claim is deemed eligible for stage two? If the NHS is serious about attracting people away from litigation to the scheme, they must make it more attractive. Providing a tokenistic, non-needs based amount of compensation at the same stage as, or later than, money could be awarded in litigation in will not achieve this.

Further, we do not understand how a scheme which provides arbitrary amounts much lower than those awarded through the court system, can work when the claimants are protected parties. Damages awarded to children must be approved by the Court of Protection. There is no provision for approval here, and this is extremely concerning. The NHS will not get good receipt for any money paid under the scheme if there is no approval of the settlement and this cannot be a proper use of public funds. Moreover, we cannot see how a court would approve any settlement that was less than that awardable in litigation.

Q9a) If yes, do you agree that the first significant payment should be made when avoidability can be established, which is on average when the child is around 4 years old?

As above, interim payments can be secured at a much earlier stage and often at a much higher level than this at present.

Q10) Do you think that periodical payments should be made "in-kind" through a personal budgets-type approach, administered by a case manager?

We require further detail as to what is meant by a "case manager" in this context. There are a lot of skillsets required in helping the families, one of which is the skill set of a case manager, but this is by no means the only one. There also needs to be access to a financial advisor, for example. A "case manager" in the normal sense will not be equipped with all of the skills to help the claimant and their family correctly handle their money to ensure that it meets all of their needs[8]. We are also concerned that those assigned as "case managers" to administer the scheme would be taking on this role as a bolt on to their existing responsibilities in, for example, occupational therapy. We stress again that if the NHS intends for this scheme to work, they must put the necessary resources into it to make it work. This includes recruiting dedicated people with the right skill sets to carry out the job properly, and giving them training and leadership status, to empower them.

Q10a) If not, do you think that they should be made as cash payments?

We are concerned that if cash payments were made, they would be given straight to parents, without the appropriate mechanisms and safeguards in place to ensure that the money is properly used to meet the needs of the injured child. When a large amount of money is awarded as a result of litigation, it must be administered by the Court of Protection, through a (usually professional) deputy. There is no mention of the need for a deputy within this consultation. Giving parents large amounts of money, without providing them with the support or knowledge about how to use the money to support their injured child will be disasterous. Additionally, we are concerned that if cash payments are made without any safeguards in place, existing benefits that the family are in receipt of will stop. Benefits given under the scheme should be protected.

Q11) Do you agree with the shift towards more staged (periodical) payments PPO?

There should not be a blanket move towards smaller lump sums and more periodical payments. What is right for one claimant will not necessarily be right for another. We query how the automatic 50/50 split between lump sum and periodical payments has been arrived at and can be justified. There needs to be access to legal advice, experts and independent financial advisors to decide, on a case by case basis what is the right mix between lump sum and periodical payment for the individual claimant.

[8] Case management can be specifically defined as an intervention to address the overall maintenance of the client's physical and social environment. While there are no professional qualifications specifically for case managers, it is best if individual case managers have either medical qualifications, for example nursing or occupational therapy, Social Services or other relevant backgrounds. It is important that the selected case manager has the necessary experience. A case manager's goals include facilitating physical survival, personal growth, encouraging community participation and assisting in recovery from or adapting to a disabling condition.

A blanket reduction in lump sum awards in favour of periodical payments will be wholly inappropriate where a person needs to adapt their existing home, or needs to move to a more suitable home. If more money is moved into periodical payments and away from the lump sum, people simply won't have the resources to do what is necessary to meet their child's needs.

We also disagree with the overall reduction of the compensation package by 10 per cent compared to the average court award. The amounts awarded at court have been carefully assessed as the necessary amounts needed in each individual case to meet the child's needs. Where there is an out of court settlement, there must be court approval of the award, to ensure that there is not undersettlement, and to ensure that the claimant's money is to be invested properly. There is simply no justification for reducing the amount awarded to these children by an arbitrary 10 per cent, and we cannot see how a court could approve this. There is, of course, no mention of court approval of awards built into the redress scheme.

The justifications for the 10 per cent reduction in damages – that there is alternative means of providing services to meet the reasonable needs of the claimant, and that there is an advantage to families in being able to access compensation without having to pursue the adversarial legal route[9] – are both extremely weak.

There are a number of reasons why there cannot be a reliance on state care to provide for victims of negligence. The families in these cases may be distrustful of the NHS and may not wish to obtain treatment from a Trust that has already let them down. Additionally, treatment or rehabilitation that the child requires may be unavailable or may only be available after a long wait due to stretched NHS resources.

Stating that there is an advantage in being able to access compensation without having to pursue the adversarial legal route is completely nonsensical if the threshold for stage two awards is the same as the threshold for existing claims for clinical negligence. We question why someone would choose to go down the rapid redress route, receiving a smaller amount of compensation in a similar timeframe to if they had gone down the litigation route. The only reason we can see that this would occur is if the family is not fully informed from the beginning about the implications of choosing "rapid redress" over the litigation route. It is likely that people will not be fully informed if they are not provided with independent legal advice from the outset.

Q12) Do you agree that there should be an ongoing needs assessment of provisions for the injured client?

It is a fiction to claim that the ongoing needs of the injured client are not taken into account when calculating damages in litigation. Awards are already carefully calculated at the outset to anticipate changes in the claimant's needs, and PPOs can be varied if required. This is a far preferable approach to continually re-assessing and re-opening the case at set stages. We assume that this would mean re-opening the whole case, and will require more legal representation, further involvement of independent financial advisors and other experts.

Q12a) If yes, at which ages should these reviews be – 5,12,18?

[9] Paragraph 2 of page 74 of the impact assessment

As above, we do not think that there should be rigid ongoing assessment.

Q12b) Any other comments on age intervals?

Q12c) Should families be able to trigger a needs assessment for their child, when services can be reviewed and care potentially adjusted (if found necessary)?

If one side is able to re-open a case (i.e. the NHSLA) then the families should also be able to re-open the case. As above, we do not believe it is necessary for the case to be re-opened as a hard and fast rule. If the Government wishes to press ahead with this proposal, we query what sort of advice and support will be available to the family at the point of re-assessment, to ensure that the needs of the child continue to be met.

Q13) Do you agree that NHSLA (or a new division within NHSLA) should administer the scheme?

We fundamentally disagree that the NHSLA or any new division within the NHSLA should administer the scheme. There is a direct conflict of interest here, with the NHSLA having an interest in more cases going through this scheme where damages will be less than if the case had gone through litigation. There are similar redress schemes operating internationally, but no other examples where the scheme is situated within the organisation which is also the defendant if the claim goes to litigation.

If this scheme is introduced, it must be completely independently administered and properly resourced. If the roles of administrator and case manager are given to consultants and NHS managers who already have their hands full, it will simply not work. New positions must be created, and people must be empowered in those positions, with status and authority, and there must be investment in IT.

Q14) Do you agree that the clinical eligibility into the scheme should be defined using the RCOG definition of avoidable brain injury?

The eligibility for stage one should be as wide as possible. It is welcome that eligibility into stage one of the scheme is triggered by the hospital and does not rely on the family realising something has gone wrong themselves.

We query the assertion that some people will be able to claim under stage two but bypass stage one. This surely means that compensation will be paid without learning having taken place.

Q15) Do you agree with the principle of administering the scheme using the avoidable harm test?

Q16) Do you prefer the proposed "experienced specialist" test (EST) or the "reasonable care" test (RCT)?

While there are many areas of the scheme, particularly at stage two, which require improvement, if the scheme is brought in we would prefer the proposed experienced specialist test as the threshold for stage two. The NHS should be leading the way on safety. There are a large number of cases that fall between just about reasonable care, but that could still have been avoided under optimal clinical practice. If these families can be given a

route to redress, this would be welcomed. Again, it is important that there is access to independent legal advice from the outset of stage one, to ensure that the family is able to make an informed choice about the right route to redress for them.

The scheme will be voluntary

We are concerned that although the scheme claims to be voluntary, without access to legal advice, people will not know how to choose the best option for them. It is absolutely vital that access to legal advice is provided from the outset. We are also extremely concerned that in a situation where a person has been provided with services under the rapid redress scheme, if the family then decides to pursue a legal claim, the services provided within the scheme will be withdrawn. Once in the scheme, the family will therefore be effectively held hostage, not wanting to risk what they have been given under the scheme, even if it is not sufficient to fully meet their child's needs. We question in any event how state care can be withdrawn from the family – this care should be available to the family whether they remain in the rapid redress scheme or not.

We would also be grateful for clarification as to how it is proposed that the family can go to court if they are unsatisfied with the decision of the eligibility panel, or for any other reason. If the family decides that they are satisfied with the package provided through the redress scheme, it is then implied that they cannot go to court. We question whether the family can finalise the award on their own, without legal advice and without the approval of the court (given that the claim involves a child and out of court settlements on behalf of a child must receive court approval).

Q17) Should the scheme be piloted?

It is vital that the scheme is piloted, and the feedback from the pilot analysed and taken into account before it is rolled out nationwide.

EVIDENCE

Evidence H – Information on impact on the clinical negligence market
Please provide any further data or evidence that you think would assist the Department in considering the proposal.

We are concerned that the scheme has not been thought through, and may even make claims more expensive. There is a lack of joined up thinking with existing schemes, for example the healthcare safety and investigation branch, as set out above.