

FREQUENTLY ASKED LEGAL AND INSURANCE QUESTIONS



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What is the difference between an admission of liability and an apology?

An admission of liability is an acceptance or acknowledgement that as a result of some negligent act or omission you are subject to pay damages to an injured party. Admissions of liability have no place in open disclosure.

An apology is defined by Section 68 of the Civil Liability Act 2002 as an expression of sympathy or regret, or of a general sense of benevolence or compassion, in connection with any matter whether or not the apology admits or implies an admission of fault in connection with the matter. An apology does not constitute an express or implied admission of fault or liability and is not admissible in any civil proceedings as evidence of fault or liability

Are there any restrictions on release of information during open disclosure?

The following restrictions prevent the release of information to the patient and their support person(s), in some circumstances:

Special Privilege under Section 23 of the Health Administration Act 1982

Clinical Reportable Incident Briefs (RIBs) prepared for the NSW Health Reportable Incident Review Committee are protected by statutory privilege. See Research and Investigation Authorised Under the Health Administration Act 1982 PD2006_058.

Statutory Privilege under Division 6C of the Health Administration Act 1982

Although a Root Cause Analysis (RCA) team's final report can and is routinely provided to interested parties, sometimes as part of the open disclosure process other working documents relating to an RCA investigation are privileged and cannot be disclosed. During the RCA process, the team will generate many documents including preliminary notes, records of interviews with staff/clinicians, minutes of discussions and records of discussions with various people either involved in the incident or with fundamental knowledge about the incident or processes involved. All of this material is privileged.

Statutory privilege does not cover documents that were not created for the purposes of the RCA, such as clinical incident summaries, medical records or other records created on providing general care of patients or management of the health service. The privilege does not cover the incident management system's advanced classification of the RCA reportable incident. See Incident Management Policy PD2014_004.

Client Legal Privilege

Client legal privilege can protect certain documents from being disclosed. Specifically, documents created, or communications made, for the dominant purpose of giving or receiving legal advice in relation to the incident or for use in legal proceedings and which remain confidential, will be subject to client legal privilege. This might include Coronial investigations and inquest hearings, Health Care Complaints Commission investigations, civil claims for compensation, and prosecutions before a disciplinary body.

Do documents created during open disclosure have any special status?

The answer to this is generally "no". However, this is subject to a claim for statutory privilege or client legal privilege. Save for any privileged communications, documents created during open disclosure should be treated in the same way as any other part of a patient's health care record. They should also be retained in accordance with the State Records Act and NSW Health policy.

Documents relating to open disclosure may be provided to patients on request, produced under Government Information (Public Access) Act 2009, or in answer to a subpoena.

Patients can also request access to records relating to them, and request amendments to their records, if the records contain incomplete or misleading information, pursuant to the Health Records and Information Privacy Act 2002.

As with clinical records, health care staff should take care when creating documents to ensure that they are accurate and do not contain inappropriate language. As far as is possible, only verified facts should be contained in documents. Documents should not:

- attribute blame to any health care team member or the health service
- contain information that is not fully informed, or statements that are emotive or emotional, ambiguous, unnecessary or which contain gratuitous or speculative comment
- contain statements which are likely to be defamatory (see below).

Although open disclosure documents will not be covered by client legal privilege, notifications of incidents to Treasury Managed Funds (TMF), professional indemnity insurers (PI Insurers), and medical defence organisations (MDOs) may be privileged and should not be provided to patients without first seeking legal advice.

In addition, documents created by a Root Cause Analysis (RCA) team for the purpose of a RCA investigation (other than the Final Report) have a special statutory privilege and cannot be provided to patients, health care staff or the general public. As noted above, the RCA Final Report can be provided to the patient and/or their support person(s).

What is a defamatory statement?

A defamatory statement is a communication (whether to one other person or to many) that insults or denigrates one person to another person, and that is capable of injuring a person's reputation. An example is an allegation by one clinician that another is incompetent.

Some ways of avoiding defamatory statements are to ensure that:

- statements are accurate and verifiable
- conclusions are based on the facts and follow logically, fairly and reasonably from the information obtained
- rumours or material known to be false or irrelevant are excluded
- the manner and extent of the disclosure do not exceed what is reasonably required for the purposes of open disclosure.

What is the Treasury Managed Fund?

The Treasury Managed Fund (TMF) is a NSW Government scheme used in place of regular insurance for most government entities, including NSW Health.

The NSW Self Insurance Corporation (SICorp) is the government division that operates the TMF.

TMF Health liability claims are managed by GIO, under contract to SICorp and on behalf of the Ministry of Health.

Does SICorp/TMF support the NSW Health Open Disclosure Policy?

SICorp/TMF recognises that open disclosure is an integral part of incident management in NSW Health, and is a key element of early response and investigation of serious patient safety incidents. SICorp/TMF supports the planned and coordinated approach to open disclosure as outlined in NSW Health's Open Disclosure Policy and this Handbook.

When a formal open disclosure response is being considered, the patient safety incident should be notified to GIO in accordance with TMF incident notification procedures.

What does TMF cover?

- a. Health liability claims, including awards, legal fees and associated expenses in the defence or settlement of claims for compensation made against a Local Health District/Specialty Network
- b. Visiting Medical Officers (VMO), Honorary Medical Officers (HMO) and Staff Specialists exercising rights of private practice are provided with cover as a separate self-contained arrangement within the TMF, including cover for legal liabilities arising from health care claims made in the treatment of public and private patients in public hospitals. TMF coverage is detailed in the TMF Statement of Cover⁴⁰.

The TMF does not cover legal advice for participating in open disclosure unless a claim has been formalised.

40. NSW Treasury Self Insurance Corporation <https://riskinsite.nsw.gov.au/portal/server.pt/community/Publications/272>

TMF cover is not provided for:

- Legal representation, legal and other costs or penalties arising out of disciplinary proceedings, criminal proceedings and any other similar actions or inquiries against an individual clinician such as those taken by the Medical Board, Health Care Complaints Commission and other disciplinary tribunals
- Legal representation or legal advice for Coronial inquests except for those matters where a claim is likely
- VMO legal representation or legal advice for Coronial inquests

Legal and insurance queries should be coordinated through the LHD/SN's manager responsible for insurable risk.

Whom should I contact for assistance?

If you are a clinician with private insurance cover, you should contact your professional indemnity insurer, medical defence organisation (MDO) or Treasury Managed Funds (TMF), for assistance with insurance or legal issues.

If you are a manager responsible for insurable risk, a Senior Manager or Director of Clinical Governance in a health service, you can contact the following:

- Insurance issues: NSW Ministry of Health Finance Branch/Treasury Managed Funds.
- Legal issues: NSW Ministry of Health Legal Branch.

Medical Defence Organisations provide an advisory service which can be accessed by members requiring assistance with participating in open disclosure processes.

The Clinical Excellence Commission is committed to providing support for clinicians and managers in relation to open disclosure. Locally, practical advice may also be available from the open disclosure advisors.

All practitioners should be aware of the need to notify the TMF or their professional indemnity insurer in accordance with that organisation's requirements for timely notification of incidents.

I am a privately insured clinician. When should I notify my MDO, professional indemnity insurer and the TMF?

Your insurance policy or Contract of Liability Cover will set out when you must notify your MDO/PI insurer and the TMF of an incident. If the incident is a notifiable incident under your insurance policy and/or Contract of Liability Cover, you should notify your insurer and/or the TMF as soon as possible after the incident.

I am a privately insured clinician. How can I ensure I do not jeopardise my insurance coverage and/or indemnity under a contract of liability cover by participating in open disclosure?

Early telephone contact with your MDO/PI insurer is the best way to obtain reassurance about how you can participate without jeopardising your insurance cover for the incident.

Generally, professional indemnity insurers, TMF and MDOs are supportive of open disclosure. However, care should be taken not to admit liability (and such an admission has no place in the open disclosure process) as this may fall within an exclusion clause of your insurance policy or contract. Such an admission may potentially have a negative impact on your insurer's decision to indemnify you or provide you with legal representation or assistance in relation to any Court or other proceedings arising from the incident. Any decision about admitting breach of duty of care or liability should be left to your professional indemnity insurer, TMF and MDO in the context of a claim for compensation by the patient.

How should open disclosure be managed when more than one indemnity provider (i.e. TMF and a MDO) is involved?

If necessary, representatives from professional indemnity organisations e.g. a MDO and TMF will liaise to ensure that the information provided to the patient and/or their support person(s) as part of open disclosure does not jeopardise the insurance cover of any of the clinicians involved in the incident.

What if an insurance claim is lodged during the open disclosure process?

Open disclosure must be managed to completion irrespective of other circumstances occurring at the same time. It is recommended that insurers are notified that open disclosure has occurred and whether any issues were raised during that process that may impact on any real or potential insurance claim. In the public health setting, this would often be the responsibility of the manager responsible for insurable risk, who would send the information to the Treasury Managed Fund (TMF) on behalf of the clinician(s).

Communicating with patients and/or their support people

What are we able to say to the patient and/or their support person(s) when an individual health care team member is being investigated as a result of the incident?

As part of the formal open disclosure discussion, the patient and/or their support person(s) should be informed that the health service is conducting a full review into the circumstances of the patient safety incident.

This review may cover a number of aspects and may include a Root Cause Analysis (RCA) investigation. An RCA will focus on any systems issues that contributed to the incident. The investigation of an individual's performance or competence is not within the scope of the RCA investigation team. The Report from the RCA can be provided to the patient and/or their family.

The patient and/or their support person can be informed that one aspect of any incident review is to consider whether or not further investigations into an individual clinician's performance are indicated. The management of complaints or concerns about an individual clinician is a formal process managed locally. It is important to emphasise that the performance assessment process is confidential to enable proper and fair processes to be followed.

Only after the completion of local processes can it be determined whether there is a need for the Local Health District/Specialty Network to make a formal complaint to the Health Care Complaints Commission (HCCC) or a notification to the Australian Health Practitioners Regulation Agency (AHPRA) into the performance, conduct or competence of a clinician. The hospital is legally unable to provide a copy of any report on an investigation into an individual clinician's performance nor any specific details of the investigation or its outcome without the consent of the clinician/s involved.

What about privacy and confidentiality?

Strict confidentiality requirements apply to persons working in the health system. These confidentiality requirements apply generally to patient information, including information gathered as part of open disclosure.

Health services and all health care staff also have an obligation to respect the privacy of both staff and patients during open disclosure. Open disclosure discussions should be conducted in accordance with the Health Records and Information Privacy Act 2002 and the NSW Health Privacy Manual (Version2).

Section 22 of the Health Administration Act 1982 and Section 289 of the Mental Health Act 1990 create offences for wrongful disclosure of confidential information.

Can a patient have two support people, and what happens if there is conflict between the support people?

For practical reasons, patients should nominate only one support person. However, in the circumstance where a patient nominates more than one support person, that is acceptable wherever feasible. Common sense should prevail with regards to the actual number of support people. If a conflict arises between the support people as to how open disclosure will progress, this should be managed using strategies such as repeat discussion, mediation, and counselling.

What about young people?

Whilst young people may elect to have a parent(s) as a support person(s), if they are competent to make medical decisions (as well as decisions in relation to open disclosure) for themselves, the consent or participation of the young person's parent is not legally required. If there are any concerns regarding consent see Section 26 of Consent to Medical Treatment – Patient Information PD2005_406 for further information.

What happens if the support person is not the patient's guardian, or 'person responsible'?

Sometimes a patient may have a legal guardian or 'person responsible', but does not elect to engage that person in the open disclosure process. In these cases, open disclosure should take place with the involvement of the support person(s), however, discussions relating to further treatment must involve the person who has the legal capacity to make treatment decisions on behalf of the patient.

What if a patient and/or their support person(s) want to record the discussion?

Patients and/or their support person may wish to record the discussion for a range of reasons. Recording of the discussion is not common practice because of concerns that it may impede the free flow of information. Open disclosure depends on the flow of open discussion for its success.

Many organisations have established alternative practices, including offering to provide the patient and/or their support person with a copy of the record of the open disclosure discussion for them to review and comment on. This may be helpful in allaying concerns about the accuracy of what was discussed and agreed upon.

If the patient and/or their support person continue to request that the discussion be recorded, inform them that everyone involved has to agree to the recording first and without that consent, the open disclosure discussion is not able to proceed.

Where the patient or support persons insist on recording the discussions, the senior team member should assess and manage the associated risks, including personal, organisational and reputation risks, as best as possible.

What to notify to the Professional Indemnity Organisations

This section has been provided as consolidated generic information from participating professional indemnity organisations. Irrespective of the degree of harm caused to the patient, clinician disclosure with the patient and/or their support person(s) should commence as soon as possible, and at the latest generally within 24 hours of identification of the patient safety incident by the health service.

If you are required to participate in formal open disclosure it is always advisable to seek advice from your indemnity organisation beforehand. Written notification of the incident may be requested by the medico-legal advisor for insurance purposes.

Without limiting the scope of the general guidance above, incidents that definitely require notification to your professional indemnity organisation include:

- > **Inappropriate or incorrect medication** or dosage leading to a serious outcome
- > **Failure to diagnose** where, in the circumstances, it would have been reasonable to diagnose a serious condition, but having failed to do so, you learn later that the condition existed at the time – for example breast cancer, other cancer, meningitis, acute abdomen, fracture, myocardial infarction, subarachnoid haemorrhage, obviously missed pathological or radiological diagnosis such as foetal abnormality
- > **Any major surgical complication** such as neurological impairment, paraplegia, incontinence, organ perforation, sexual dysfunction, nerve injury, blindness, loss of extremity or death
- > **A clear error** such as operating on the wrong site or the wrong level
- > **Any major unanticipated foetal damage** such as neurological injury, Erb's palsy or death
- > **An unanticipated death** if death was not a likely possibility of the patient's disease
- > **Foreign bodies** left within the patient
- > **A patient safety incident** that has resulted in significant anger in the patient or a relative
- > **Significant patient dissatisfaction** with the results or elective procedures such as cosmetic surgery or laser eye surgery
- > **Conflict** between patient/family and health care facility staff
- > **Patient** complaint relating to a serious incident

Indemnity organisations appreciate that clinician disclosure – the initial explanation and apology for a patient safety incident – often occurs spontaneously in circumstances where it would be impractical to provide prior notification. However, the guiding principle should be if in doubt, notify and this principle should certainly apply where planned formal open disclosure is to be undertaken.