



Gníomhaireacht Bainistíochta an Chisteáin Náisiúnta
National Treasury Management Agency

An Ghníomhaireacht um Éilimh ar an Stát
State Claims Agency

Clinical Risk Unit & Snapshot Insights

Presenter:

Dr Cathal O’Keeffe,
Deputy Director - Head of Clinical Risk

30 April 2026



Clinical Risk Unit & Snapshot Insights – Agenda

State Claims Agency's risk mandate

Clinical Risk Unit updates

Snapshot insights from claims and incident analysis

Learning from claim case study



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About Clinical Risk Unit & updates



Our services

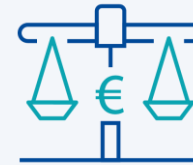
We provide a number of **specialist services** to State Authorities, in line with our mandate.



Claims
Resolution



Risk
Management



Legal Costs
Management

The SCA's Statutory Risk Management Mandate

NTMA (Amendment) Act, 2000, Section 8(4)

The Act sets out that the SCA shall advise and assist a State Authority whenever it considers it appropriate to do so for the purpose of reducing risks that may occasion claims. Such advice may include:

- the **provision of information, instruction and training** for the purposes of identifying and taking appropriate measure to counter such risks
- the **assessment of any such risk**, including the determination of whether it could give rise to a serious hazard
- the **evaluation of the adequacy of the measures adopted by such an authority** to counter any such risk
- the provision to such an authority of **safety audits, inspections and reviews**

Delivering our mandate through State indemnity schemes

Two State Indemnity Schemes operated by the State Claims Agency:

General Indemnity Scheme



- State indemnity is provided to State Authorities for injuries to people, such as staff members, members of the public, or service users which was the result of negligence on the part of the State Authority, its servants and/or agents, other than the delivery of professional medical services
- Also provides indemnity to third-parties for damage to their property, where a State Authority has been negligent

Clinical Indemnity Scheme



- State indemnity is provided to State Authorities in respect of the provision of professional medical services

Statutory requirement

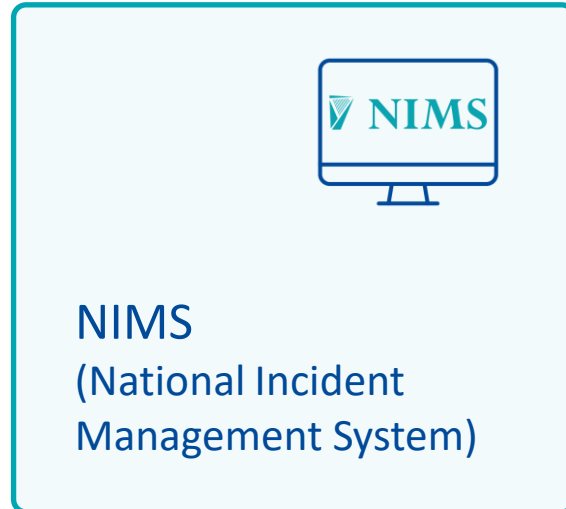
Under Section 11 NTMA (Amendment) Act 2000, State authorities must:

Report adverse incidents/claims to the State Claims Agency

Furnish all necessary and requested information and documentation to the State Claims Agency

Permit and assist the State Claims Agency to investigate adverse incidents/claims

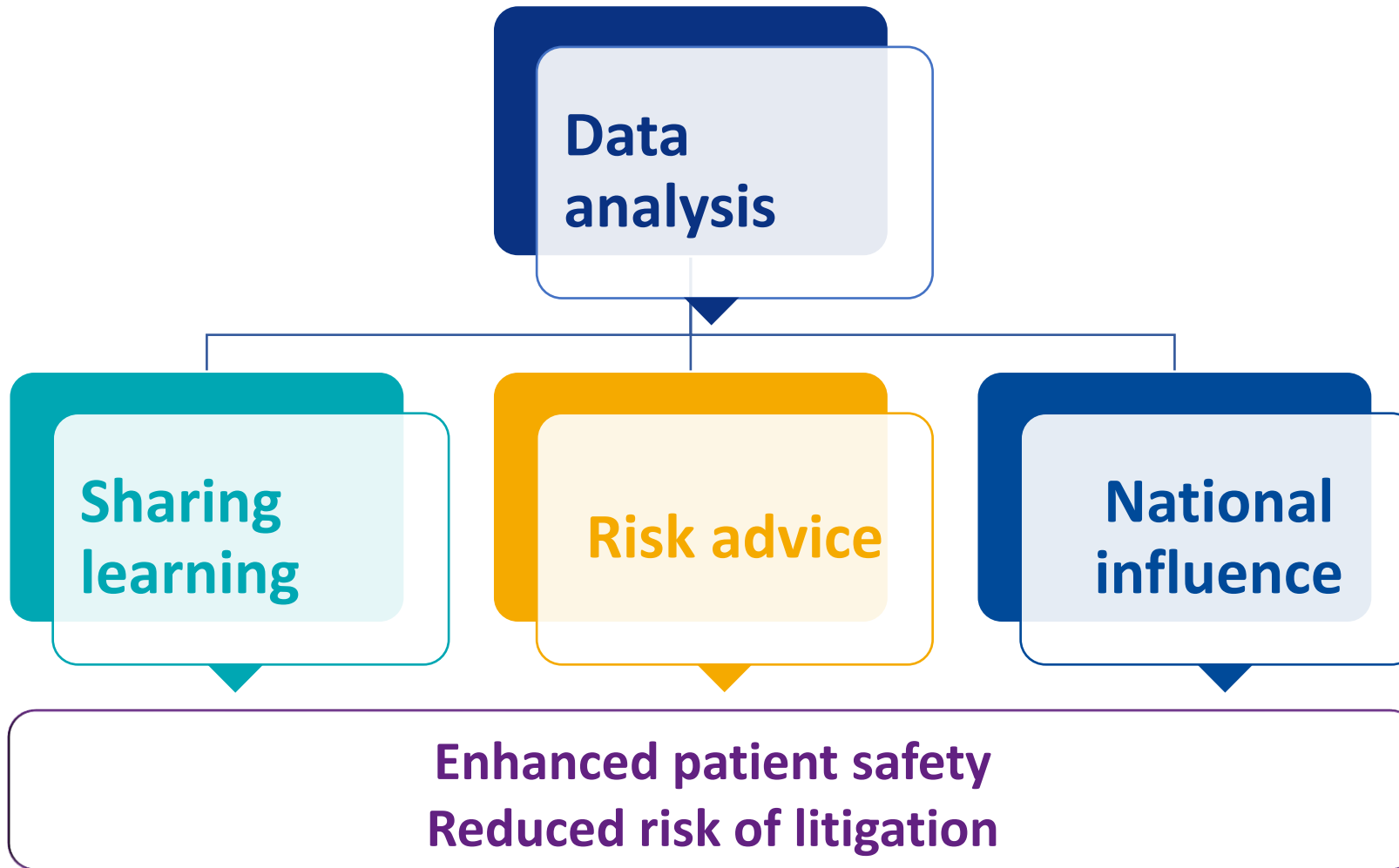
NIMS – the National Incident Management System



- A confidential national end-to-end incident, risk and claims management platform
- System used by State authorities to fulfil the statutory requirement to report incidents to the State Claims Agency and for their own incident and risk management purposes

Safety and insights. Powered by data.

Clinical Risk Unit: how we use the data



Clinical Risk Unit: engagement with services

- ✓ Incident data analysis
- ✓ Closed claim data analysis
- ✓ CLAIM initiative
- ✓ Patient Safety Notifications
- ✓ Educational resources
- ✓ Conference & webinars

C.L.A.I.M Project: Claims, Learning, Actions, Implementation, & Monitoring

Our Aim

Continuous feedback to hospitals in relation to concluded claims* in order to share learning and seek assurance about risk mitigation.

What do you need to do?

- ✓ Liaise with State Claims Agency Clinical Risk Advisor/Manager
- ✓ Consider/analyse any learning from the claim internally
- ✓ Provide assurance to State Claims Agency about measures taken to prevent reoccurrence

*High value claims and those where there was a serious outcome for the patient



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Overview (2024 – 2025)

48 letters issued
to **28** hospital/services

Most common specialties involved:

- surgery
- emergency medicine
- obstetrics and gynaecology

What's new: Clinical Risk Insights newsletter (issue 10)



- Clinical Risk Insights is the regular newsletter issued by the Clinical Risk Unit
- Each edition includes articles on managing clinical risk, information on upcoming webinars and events, and notifications of any updates to NIMS
- Issue 10 is now available on our website www.stateclaims.ie



What's new: Claim review report - Claims relating to Emergency Departments

Claims relating to Emergency Departments
Claims Review Report

The State Claims Agency completed a five-year review of claims related to the care of patients in emergency departments (EDs) nationally. The aim of this report is to present the key findings of that review and provide advice for healthcare staff to help mitigate the risk of similar claims occurring.

This review included claims taken by patients, or their family members, related to the clinical care of those patients, and claims taken by patients related to non-clinical issues (e.g., slips trips and falls due to state of premises). Claims concluded and finalised, and where damages had been paid, from 2018-2022, inclusive, were included. Claims where the incident resulting in the claim occurred before 2017 were excluded.

Claim files related to the care of 61 patients were reviewed; in 55 cases, the claims were related to the direct provision of clinical care, and, in 6 cases, they were not related to the provision of care.

Review of Claims - A Snapshot

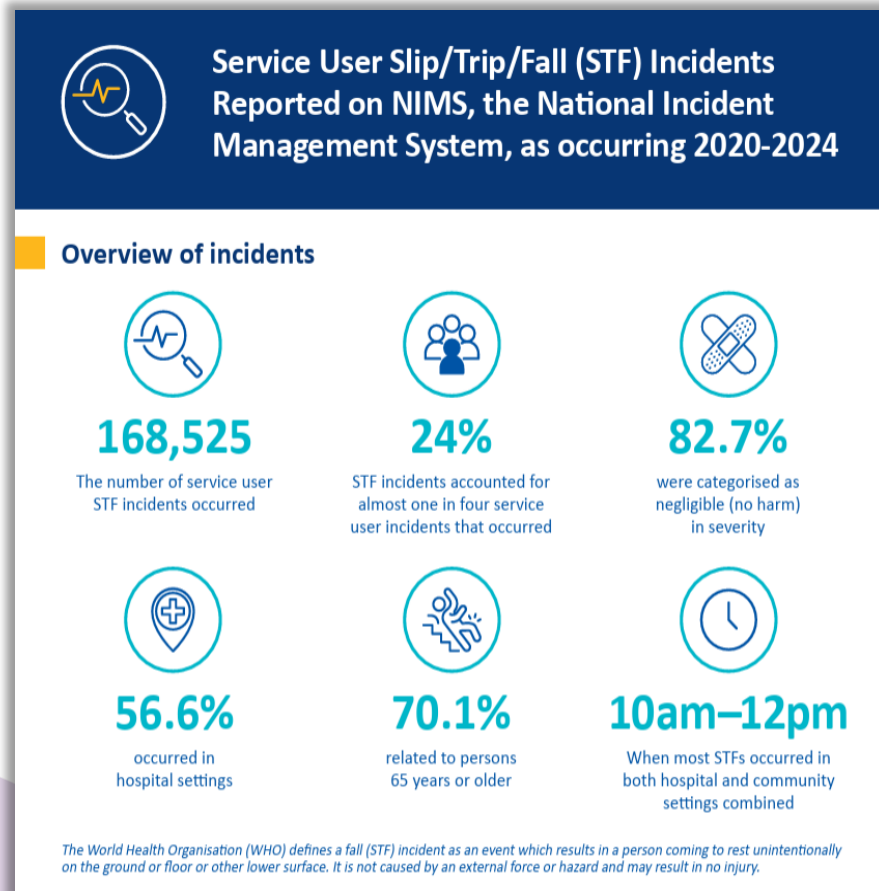
- The paid damages for all 67* claims amounted to €11,242,277: almost half (45%) of the claims resulted in paid damages of less than €50,000; in 93% of claims, the paid damages were less than €500,000.
- In 48% (n=29) of cases, the patient re-presented to an ED at least once with the same issue.
- 31% (n=19) of cases involved delays seeing a doctor post-triage. Of these, seven breached Manchester triage category 2 and twelve breached Manchester triage category 3 (Table 1).
- Diagnostic error featured as both the most common NIMS 'sub-hazard', and the most common cause of claims on qualitative analysis.
- In 21% (n=13) of cases, the patient deteriorated while waiting to see a clinician.
- After 'Other', which is typically selected if there is more than one injury, the most common NIMS 'Type of Injury' was 'Fracture' (n=13).
- The service of Emergency Medicine accounted for most claims; claims also occurred under the services of Medicine, Surgery, Mental Health, Radiology, and Maternity (non-obstetric).

*n=67, which includes claims taken by patients and claims taken by family members (dependents) in relation to the death of a patient

- The review included claims taken by patients, or their family members, related to the clinical care of those patients, and claims taken by patients related to non-clinical issues (e.g., slips trips and falls due to state of premises).
- Claims concluded and finalised, and where damages had been paid, from 2018-2022, inclusive, were included. Claims where the incident resulting in the claim occurred before 2017 were excluded.



What's new: Infographic on learning from service user slips/trips/falls



- In line with our statutory risk management mandate the Clinical Risk Unit completed an analysis of **slip, trip & falls incidents reported on NIMS** between 2020 – 2024
- This infographic shares **national data on reported service user slip, trip & falls incidents** and provides **learning opportunities** for health and social care services





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Snapshot insights from incidents and claims



Clinical Risk Snapshots: Focus on medication - vancomycin



- Vancomycin is a glycopeptide antibiotic which is active against methicillin resistant *Staphylococcus aureus* (MRSA). It has been designated as a high-risk (high-alert) medication by the World Health Organization (WHO).
- Analysis of NIMS data shows that incidents related to vancomycin occur across during **prescribing, administration and monitoring**.

Example of incident reported on NIMS

Patient started on a loading dose of vancomycin 2g IV. Dose infused over 1 hour. Patient developed a new rash, likely Red Man Syndrome. Treated with chlorphenamine 10mg IV stat.

Clinical Risk Snapshots: Focus on medication - Vancomycin

Key take home advice

- ✓ The intravenous dose should be **calculated in mg/Kg**. The initial dose should be based on total body weight. Subsequent doses should be based on serum concentrations and take account of renal function.
- ✓ In patients with impaired renal function or renal failure, local guidelines should be consulted, or expert advice sought
- ✓ Prescribers should **provide the actual dose required** rather than stating the dose in mg/Kg
- ✓ Vancomycin should be **administered as a slow intravenous infusion** of at least one hour or at a maximum rate of 10mg/min³



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Learning from claim case study: Missed chest lesions on CT imaging



Patient

A patient in their sixties presented to the Emergency Department (ED) with spiking temperatures, a persistent cough, and mild dyspnoea.





Investigations

CT scan of the thorax, abdomen, and pelvis (CT TAP) was reported as normal apart from emphysematous changes in the lungs.



The patient was discharged home with treatment for a chest infection.

Second presentation

A few years later, the patient became generally unwell and was admitted for investigation. A CT TAP showed a large peri-hilar lung neoplasm with truncation of the bronchus.

A healthcare professional, likely a nurse or doctor, is shown in a hospital setting. She is wearing blue scrubs, a red stethoscope, and glasses. She is looking at a computer monitor and has her hands on a mouse. The background is slightly blurred, showing other people in a clinical environment.

The patient was diagnosed with metastatic lung cancer and bone metastases.

What did the experts say?

Expert opinion concluded that the lung nodule was evident on the initial CT scan. Nodules like this are at higher risk of being overlooked as they are often difficult to distinguish from adjacent mediastinal structures.



The clinical picture would have lowered the reporting radiologist's index of suspicion for lung nodules, as the primary concern was the identification of a source for the patient's fever.



Further reading: missed chest lesions on CT imaging



ARTICLE

10 Mar 2026

Missed chest lesions on CT imaging

Read Time: 3 min

[Read More](#)

Learn more about biases that can impair detection of significant abnormalities in imaging in an article by **Dr John Bruzzi, FFRRCSI Consultant Radiologist, Galway University Hospital**



Dr John Bruzzi

Consultant Radiologist,
Galway University Hospital





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Clinical Indemnity and Frequently Asked Questions

Presenter:

Clíodhna Grady,
Senior Clinical Risk Manager

30 April 2026



Clinical Indemnity and FAQs - Agenda

How clinical indemnity works

Who and what is covered by the Clinical Indemnity Scheme

Clinical indemnity FAQs



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Clinical Indemnity Scheme



Delivering our mandate through State Indemnity Schemes

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Clinical Indemnity Scheme



- State indemnity is provided to State Authorities in respect of the provision of **professional medical services**

How does clinical indemnity work?

Enterprise liability operates on the basis that the State authority assumes liability for the acts and omissions of its employees providing **professional medical services.**

When a claim is made against a State authority, the State authority remains the legal defendant.

The SCA manages and resolves the claim on the State authority's behalf, in line with its statutory mandate.

What does professional medical services mean?

Professional medical services means —

- a. services provided by registered medical practitioners or registered dentists of a diagnostic or palliative nature, or consisting of the provision of treatment, or the conduct of research in respect of any illness, disease, injury or other medical condition (as amended by S.I. No. 628 of 2007),
- b. services provided by health professionals including but not limited to nurses, midwives, pharmacists, paramedics, ambulance personnel, laboratory technicians in the performance of their duties, or
- c. services connected with the provision of health or medical care provided by persons acting under the direction of a person to whom paragraph (a) or (b) applies.

Relevant legislation is S.I. No. 63/2003 – National Treasury Management Agency
(Delegation of Functions) Order 2003 Section 2



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Clinical Indemnity Scheme – what is covered?



Covered

- **Professional medical services** provided in public hospitals, clinics and healthcare facilities
- Clinical care during transfer of patients
- Representation at Coroners' Inquests
- Good Samaritan Acts within the island of Ireland

Principle of “enterprise liability” applies – the health and social care service assumes vicarious liability for the acts and omissions of its employees providing professional medical services.



Not Covered

- Private hospitals
- Private practice in private settings
- Disciplinary hearings
- Criminal cases
- GPs

NB: Supplementary professional/indemnity insurance required

Good Samaritan Acts explained



- The Clinical Indemnity Scheme covers personal injury claims against staff employed by agencies, covered by the Scheme, who provide care or treatment in emergencies within the island of Ireland
- Good Samaritan Acts outside the island of Ireland are not covered
- The above cover does not extend to informal non-emergency diagnosis, treatment or prescribing for families, friends, colleagues, or sporting clubs other than in the context of a formal attendance for treatment at an agency covered by the Scheme

Obligations of State indemnity

Under Section 11 NTMA (Amendment) Act 2000, State Authorities must:

Report adverse incidents / claims to the State Claims Agency

Furnish all necessary and requested information and documentation to the State Claims Agency

Permit and assist the State Claims Agency to investigate adverse incidents/claims



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Clinical indemnity FAQs



Clinical indemnity query:

Are consultants covered by the Clinical Indemnity Scheme if they perform un-rostered overtime at weekends to complete clinical work which they were unable to complete during normal working hours?

Yes, consultants undertaking un-rostered overtime to catch up on clinical work are covered by the Clinical Indemnity Scheme in these circumstances. The indemnity is provided on an "Enterprise Liability" basis. This offers indemnity for the acts or omissions of the State authority's practitioners, provided the practitioners are acting with the authority and consent of the State authority.

The relevant legislation is Statutory Instrument (S.I.) 63/2003 – National Treasury Management Agency (Delegation of Functions) Order 2003 and S.I. 628/2007 National Treasury Management Agency (Delegation of Functions) (Amendment) Order 2007.

Clinical indemnity query:

Are HSE healthcare staff responding in their workplace to medical emergencies involving individuals who are not HSE service users, such as visitors or passersby, covered as ‘Good Samaritans’ under the Clinical Indemnity Scheme in these cases?

Yes. HSE staff are covered by the Clinical Indemnity Scheme when responding as “Good Samaritans” in such cases. The Clinical Indemnity Scheme covers personal injury claims against staff employed by agencies, covered by the scheme, who provide care or treatment in emergencies within the island of Ireland. Good Samaritan Acts outside the island of Ireland are not covered.

The above cover does not extend to informal non-emergency diagnosis, treatment or prescribing for families, friends, colleagues, or sporting clubs other than in the context of a formal attendance for treatment at an agency covered by the scheme.

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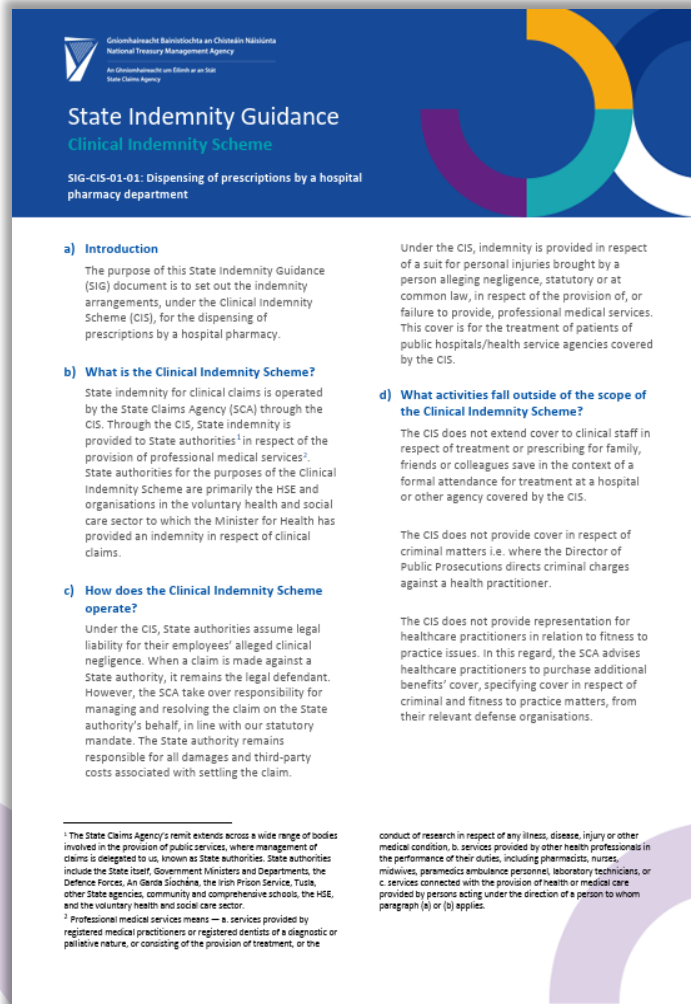
Clinical indemnity query:

If a doctor does not reference the Civil Liability (Amendment) Act, 2017, in their correspondence with a patient or their family regarding an open disclosure meeting, would this omission affect the professional indemnity provided by the Clinical Indemnity Scheme for that doctor in relation to any claim arising from the care and treatment they delivered?

If open disclosure is not carried out in accordance with the requirements of the Act, Clinical Indemnity Scheme cover remains in place. This means that, should medical negligence be alleged, the Clinical Indemnity Scheme will manage any subsequent claim.

The relevant legislation is Statutory Instrument (S.I.) 63/2003 – National Treasury Management Agency (Delegation of Functions) Order 2003 and S.I. 628/2007 National Treasury Management Agency (Delegation of Functions) (Amendment) Order 2007.

New State Indemnity Guidance: dispensing of prescriptions by a hospital pharmacy department



Key Messages for hospital pharmacists

- Dispensing of outpatient prescriptions issued by the hospital's clinicians for patients under the care of the hospital are covered by CIS
- The dispensing of prescriptions written by clinicians not associated with the hospital, provided the patient is under the care of the hospital are covered by CIS
- Dispensing of staff prescriptions generated by clinicians not associated with the hospital, for staff members who are not under the care of the hospital are **not covered** by CIS





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Spotlight on Service User Slips, Trips, and Falls (STF)

Presenters:

Irene O'Byrne Maguire, Clinical Risk Advisor

Wayne Meehan, Clinical Risk Advisor

30 April 2026



Agenda

Background

Overview of service user STF incidents reported on NIMS (2020 - 2024)

Learning from claims case studies

Advice to frontline staff to help reduce harmful slips, trips, falls in health and social care



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Service user slips, trips and falls (STF): Background and definition

Definition: Fall

‘The World Health Organisation (WHO) **defines a fall** as an event which results in a person coming to rest **unintentionally** on the ground or floor, or another lower surface.

It is not caused by an external force or hazard and may result in no injury.

WHO (2021). Falls fact sheet

Background

- Globally the WHO classify falls as a major public health problem that may result in the requirement for medical attention, pro-longed hospital stay, disability, or fatality.
- The National Major Trauma Audit reports that low falls (falls from less than 2 metres height) continue to be the leading cause of major trauma in Ireland, at 61% of all major trauma cases, often resulting in life-changing or life-threatening injuries.
- In UK hospitals, inpatient falls are the most common safety incident reported, with around a third resulting in physical injuries, and higher harm rates noted in patients aged 65 or over
- Falling is a cause of distress, pain, injury, loss of confidence, loss of independence and mortality.



Reporting of service user 'STF' incidents on NIMS



- Incident reporting affords health and social care services the opportunity to learn from adverse incidents.
- Publicly funded health and social care services have a statutory obligation to report incidents to the State Claims Agency on NIMS, including those involving slips/trips/falls (STFs)
- The SCA reviews incident and claims data to **foster, promote and disseminate learning**, in line with our statutory risk management mandate.

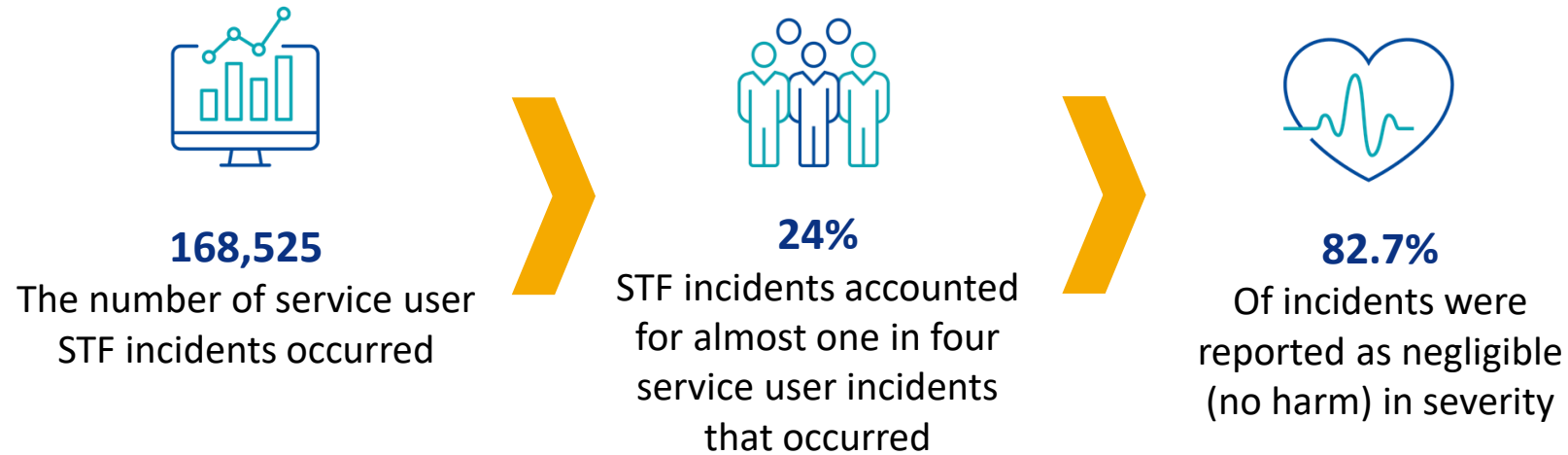


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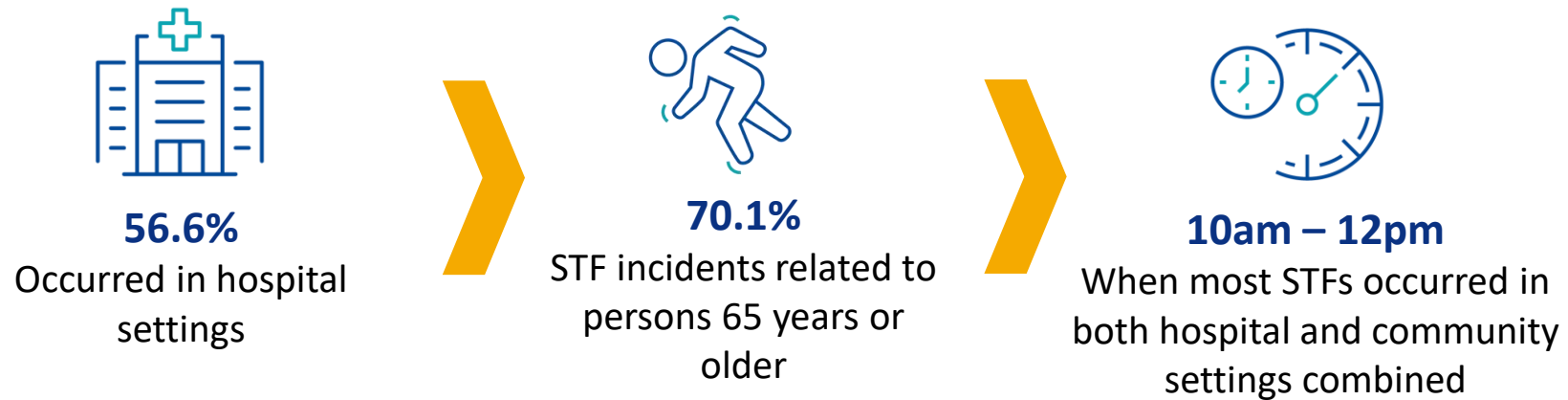
Overview of service user slip, trip and fall incidents reported on NIMS (2020 - 2024)

Overview of service user STF incidents reported on NIMS by 'date of incident' for 5 years, 2020 – 2024 inclusive



*Date of incident is the date the incident happened/occurred in the service reporting the incident

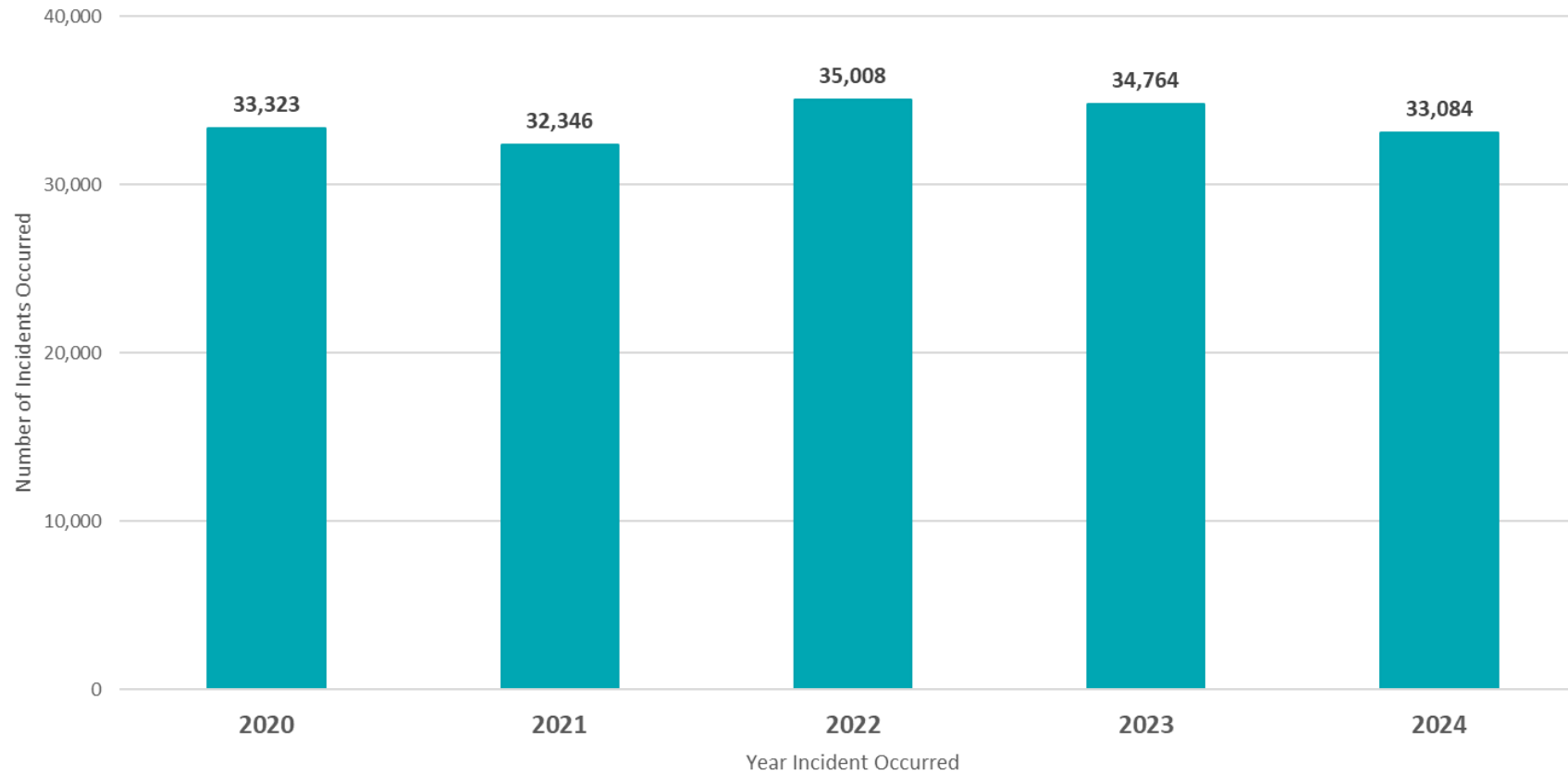
Overview of service user STF incidents reported on NIMS by 'date of incident' for 5 years, 2020 – 2024 inclusive



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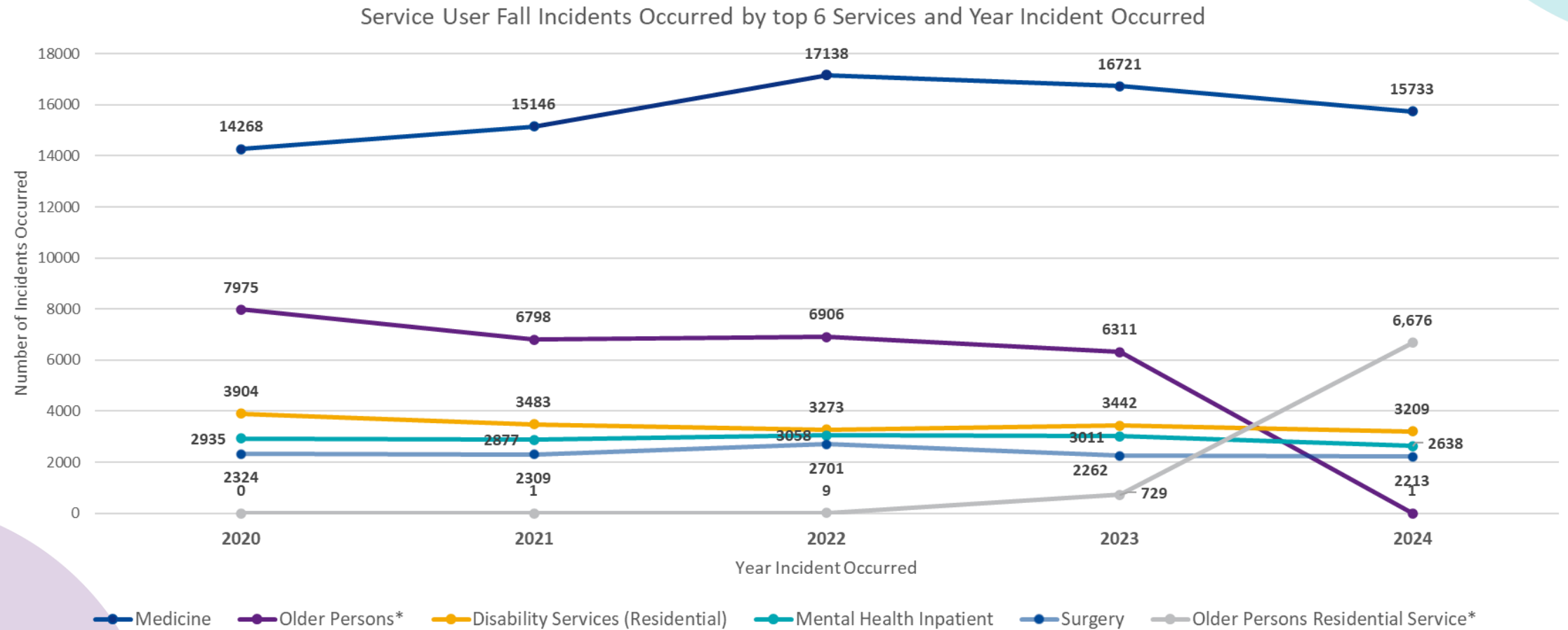
Service user STF incidents in detail:

Service user STF incidents by year incident occurred



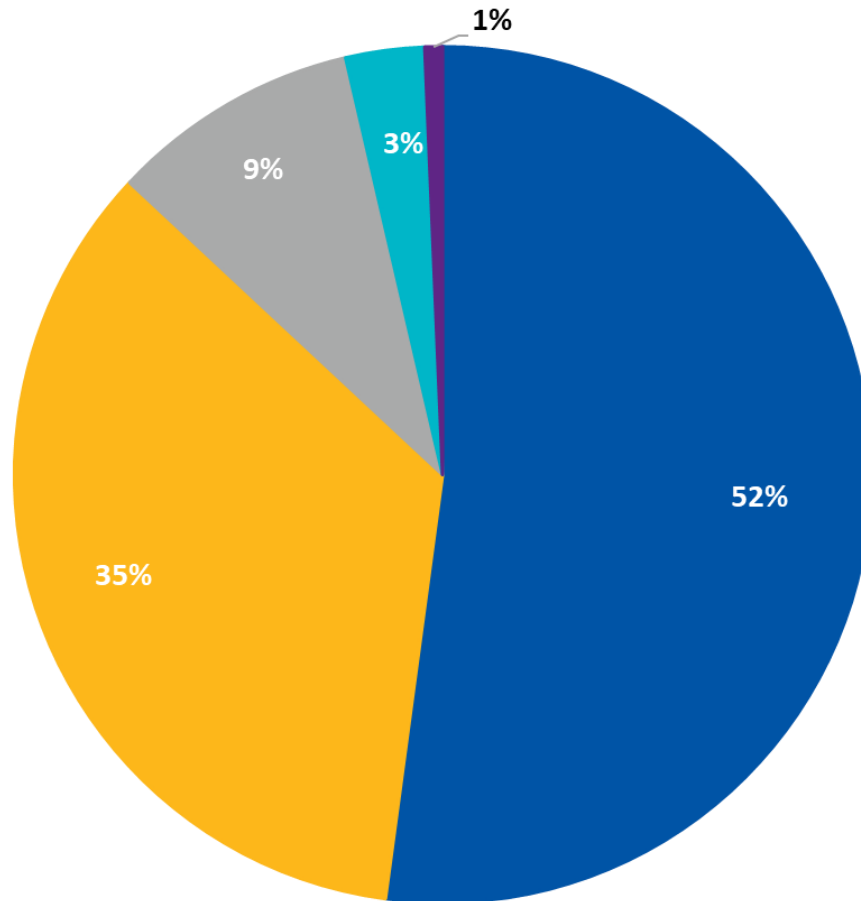
What services are reporting STF incidents?

Top service categories selected on NIMS for STF incidents and year incident occurred



* "Older Persons Residential Service" was introduced as a new NIMS category from January 2021. This helps explain the respective increases and decreases seen in the figures of the "Older Person" services.

In what circumstances are reported STF incidents happening? Top 5 STF 'sub-hazard' categories selected on NIMS



When injuries were reported they most frequently involved the head, accounting for 40.7% of these incidents

Top 5 causes of STF incidents reported on NIMS

Unknown

e.g. Pt found lying on the ground, often unwitnessed, mobilising with/without supervision.

Pre-Existing Medical Condition

e.g. acute/chronic cardiac/respiratory/musculoskeletal condition(s), sudden deterioration, cognitive impairment, cancer, pain.

Inadequate supervision general health care

e.g. un/under supervised, unwitnessed, loss of balance/consciousness/orientation, falls history, visual impairment, deterioration.

Inappropriate use of equipment

e.g. mobilising with/without aid, hoist sling/brakes secured incorrectly, climb over bedrail/fall over catheter tube/chair leg.

Obstruction/protruding object

e.g. trip over furniture/bed or loose cloths/loose footwear/foot pedal/flex/mat/wheelchair tipped passing around a blockage in their way.



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Learning from claim case studies

Learning from claims case study: Postoperative fall after revision of below-knee amputation

Vignette

A patient in their 40's was admitted for elective revision surgery of a below-knee amputation. The original amputation had been performed due to complications of long-standing diabetes mellitus, including peripheral vascular disease and diabetic neuropathy.

The patient underwent a scheduled revision of the below-knee amputation without any intraoperative complications and was transferred to a ward for routine recovery, monitoring, and rehabilitation.

Early postoperative observations were within acceptable parameters, and the patient commenced mobilisation as part of standard postoperative care. The patient attempted to mobilise independently to use the shower. While mobilising in the shower, the patient sustained a fall and was subsequently found on the floor by a nurse after an unspecified period of time.

As a result of the fall, the patient sustained injuries to the cervical and lumbar spine. These injuries required further medical assessment, management, and monitoring, leading to a prolonged inpatient stay.

Learning from claims case study: Postoperative fall following revision of below-knee amputation

Learnings

- The patient was initially assessed as at low risk of falls. However, postoperative patients have an elevated and evolving falls risk, therefore, falls risk should be reassessed following surgery and before independent mobilisation.
- The fall occurred in the context of several recognised risk factors which are all indications that this patient was at high risk of a harmful fall.
- Mobilisation to and within high-risk areas such as bathrooms and showers should be supervised or supported, particularly in the early postoperative phase.
- Clear instructions should be given to patients regarding the need to seek assistance with mobilisation, especially in unfamiliar environments or during activities requiring balance e.g. bathing, dressing etc.
- Of note there was no documentation of any verbal instructions being given in this case.

Learning from claims case study: Fall following sedated endoscopic procedure

Vignette

A patient in their 70s attended hospital for an elective endoscopic procedure planned as a day case.

During the procedure, the patient was administered 3 milligrams of midazolam, which is within accepted dosing parameters for procedural sedation in older adults. The procedure itself was completed without immediate complications.

Following the procedure, the patient was transferred to the recovery area for routine post-sedation monitoring. Whilst in recovery, the patient bent forward to retrieve their shoes. During this movement, they lost their balance and fell sideways.

The fall resulted in two spinal fractures, requiring further medical evaluation and management, and converting what had been planned as a day-case procedure into a more complex inpatient episode.

Learning from claims case study: Fall following sedated endoscopic procedure

Learnings

- The patient's age should have placed them in a higher-risk group for the effects of procedural sedation which can include impaired balance and delayed recovery of alertness.
- The patient had a history of a previous fall following sedation clearly documented in their clinical notes. Given their history of a previous fall and advancing age, a multifactorial falls risk assessment (MFRA) should have been carried out prior to sedation.
- NICE guidelines recommend routinely asking older persons about any falls over the past 12 months, their fear of falling and any other mobility issues. In addition, persons aged 65 and older and those 50 and older at higher risk of falls, need a comprehensive MFRA when in inpatient hospital settings.
- Midazolam, commonly used as a sedative, is known to cause impaired coordination, reduced reaction time, and postural instability. Patients recovering from sedation should be assisted or supervised during initial mobilisation and dressing, especially when bending is required.







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Advice to frontline staff to reduce service user STFs



Key advice to reduce service user slip, trip and fall incidents


Risk Assess 	Persons aged 65 and older and those 50 and older at higher risk of falls in inpatient hospital settings and residential care need a comprehensive multifactorial risk assessment so as to identify and effectively manage their falls risk.
Remediate 	Conduct a proportionate and responsive post-fall review to identify factors that contributed to the fall and opportunities to prevent another fall.
Report and learn 	Continue to report clinical incidents in a timely manner in accordance with the statutory requirement to report incidents to NIMS, and in line with the HSE's Incident Management Framework
Reform 	Collaborate and foster standardisation of fall prevention clinical approaches and guidelines within and between different services, settings, and regions to streamline the approach to falls risk and prevention.

Other SCA 'falls' resources


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Patient Safety Notification

Bed rails/cot sides – falls prevention and safety practices

 **52** The number of incidents relating to bed rails/cot sides reported on NIMS in a three-month period

Incorrect or inappropriate use of bed rails/cot sides can result in:


- Harmful falls from beds/trolleys
- Entrapment involving the head and limbs
- Allegations of inappropriate restraint



Issue Date: 14 January 2025 Reference Number: SCA-PSN-12-01


T +353 (0)1 238 4900 E stateclaims@ntma.ie W www.stateclaims.ie


The State Claims Agency has provided this advice with reasonable care and skill, based on analysis of the information available on NIMS and best practice guidelines and research.


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Patient Safety Notification

Risk of Newborn Falls

 **65** The number of incidents relating to newborn falls reported on NIMS from 2017 to 2019 inclusive

 Examples of incidents relating to newborns falling or being dropped during the postnatal period:

- Baby falling from a height, eg bed, weighing scales, resuscitaire
- Baby falling from the mother's arms during / after feeding
- Baby not securely strapped into car seat when leaving the ward / department

Issue Date: 2 October 2020 Reference Number: SCA-PSN-03-01

T +353 (0)1 238 4900 E stateclaims@ntma.ie W www.stateclaims.ie

The State Claims Agency has provided this advice with reasonable care and skill, based on analysis of the information available on NIMS.

In line with our statutory [risk management](#) mandate, the [State Claims Agency](#) reviews and analyses [incidents reported](#) on [NIMS](#), the National Incident Management System, to identify any incidents of interest.

Visit www.StateClaims.ie

