



**Response to Ministry of Justice Consultation on
Proposals for the Reform of Legal Aid in England and
Wales**

Time for response: 14th February 2011

About AvMA

As a UK charity Action against Medical Accidents (AvMA), established in 1982, has been specialising in advice and support for patients and their families affected by medical accidents for nearly thirty years. Since its inception AvMA has provided advice and support to over 100,000 people affected by medical accidents, and succeeded in bringing about major changes to the way that the legal system deals with clinical negligence cases and in moving patient safety higher up the agenda. The legal reforms of Lord Woolf in the clinical negligence field and the creation of agencies such as the National Patient Safety Agency and the Healthcare Commission have followed after years of campaigning by AvMA.

AvMA is proud of the key role it has played in making clinical negligence a specialism within legal practice. It continues to accredit solicitors for its specialist panel (without membership of AvMA's or the Law Society Panel a law firm is not entitled to an LSC clinical negligence franchise) and promotes good practice through comprehensive services to claimant solicitors.

Introduction

The contribution that AvMA makes in responding to the consultation is confined to those areas within our knowledge. AvMA has specific expertise in clinical negligence and healthcare law; we have considerable experience in providing assistance to clients who have suffered medical accidents either to assist in making a complaint under the NHS complaints scheme or in finding legal representation from one of our panel members to pursue a civil claim.

Clients approach us directly by letter or e-mail or through our telephone helpline. Although we have consulted widely amongst our various stake holders our response is on behalf of patients who are our prime concern. Our aim is to ensure patients who have been injured in the course of healthcare have access to justice and that they are properly compensated for their injuries and that any deductions they suffer from their damages do not reduce their compensation below that necessary to supply the needs they have as a result of clinical negligence.

In our on going campaigns for patient safety and justice we have seen clinical negligence litigation as a major force in putting patient safety at the top of the agenda and in improving training for doctors, nurses and midwives

In forming our response to this consultation we had preliminary discussions with people from our extensive network of contacts. The majority of solicitors and barristers who specialise in clinical negligence are either members of AvMA or have regular contact through our seminars and conferences. We maintain a data base of nearly a thousand medical, para-medical and nursing experts who act for both claimants and defendants in clinical negligence claims, lecture at our conferences and write for the AvMA journal. We have sought the views of all these groups on the effects of these proposals.

Nevertheless this response is our own based on our opinion of the effect these proposals will have on those who have suffered a medical accident and does not represent the individual views of any of the groups referred to above.

Our position is unique in that we help and advise clients individually through our casework department and are in an ideal position to hear the views of those

who have suffered adverse outcomes following medical treatment. We also are able to listen to the opinions of legal professionals whose association with us is through membership of our Lawyers' Service and sponsorship. The annual AvMA clinical negligence conference is attended by 450 to 500 specialist clinical negligence solicitors and barristers. Over time almost all of these specialists will have attended one of our conferences

Summary

At the same time as publishing this consultation the Ministry of Justice published a consultation on proposals for reform of civil litigation funding and costs, the issues covered in that consultation, and this on Legal Aid are inextricably linked. Our response to the civil litigation costs consultation paper should be read in conjunction with this response. In the ministerial forward it is stated that the government is 'endeavouring to ensure that necessary claims can be brought'. In this response and in our response to the civil costs consultation we set out our opinion that the combined effect of the two sets of proposals will not ensure that necessary claims can be brought but that they will form a significant impediment to access to justice

AvMA opposes the abolition of Legal Aid for clinical negligence claims. We dispute that the availability of Conditional Fee Arrangements to some claimants is a guarantee that there will be a viable alternative form of funding for all those injured in medical accidents. The evidence is that many of the most vulnerable, the poor, elderly and children will in many circumstances find it impossible to investigate and litigate their claims. Further, many claims of modest value, particularly fatal claims, will suffer the same fate. Such cases in the main are unlikely to be economical to run.

This is particularly so if the Jackson primary proposals¹ are adopted. From the solicitor members who have responded to our questionnaire and who represent a broad cross-section of our membership, they would not take on under the Jackson primary proposals 56% of publicly funded cases that they took on in the last two years. This evidence flatly contradicts the assertion made in the consultation paper (without evidence) that there is a viable alternative to public funding of clinical negligence claims. Further, of the cases that our responding members took on a CFA in the last two years only 55% of those cases would have been taken on under the Jackson primary proposals. Denial of access to justice on this scale posed by the compounding effects of the abolition of public funding for clinical negligence disputes and the Jackson primary proposals are startling and in our view unacceptable in a civilised society. We would hope that this is a state of affairs that no Government would be prepared to contemplate. As a patient safety organisation who specialise in providing advice and support to those who have suffered as result of medical accidents we are committed to work with Government to find ways of avoiding such a significant denial of access to justice, whilst having regard to the straightened state of the public finances and being committed to drive down the cost of litigation.

Restriction of access to legal redress on this scale for those who have suffered medical accidents needs to be placed in context. It is a common and popular misconception among the public that those who suffer medical accidents are litigious. The evidence is strongly to the contrary. Of adverse incidents which occur in a healthcare setting only a very small fraction are ever investigated let alone litigated². In 2009/10, the NHSLA received 6,652 claims (including

¹ Jackson Primary A reformed CFA regime where success fees and after the event insurance premiums should no longer be recoverable from the losing side. An increase of 10% in general damages is proposed and a strengthening of P36 arrangements and qualified one way costs shifting Jackson Alt 1 The percentage success fee recoverable would be fixed, non recoverable (or chargeable to the claimant) if settlement is achieved in the protocol period or for any element that relates to P36 risk. There would be no recoverability for detailed assessment or when the claimant could have used funding other than a CFA. Recovery of ATE premiums would be limited to 50% of damages awarded and only under certain conditions.

Jackson Alt 2 ATE insurance would cease to be recoverable but success fees would be recovered as in alternative 1. Two way costs shifting would be retained in alternative 2.

² Estimate based on the best available data in England, extrapolating from a small study in two acute care trusts based in London, it is estimated that around 10% of patients (900,000 using admission rates for 2002/3) admitted to NHS hospitals have experienced a patient safety incident, and that up to half of these incidents could have been prevented. This study also estimated that 72,000 of these incidents may

potential claims) under its clinical negligence schemes, in the same period it is estimated that there were 500,000 avoidable incidents³ (although not all would have been actionable) Further our members report to us that of the enquiries they receive about the possibility of pursuing a health care related claim they screen out (i.e. do not take on) 75 – 80%. As matters presently stand there is no duty of candour about adverse incidents on healthcare providers. Learning lessons from medical accidents is an important by-product of claims brought against the NHS. No one who has such an accident wants to see that experience repeated for other members of the public and nor should the Government. Litigation against the NHS is a driver for improving standards, particularly in the fields of infection control, obstetrics and prescription error. Much important work has been done by the NHSLA in this regard, which would be put at risk by these proposals. Thus against that backdrop such a set of proposals (which in our view) in the field of clinical negligence at least must be read together), represents a **fundamental** erosion of the right of patients (both within the NHS and in private medicine) to seek redress when an adverse incident occurs, particularly where there is serious injury or death. Society and Government should focus on getting at the heart of the problem – the unacceptable rate of adverse incidents – not eroding the right of redress when such an incident occurs.

A group of our solicitor members have provided us with information on costs and damages of past cases, which we use to illustrate our point that the loss of Legal Aid in combination with the Jackson proposals will constitute a fundamental denial of access to justice. Their opinions were based on the models of funding by conditional fee arrangements as set out in the Civil Litigation Funding consultation. Summaries of this research are contained in Annexe 1

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We have made Freedom of information requests to the LSC and NHSLA for figures to assist our response. Those letters are at Annexe 2. To date the only response we have received is the e-mail from David Keegan of the LSC (Annexe 2).

However we do recognise that in the present economic climate government must make savings. We wish to be involved at every level in discussing the provision of alternative ways (including self funding schemes) of funding Legal Aid to ensure that access to justice for vulnerable people injured in medical accidents remains.

We are also concerned that other very important benefits of Legal Aid, developed over the last 20 years such as through franchising, ensuring supervision by panel members and expert evidence of the highest quality, and through the LSC's quality control and monitoring of key performance indicators will be lost if clinical negligence is taken out of scope. Accreditation of lawyers is an important driver for the efficient, economic and early resolution of clinical negligence disputes, which Government should not wish to remove.

We support the proposal to establish a specialist help line for clinical negligence but maintain it should remain free to all clients and there should be a pilot of any such scheme. We wish to be involved in further discussions on the establishment of such a scheme.

Catherine Hopkins
Legal Director
AvMA
February 2011

AvMA Response to Consultation

Scope

Question 1: Do you agree with the proposals to retain the types of case and proceedings listed in paragraphs 4.37 to 4.144 of the consultation document within the scope of the civil and family Legal Aid scheme? Please give reasons.

Answer – Yes

AvMA's stated position is that in order for there to be access to justice for all citizens there should be public funding for those with qualifying means. As such we strongly support the provision of Legal Aid and by inference agree that there should be funding for the types of case and proceedings listed in paragraphs 4.37 to 4.144. However, AvMA is a charity campaigning for patient safety and justice. A part of AvMA's work is advising and supporting clients who pursue complaints and or civil claims relating to healthcare. Thus in responding to this consultation we confine our responses to the proposals relating to Legal Aid funding for clinical negligence claims.

Question 2: Do you agree with the proposal to make changes to court powers in ancillary relief cases to enable the Court to make interim lump sum orders against a party who has the means to fund the costs of representation for the other party? Please give reasons.

Not applicable to clinical negligence

Question 3: Do you agree with the proposals to exclude the types of case and proceedings listed in paragraphs 4.148 to 4.245 from the scope of the civil and family Legal Aid scheme? Please give reasons.

Answer - No

Paragraphs 4.151 and 4.152

While we accept that in the present economic climate the bringing into scope something that was hitherto not legally aided was very unlikely to happen we wish to register here our deep concern and disappointment that S51 of the Coroners and Justice Act will not come into force. We only comment in connection with inquests relating to healthcare deaths, where proceedings often last for several days with many witnesses called. Witnesses may include hospital consultants, nurses, pathologists and hospital administrators. All these witnesses will be legally represented at either the expense of the NHS Trust or (for many doctors) their insurer. The evidence they give is highly technical. Faced with this number of witnesses, experts in their own fields all represented by counsel, the bereaved have little chance of fully understanding the issues (beyond a feeling that something is not right) or being able to ask the questions for which they need answers

Paragraphs 4.163 - 4.169

We firstly make the point that to take away Legal Aid funding from patients who have been injured in the course of medical treatment, more often than not provided by the state via the NHS, is to deny access to justice for some of the most vulnerable groups in the country; children, the sick and the disabled. Often their injury means that they are wholly dependant on state assistance in the form of income support, housing benefit and sometimes long term residential care. Some may be in work but just making ends meet and where even a short time off work makes the difference between paying their mortgage or defaulting. Claims for the cost of care, accommodation and earnings are for some of the most basic

needs a person can have. This group of people being among the poorest and most disadvantaged in the country by definition cannot afford even a contribution to their legal fees because of the effects on their lives as a result of their injuries caused by their medical accident.

Thus the stated basis on which it is proposed to remove all clinical negligence from scope is erroneous. To state that alternative funding in the form of Conditional Fee Arrangements will fill the gap left by the loss of Legal Aid in all circumstances is wrong and will be exacerbated if all the recommendations made by Sir Rupert Jackson are implemented. Applying the publically available statistics published by the NHSLA and the LSC under their FOI publication schemes, it appears that 57% of cases notified to the NHSLA in 2009/10 (some 3,800) were funded by the LSC either through Legal Help or full representation.

Our member firms who reported to us state that on average they would only take on 44% of presently legally aided claims on CFAs (Jackson primary proposals).

If the views of our member firms turn out to be correct (and we see no reason to think they are wrong and have seen no contrary data) then, using this year's figures for the number of new LSC certificates of funding notified to the NHSLA, of around 3,800, and assuming 56% of those will not be taken on under a CFA regime as it currently operates, then removing Legal Aid will remove the opportunity to obtain recompense for injuries from around 2,128 claimants per annum potentially.

The proposal for exceptional funding will not come close to plugging the resulting gap. If we have correctly understood the Impact Assessment on Scope Changes, then comparing tables 1 and 3 it appears to be contemplated that 10% of legal representation certificates would qualify for exceptional funding.⁴ Using the figures in those tables (a different data source to that above based on a

⁴ No evidence is provided for why 10% of cases would be readmitted through the exceptional funding route and we are far from sanguine that it would even be this high having studied such detail as is available on this proposal.

2008/9 baseline) would suggest only some 250 claimants or so per annum having public funding. This would be a quite unacceptable loss of access to justice in our view, suggesting that around **90%** of those would not be funded through the CFA route because solicitors could not take on those cases according to the responses of our solicitors and would thus find themselves remediless.

This denial of access to justice has to be seen in the context of the effect of the primary Jackson proposals on claimants whose cases are currently funded by CFA. We address this in our companion response, but it will be seen that of the cases that our responding members took on a CFA in the last two years only 55% of those cases would have been taken on under the Jackson primary proposals.

In considering these proposals and the Impact Assessments, we have been struck by the apparent complete absence of evidence obtained by Government about the interaction between the Legal Aid scope proposals in this area and the Jackson proposals. Having now been presented with hard data about the devastating effect of these proposals, we trust that Government will rethink its proposals and before legislating on this issue engage with stakeholders, such as ourselves and our members, so it can properly understand the real impact of its proposals on access to justice.

The cases that we are concerned are by definition brought by claimants with no means to fund a claim themselves. As our data illustrates many of the cases will not have been cases that a firm would be willing to fund under a CFA because of the high risk to the legal practice of not being paid at all, together with the high cost to that practice of funding disbursements over a lengthy period of time (on average 54 months). It needs to be understood that clinical negligence investigations are disbursement heavy throughout investigation and then litigation (see below). There is no realistic way to reduce that burden.

While CFA funding for clinical negligence claims is well established it is not a suitable form of funding to extend to all claims presently funded by Legal Aid. We provide figures from our member solicitors [Annexe 3] providing details of costs, disbursements and damages for the last that demonstrate that a significant number of cases currently legally aided would not qualify for a CFA. Where CFA agreements are offered (and we emphasise these will be the **minority** as stated above – most not being offering any funding) and assuming the Jackson primary proposals for reform of costs recovery in CFAs are adopted, then the deduction from general damages and past losses will significantly exceed the proposed 10% increase in general damages proposed by Sir Rupert Jackson. For cases that would attract CFA funding those in the higher damages bracket might recover sufficient damages to pay success fees out of 25% of uplifted general damages and past loss, but those cases in the low to medium categories would not.

Furthermore, the proposed reforms in public funding and conditional fee arrangements will have the effect of reducing the damages received by claimants often very significantly. We address this issue further below.

It is estimated that 30% of the population would be eligible for Legal Aid if they had a clinical negligence claim (and 57% of all those who actually wish to pursue a claim). This is a significant minority of people who instead will be subject to the new CFA arrangements if they wish to pursue a claim. The effect on children's claims will be greater as almost 100% are currently funded by Legal Aid. These changes will amount to a fundamental denial of access to justice for this group of people, many who will not find a solicitor to act for them under a CFA and others experience a high deduction from damages to pay for success fees and ATE policies.

The average cost of disbursements in the cases reported to us is similar in CFAs and LSC funded cases (£19-21,000), but in cases involving serious and persisting injury are much higher (see cases 96 and 118 -122). Removal of LSC

funding means that either the claimant has to bear the burden of disbursement funding themselves for an average of 54 months (the average length of time for a publically funded case to reach a successful conclusion according to the LSC) or their solicitor does. The additional burden to solicitors' practices of all previously legally aided clients requiring disbursement funding involving serious and persisting injury will be too big a financial burden for many law firms to carry. If that burden were to fall on claimants, then it is going to be the exceptional person of means who will have the funds to take their cases forwards

We note here that the proposal that greater uptake of BTE insurance would provide access to justice is a misappraisal of the situation given that claimants who are legally aided in the main do not own their home, are living on the "breadline", and do not have spare funds to pay for basic home contents insurance, let alone an extra premium for LEI.

Sir Rupert Jackson's proposals

It should be noted here that the reforms to CFA costs recovery proposed by Sir Rupert Jackson were recommended in the understanding that Legal Aid funding would remain as it was at the time of the publication of his report; where in chapter 7 at paragraph 4.2 page 70 he stated

'I do not make any recommendation in this chapter for the expansion or restoration of Legal Aid. I do however, stress the vital necessity of making no further cutbacks in Legal Aid availability or eligibility... the maintenance of Legal Aid at no less than the present levels makes sound sense and is in the public interest'

From the foregoing analysis it is immediately obvious why Sir Rupert made that observation. The effect of doing otherwise is a quite unacceptable denial of access to justice.

The consultation states that clinical negligence may be removed from the scope of Legal Aid because there is a viable alternative (CFA) yet it is proposed to introduce all the reforms to CFAs recommended by Sir Rupert which were made only on the basis that Legal Aid funding remains as it is now with 'no further cutbacks'

The loss of Legal Aid together with the reforms to Legal Aid funding will profoundly affect access to justice for all claimants, from lower value claims to those with maximum severity injuries who currently have the benefit of Legal Aid, when taken with the reforms to CFA funding.

We deal substantively with the effect of the Jackson primary proposals in our companion response, it does need to be noted that damages for past loss are fundamentally restitutionary in character and should never be the subject of retrospective levy. Indeed, we do not see how damages for past care and other loss which are held on constructive trust for a third party could be made subject to such a levy lawfully, requiring claimants to pay out such third parties out of funds for other purposes. General damages are not in many cases "free damages". Leaving aside the fact that they are designed to recompense claimants for their injuries, they form an integral practical component in serious damage cases of meeting the shortfall posed by the Roberts –v- Johnstone formula for alternative accommodation claims. We believe these proposals will make the practical application of damages awards unworkable where significant accommodation claims are made, particularly in short life expectancy cases and/or where there is a discounted liability settlement, which is commonplace, particularly in the most serious injury clinical negligence claims (such as cerebral palsy claims).

The 100% damages principle which is enshrined in common law and the subject of repeated affirmation by the courts should only be breached in exceptional circumstances such as for liability related reasons (such as a finding of contributory negligence or an agreement by the parties that the claimant shall

only receive a proportion of damages to reflect the litigation risk to both parties). Damages are awarded to meet claimant's needs and losses and should wherever possible be applied to that end. We recognise below there may be a public policy exception in relation to general damages and the public funding of clinical negligence claims and address that below..

Further, previously legally aided claimants with claims consisting of general and past losses only will suffer a disproportionately large deduction from damages.

We provide a summary of responses to a questionnaire that we sent to our members which illustrates the extent that these proposals will disadvantage claimants [Annexe 1]. At Annexe 4 we provide some cases in the form of studies where the claims could not have been pursued had it not been for public funding. Of the members responding almost half their cases are legally aided.

It is our belief that the effect of these reforms will be to prevent valid claims being brought against all healthcare providers but particularly the NHS, and consequently a denial of justice and redress for people who have suffered injury and financial loss due to another's negligence.

We also contend that publicly funded clinical negligence work is good value for public money. The LSC's figures show that cases with poor prospects of success after an initial investigation do not proceed, thus NHS defendants (or any defendant) are put to no expense beyond providing documents. Of the publicly funded cases that proceed there is a success rate of around 90% It is in the nature of such work that there are unavoidable investigation costs which will be incurred on cases that cannot be proceeded with which through the use of key performance indicators the LSC and franchise holders have consistently managed to reduce. Further, it is our strong view that there is an important public interest served by those who are among the most vulnerable and needy in our society having access to an accredited lawyer working under tight supervision and quality control by the LSC to investigate their cases, even if their cases do

not go forward. This is particularly true in the context of a complaints system which is manifestly inadequate. If clinical negligence is taken out of scope, there is no realistic prospect that such cases will be investigated. .

The work over recent years between the LSC and providers, including the requirements for quality standards and panel membership have led to consistently improved outcome measures as solicitors improve their screening processes and meet the LSC criteria. This improvement began with franchising and the requirements set down by the LSC for panel membership (at least one panel member per franchised firm), supervision by panel members of all legally aided files and certain minimum standards of file management. The LSC franchising requirements led to firms incorporating the standards into all their clinical negligence work. AvMA has played a large part in supporting these improvements, its membership was the first of its kind and ranks along with the Law Society panel membership as a primary qualifying requirement for holding a LSC franchise (now contract). Similarly its expert data base is relied upon by its member solicitors (most of whom hold an LSC contract) as complying with the LSC requirement to use experts who are known to them to be of a suitable standard for clinical negligence work.

By taking clinical negligence out of scope will end these important gains in ensuring appropriate investigation of claims, quality standards in the provision of legal advice and ensuring only those cases which ought to be put into the litigation process will be. The increasing risk of unaccredited lawyers taking speculative punts on cases through CFAs using the shield of qualified one way costs shifting is not one that should be welcome to Government, the NHS or the NHSLA.

While we fundamentally oppose the proposal to take clinical negligence out of scope we recognise that in the present economic climate the government is seeking to make savings in all areas of Government and state provided services. As such we make suggestions below as to the form those savings may take

while preserving access to justice for injured patients by retaining clinical negligence within scope. These suggestions are made having consulted a cross section of our membership but the views put forward here are our own and not those of our members who are broadly solicitors and barristers in private practice and not all of whom will agree or have agreed with each proposal. The views of those we consulted were varied on the possible new ways of funding Legal Aid but unanimous in opposing the removal of clinical negligence from scope.

We have considered Self Funding Legal Aid Schemes, but not Contingent Legal Aid Schemes, which we believe would require more funding to provide income for the independent provider. We have looked at the various ways in which successful claimants may pay back to the fund over and above the funding provided for their claim to enable the financing of future claims. In doing this we have taken into consideration the additional damages payable as recommended by Sir Rupert Jackson in his report and made the assumption that this reform will be implemented.

Payment out of damages – A levy on general damages of 25% is proposed in paragraph 9.27 ff of the consultation paper in relation to all civil cases where a legally aided claimant is successful and awarded general damages. This would include all cases which qualify for exceptional funding. It could be applied instead to keep claims within scope. We have made the important principle that the erosion of general damages should be limited to exceptional circumstances (such as the ones we identify that already occur) and not as a general source of litigation funding. We have identified in particular, problems that will be caused in the practical application of damages awards by such a proposal. However, we recognise that given the need for reduction in the Ministry of Justice budget there may be an exceptional public interest case for doing so if scope for public funding of clinical claims can be maintained. We take the view that there is no such exceptional public interest case that applies when the Government is considering whether or not to adopt the Jackson primary proposals and indeed would strongly suggest that their effect would be inimical to access to justice in this area

(we cannot speak for other areas of civil litigation). The opposite logic applies in relation to public funding of clinical negligence claims where we consider there is a very strong public interest in exploring all ways in which clinical negligence can be kept within scope (which itself would mitigate the cost implications of introducing a modified set of Jackson proposals).

From the impact assessment on the SLAS it is clear that the Government assumes that £9m could be raised from clinical negligence claims which qualified for exceptional funding (annex 1A p 15 of the IA). The total cost of legal representation and legal help for clinical negligence it is inferred is £19.6m (IA on Scope p 17 table 2) although published figures for 2009/2010⁵ are given as £16,646,000. If all clinical negligence claims are kept within scope we anticipate that the shortfall in funding for CN could be met entirely or very nearly so by such a charge.

We address separately the question of a SLAS below. The figure could be between the additional 10% awarded as advised by Sir Rupert to a higher but a fixed percentage subject to an overall cap at 25% of general damages. We note that it is not suggested that the SLAS levy proposal should apply to past losses and we retain our opposition to this in all circumstances (including CFAs). Our reason for this is that in most cases a significant proportion of past losses are held in trust for another (gratuitous care provided by friend or relative, sick pay payable back to an employer under the terms of the employment contract, payments made by family members). It would put claimants in an impossible position and is unworkable.

Payment out of costs by solicitor and counsel – here a levy (of up to 10%) would be paid by solicitors and counsel of a fixed percentage of the inter partes costs recovered. Subject to a considerable amount of further discussion we suggest that this levy could be paid by either claimant or defendant solicitors or

⁵ http://www.legalservices.gov.uk/docs/stat_and_guidance/Stats_Pack_0910_23Jul10.pdf table CLS8 p7

a combination of both, where the defendant contested liability after completion of the pre-action protocol. We recognise that there would need to be careful discussion with the profession. We understand that the total costs (excluding disbursements) in clinical negligence claims recovered in the year to April 2010 in publicly funded cases was £60m.⁶ This could potentially yield £12m, (if a 10% levy is paid by Defendant and Claimant solicitors) which in combination with other proposals, could make clinical negligence claims self-funding. Given the need to ensure that claims which are eligible for public funding are funded there would need to be appropriate rules to ensure that cases are not inappropriately removed from the ambit of public funding. This would be necessary under whatever proposals are brought into being. We have not carried out a detailed assessment of this proposal with our members. It is fair to say some of our lawyer members would not support such a proposal on the ground of affordability whereas others would. To our mind, this underscores the need for informed dialogue with the legal profession about potential alternative means of preserving scope for clinical negligence,

While not self funding, other possible ways of reducing the cost of Legal Aid would be for funding to be provided for all cases currently in scope for investigative help only, with cases then transferring to CFAs at the protocol letter stage. Alternatively, for Legal Aid to be for all cases currently in scope for disbursement funding only, with solicitors acting under a CFA in respect of their fees from the outset.

One of the major barriers to greater use of CFAs is disbursement funding and the costs of investigation. These costs are necessarily substantial in clinical negligence claims. We attach a copy letter (Annexe 5) from one of our member solicitors providing details of a client's claim, where the total disbursements and counsel's fees to January 2011 are just under £50,000. This case has not yet reached the stage of exchange of expert evidence. The claim involved a young

⁶ http://www.legalservices.gov.uk/docs/stat_and_guidance/Stats_Pack_0910_23Jul10.pdf

man now over 18 years of age but aged 16 at the time of injury, which was allegedly caused by a delay in diagnosis of a cyst on the brain.

There have been suggestions of providing a form of exceptional funding for children and those with Human Rights claims. As the proposals stand at the moment exceptional funding would not assist claimants such as in the case described here. Yet in this case there is a very severe injury, a case with merits that should be pursued, but that is costly in terms of disbursements and under the new dispensation would have somewhat remote prospects of finding a lawyer agreeing to take it on. We have been told and know of many such cases where there is a danger of the claimant being unable to obtain funding for disbursements if the proposals under consideration go ahead.

There is a further alternative which is to limit the scope of Legal Aid to claims involving death or serious persisting disability arising from a medical accident. Whilst we are in principle opposed to the concept of reducing scope of Legal Aid, we would regard the retention of such cases within scope as a matter of fundamental public importance.

Medical accidents involving death are a matter of very great public importance which should be afforded public funding. There are many such cases where because of limited quantum such cases will never be brought under a CFA whatever regime is ultimately implemented by Government. In a civilised society such cases should be capable of being investigated and be the subject of appropriate compensation where relevant. Without public funding many such cases will never see the light of day resulting in a serious denial of justice.

Cases of serious persisting disability speak for themselves and are illustrated by the case study referred to above. These will be claimants who have suffered

devastating sequelae from medical accidents and should be able to bring their claims with the benefit of public funding. A scoping exercise would need to be undertaken to work out what savings would be engendered by such an approach and to identify a robust and workable definition of serious persisting disability

Any reform of Legal Aid funding will require considerable discussion. As a charity representing patients injured in the course of medical treatment, many of whom wish to recover damages for their injuries, we would expect to be involved in any discussion involving Legal Aid

At paragraph 4.169 alternatives to litigation are discussed in the form of NHS Redress. AvMA was involved in the discussions and consultations that led to the NHS Redress Act and broadly support the premise that there should be an alternative to litigation for clinical negligence claims, particularly those of lower value. However we would not support the NHS Redress Act coming into force in its present form. Our concerns are that at present the act does not provide sufficient safeguards for claimants in the form of independent advice or evidence.

We would expect that as an organisation which campaigns for access to justice for injured patients that we would be consulted directly on any proposals for an alternative to litigation for clinical negligence claims or the bringing into force of NHS Redress.

In the Annexes to our response we provide figures from some of our member firms. It is clear that while some firms will be able to provide representation for claimants in clinical negligence claims others will not. This could lead to there being no access to legal advice in large areas of the country if the work is concentrated in fewer but larger firms. Telephone advice and other electronic forms of communication are no substitute for personal contact at key stages of a claim, including and in particular when taking initial instructions. Solicitor choice will be adversely affected. There are already areas in the country where the

choice of accredited firms is very limited or practically non-existent. The removal of clinical negligence from scope will make this problem significantly worse.

Question 4: Do you agree with the Government's proposals to introduce a new scheme for funding individual cases excluded from the proposed scope, which will only generally provide funding where the provision of some level of Legal Aid is necessary to meet domestic and international legal obligations (including those under the European Convention on Human Rights) or where there is a significant wider public interest in funding Legal Representation for inquest cases? Please give reasons.

Answer - No -

We believe that clinical negligence should not be removed from scope. We accept that during the current financial situation alternative ways of funding a Legal Aid scheme for clinical negligence should be sought but we do not believe that exceptional funding is a substitute for keeping all clinical negligence in scope. This question assumes that such exceptional funding would provide a safety net for clinical negligence claims. We do not believe it will, We have identified above on the basis of the data assumptions made in the relevant impact assessment approximately 90% of claims that solicitors would not take on under the primary Jackson proposals would not be funded through exceptional funding.

Exceptional funding will not be required for clinical negligence claims if there is proper provision of Legal Aid (subject to the present financial means test and exploring alternative ways of providing that funding).

We also note that consultees are being asked to comment on a proposal for which no detail at all is being provided. There is no basis upon which we can evaluate these proposals in relation to the very limited pool of cases it would

appear to be assumed to apply to (approximately 250 case per annum) [see above]. The proposal gives no details as to how it would operate, when the assessment would be made, by what means it would be made and upon what materials. It would be an entirely worthless procedure if the assessment of whether a case qualified for exceptional funding would require the solicitor to produce a complement of reports to show the case had merit. It is exactly that expense which will not be capable of being incurred. It is quite unclear how the assessment of "practical impossibility" for article 6 is to be adjudicated upon.

The suggested removal of the "significant wider public interest" and "overwhelming importance to the client" criteria will not in our judgment lead to any expansion of exceptional funding. Rather the exclusive focus will be on the practical impossibility test under article 6 and we do not see how that is likely to be a more expansive form of exceptional funding when applied either to clinical negligence claims or indeed personal injury claims more widely.

Further, as noted above we are far from sanguine that even 250 cases per annum would be granted such funding as the relevant impact assessment annex appears to imply. This is at odds with practical experience of the current exceptional funding regime of our members. We would note here that at present where exceptional funding is available (e.g. at inquests where Article 2 may be engaged) in order for the UK to fulfil its obligations under the European Convention on Human Rights the funding is subject to such scrutiny that many applications are rejected. Further, our members report that under the present regime exceptional funding is hardly ever granted. Although in theory available since 1998, members report that they have applied but never been granted exceptional funding for a personal injury claim and only very rarely in other exceptional funding categories such as inquests.

We have no reason to believe that a form of exceptional funding to provide legal representation for clinical negligence would be any different. Further we assume such funding may be subject to a limit on resources, akin to the affordability

criteria used by the LSC currently in relation to Multi Party Action work. As a consequence as well as being inherently unfair and not providing access to justice, as we believe any civilised society should, we also envisage that there will be more and more legal challenges (including by Judicial Review) to any refusal of funding

We do not agree to this being a viable substitute for taking all clinical negligence cases out of scope for the reasons we have given. . We strongly disagree with the premise that a viable alternative in the form of CFAs will replace public funding in order to provide access to justice for those individuals whose claims would be excluded from scope under the new proposals. The figures we produce at Annexe 1 demonstrate that solicitors will take on 56% less cases (that otherwise were within scope) if CFA funding is substituted for all cases under the Jackson primary proposals presently legally aided (see above).

Exceptional funding by definition cannot cover the present scope of provision which already provides the absolute minimum level of access to justice for means qualifying litigants.

We cannot comment more on this subject. We are unable to make any constructive comments or criticism because of the lack of detail. It is quite unreasonable to ask any respondent to a consultation to state whether they support a proposal or not without having been given any details. We do not accept that it is impossible for the MoJ to set out provisional proposals in this regard, which are essential for us to comment on the adequacy of the proposal in the context of the removal of clinical negligence from the scope of Legal Aid altogether.

Question 5: Do you agree with the Government's proposal to amend the merits criteria for civil Legal Aid so that funding can be refused in any individual civil case which is suitable for an alternative source of funding, such as a Conditional Fee Arrangement? Please give reasons.

Answer – No

The consultation already proposes to take clinical negligence out of scope and cites the availability of alternative funding in support of the decision. This premise is wrong and should not be held up as the solution to access to justice for clinical negligence claimants. The fact that some form of alternative funding does exist does not mean that it is suitable for those claims presently funded by Legal Aid. Clients currently in receipt of Legal Aid are by definition the poorest and often the most severely injured of claimants, least able to pay even for a screening medical report.

Our view remains the same if charging mechanisms either on costs and/or damages are introduced then it is necessary to ensure that cases which are eligible for public funding are funded by that route, subject to appropriate exception where for instance a client could not afford the capital/income contributions required.

Legal expenses insurance (or before the event cover) is available to some and already can be a bar to obtaining Legal Aid. But BTE policies are rarely taken out as a stand alone item and more usually a part of comprehensive house insurance. Those who presently pass the qualifying means test for Legal Aid are the least likely to have such insurance. However sensible and desirable, house contents insurance (or similar) is not an affordable option for those of limited means.

Conditional fee agreements are also not affordable for all claimants. While some firms may be able to offer disbursement funding to their clients from the outset many do not offer this for the initial investigation costs including obtaining expert reports. More firms are likely to ask their clients to pay for the initial reports and/or costs, (see Annexe 1) and the cost of disbursements that firms are likely to be asked to fund will increase hugely if there is no longer Legal Aid funding,

particularly for claims involving serious persisting injury. At present nearly all the claims that are very disbursement heavy are mainly legally aided which increases accessibility to justice to a wider group of potential claimants than would be the case if Legal Aid is removed.

Question 6: We would welcome views or evidence on the potential impact of the proposed reforms to the scope of Legal Aid on litigants in person and the conduct of proceedings.

We do not believe many people will find it possible to act on their own account and those people without access to legal advice and lawyers will simply not be able to pursue their cases. However, it is inevitable that more people unable to find lawyers to act for them will become litigants in person. While at present the numbers are small there could be a significant increase in litigants in person. There has been no impact assessment on the costs to the courts service or the NHS of increases in the numbers of litigants in person.

Those that are brave enough to try and litigate alone will experience almost insurmountable hurdles and require a large amount of help support and guidance from the court. We have not seen what the cost of such support will be but it must be considerable on a case by case basis compared with the conduct of the case where both parties are legally represented. At the time of issue of proceedings the litigant in person may need help with the technicalities of the documentation and there will inevitably be more mistakes leading to challenges and delays. Hearings are likely to be prolonged and there may be more of them at the interlocutory stages with challenges and problems with disclosure of documents and expert evidence. It is likely there will be multiple adjournments leading to disruption of the Court's timetable..

Clinical negligence is highly reliant on expert witness evidence; it is close to impossible for litigants in person to source experts to act for them or to know how

to give proper instructions. Further most expert witnesses will not accept instructions from a litigant in person. Experts are not lawyers, they need clear instructions on what issues to comment on and what not

We do not contend that an individual cannot by his or her own research acquire the necessary knowledge of their medical condition or become familiar with the issues of liability and causation in their case, but the reality is that most can not. The reasons are numerous, including limited access to experts, lack of legal and medical knowledge, lack of ability either through learning difficulties or the injury itself, and that even the most well informed will be tackling these complex issues and procedures for the first time. One would not expect a newly qualified solicitor or barrister to have sole conduct of a clinical negligence claim.

The experience of other courts (such as in the family division) where litigants in person appear more often is that the litigant requires a huge amount of guidance and help both during the pre trial process and the hearing itself.

We also have concerns about individuals who seek to settle their claims without issue of proceedings, as without appropriate independent advice claimants may be encouraged to under settle their claims, or on receiving a denial of liability in correspondence drop their claims altogether when they have meritorious claims. It is theoretically possible to settle claims by correspondence but we have had clients contact us for advice where in initial correspondence with a trust individuals have been offered sums far less than their claim is worth.

The Community Legal Advice Telephone Helpline

Question 7: Do you agree that the Community Legal Advice helpline should be established as the single gateway to access civil Legal Aid advice? Please give reasons.

As the proposal presently stands anyone requesting advice on a clinical negligence matter would be screened out at the Operator Service stage and signposted to a paid for service. There is some advantage in streamlining but for those with clinical negligence claims it will be of little assistance. We are also concerned at what criteria may apply when determining which organisations cases should be directed and that the quality of advice now available to claimants will be downgraded.

Question 8: Do you agree that specialist advice should be offered through the Community Legal Advice helpline in all categories of law and that, in some categories, the majority of civil Legal Help clients and cases can be dealt with through this channel? Please give reasons.

This service is not proposed for clinical negligence.

Question 9: What factors should be taken into account when devising the criteria for determining when face to face advice will be required?

This service is not proposed for clinical negligence.

Question 10: Which organisations should work strategically with Community Legal Advice and what form should this joint working take?

AvMA already operates a help line for patients who have complaints or claims against healthcare providers coupled with a signposting service to specialist solicitors for those who have claims that may merit investigation. This level of advice and assistance should always remain free to injured patients and their relatives. The advice at this level should always be provided by specialists in

clinical negligence issues who have sufficient medical and legal knowledge to be able to advise appropriately.

AvMA would like to have more detailed information on the service envisaged. We would then wish to discuss the possibility of expanding our medical accident helpline service to provide this level of help.

Financial Eligibility

Question 11: Do you agree that the Legal Services Commission should offer access to paid advice services for ineligible clients through the Community Legal Advice helpline? Please give reasons.

We agree that the LSC should signpost clients with clinical negligence claims to a specialist advice service such as AvMA's medical accident helpline but we strongly believe that advice at this stage of a claim or complaint should be delivered free.

Question 12: Do you agree with the proposal that applicants for Legal Aid who are in receipt of passporting benefits should be subject to the same capital eligibility rules as other applicants? Please give reasons.

Our response to this question is based on the assumption that clinical negligence cases remain in scope. While this would appear to treat all applicants equally this would deny a large number of presently eligible claimants access to justice. We also question whether this would in any event be a costs saving measure as the number of fully means assessed claimants would increase considerably.

Question 13: Do you agree with the proposal that clients with £1,000 or more disposable capital should be asked to pay a £100 contribution? Please give reasons.

The principle of making a contribution towards Legal Aid is well established. However, lowering the bar to those with capital of £1,000 penalizes those least likely to afford representation. The principle should remain that those least able to pay should be protected

Sir Rupert's contention (repeated in P5.6 of the consultation) that claimants need to pay towards their legal fees to understand the value of what they receive is erroneous. Claimants are regularly updated on the costs of their claim, they are aware that they may in certain circumstances have to pay costs at the end of the case. Legally aided claimants who presently make a contribution to their funding know that they will lose this if their claim fails. Further the solicitors with the conduct of the claim will not continue to pursue a claim on behalf of their clients if they do not consider it has reasonable prospects of success, whether the case is publicly funded or funded by way of a CFA or BTE, and claimants are made aware of this at frequent intervals during a claim.

One hundred pounds is a small amount in the context of the cost of a clinical negligence claim to make minimal difference to the costs paid by the LSC, yet represents a large contribution out of the limited resources of the claimant

Question 14: Do you agree with the proposals to abolish the equity and pensioner capital disregards for cases other than contested property cases? Please give reasons.

This proposal discriminates against the elderly. The assumption is that people with equity in their houses should raise a loan to cover the cost of their litigation yet their homes are their only source of security and they are unlikely to have the resources to pay back the loans.

Question 15: Do you agree with the proposals to retain the mortgage disregard, to remove the £100,000 limit, and to have a gross capital limit of £200,000 in cases other than contested property cases (with a £300,000 limit for pensioners with an assessed disposable income of £315 per month or less)? Please give reasons.

Our concern is that while there must be a means test for access to Legal Aid that it should be fair. However house values vary considerably throughout the country and in areas such as Greater London the £200,000 gross capital limit would exclude most home owners.

Question 16: Do you agree with the proposal to introduce a discretionary waiver scheme for property capital limits in certain circumstances? The Government would welcome views in particular on whether the conditions listed in paragraphs 5.33 to 5.37 are the appropriate circumstances for exercising such a waiver. Please give reasons.

If the discretion applied to residents in areas with high property values we would support this.

Question 17: Do you agree with the proposals to have conditions in respect of the waiver scheme so that costs are repayable at the end of the case and, to that end, to place a charge on property similar to the

existing statutory charge scheme? Please give reasons. The Government would welcome views in particular on the proposed interest rate scheme at paragraph 5.35 in relation to deferred charges.

We assume that if funding for clinical negligence claims is retained (or a SLAS introduced) legally aided claimants would continue to have the benefit of partial costs shifting. Thus there is no need to replace the statutory charge with a charge on the property (which could cause problems if the assisted person wished to move house during the course of a claim). As solicitors are subject to an undertaking to retain damages (or an agreed portion of them) until costs are paid and Legal Aid outlay refunded, this could extend to any contribution required to the SLAS.

Question 18: Do you agree that the property eligibility waiver should be exercised automatically for Legal Help for individuals in non-contested property cases with properties worth £200,000 or less (£300,000 in the case of pensioners with disposable income of £315 per month or less)? Please give reasons.

We refer you to our answer to Q15.

Questions 19 – 21 do not apply to clinical negligence

Question 22: Do you agree with the proposal to raise the levels of income-based contributions up to a maximum of 30% of monthly disposable income? Please give reasons.

The client group who fall within the 'financially eligible with contribution' category are in one of the lowest income groups in the country - while a reduction in contribution for the lower income brackets is welcome a 10% increase in contribution for those within the higher brackets may be the difference between affordability and non affordability. Those on low incomes live on the narrowest of margins, the disposable income category already makes little allowance for items such as clothing and household goods.

Question 23: Which of the two proposed models described at paragraphs 5.59 to 5.63 would represent the most equitable means of implementing an increase in income-based contributions? Are there other alternative models we should consider? Please give reasons.

Given our opposition to the proposals to increase contributions we have no further comment.

Questions 24 - 38 are a matter for private practice in the areas of law referred to in this section and (under present proposals) do not apply to clinical negligence

Expert Remuneration

Question 39: Do you agree that:

- there should be a clear structure for the fees to be paid to experts from Legal Aid; **YES**

- in the short term, the current benchmark hourly rates, reduced by 10%, should be codified; **NO** (*see below, the rates are already too low*)
 - in the longer term, the structure of experts' fees should include both fixed and graduated fees and a limited number of hourly rates; **NO**
 - the categorisations of fixed and graduated fees shown in Annex J are appropriate; **YES** (*these are similar to the categories used in the experts' terms and conditions, our concern is low hourly rates*)
- and
- the proposed provisions for 'exceptional' cases set out at paragraph 8.16 are reasonable and practicable? **NO**

Please give reasons.

We have serious concerns about seeking to limit experts' fees. In the main the fees are regulated by the market and while experts in some specialties may already charge similar fees to those proposed in this consultation, those in others (such as neurosurgery) do not. These experts are likely to withdraw from this work which is increasingly time consuming, if they are not adequately remunerated. Further some expert fees include the cost of locum cover when they are required to attend court and conferences, thus the fees they charge do not represent profit for the expert. There is already a problem in clinical negligence in that the present restriction imposed by Legal Aid of a maximum hourly rate of £200 renders some leading experts unavailable to claimants. Some such experts are leaders in their fields and operate in fields where there are vanishingly few experts available. Such doctors are leaders in their field, their opinions carry the highest authority in matters of causation of brain injury in babies, but their hourly charging rates are above LSC current limits. Yet these same experts remain available to defendants, which creates inequality of arms..

If experts are able to maintain the present level of fees when advising defendants they could cease to do claimant work but will continue to do defendant work. This is the general view of experts we have consulted. If there is no equality of arms, claimants will be disadvantaged and denied access to justice as is their right.

The proposal to categorise work as in Annexe J is reasonable and experts' terms and conditions but the hourly rates will be unacceptable. We agree that there should be exceptional criteria. However, it is our view that when compared to the level of reporting required in personal injury claims (where perhaps some of the lower rates originate) that all expert evidence in clinical negligence cases merits categorising as exceptional. The current system is already close to breaking point with experts beginning to decline instructions on the grounds that the rates allowed by the LSC are not acceptable. The work of an expert witness is only one part of private medical practice and if providing expert opinion and appearing in court on behalf of claimants is less remunerative than other parts of their practice doctors in particular will cease to undertake this work.

At Annexe H and F the consultation paper suggests £135 per hour for an obstetrician, £90 for a midwife, £135 for a paediatrician and £135 for a radiologist. Our review of expert views confirms that no expert of the quality needed for clinical negligence cases would work for these rates when almost all but midwives are currently charging £200ph (and have held their rates at this level since 2005) , and that consultants can earn twice that hourly sum in private medical practice. Such proposals should be the subject of detailed discussion through an appropriate forum with relevant stakeholders (such as the Academy of Experts, EWI, bodies such as ourselves, CDF and the like) under the aegis possibly of the Civil Justice Council which we understand continues to have an experts' working group. The proposals applied to the clinical negligence field we regard as unworkable and unrealistic in their current form.

Alternative Sources of Funding

Questions 40 – 42 are a matter for private practice, the only point we would make is that nothing done in respect of client money should prevent paying interest to clients in accordance with current solicitors accounting rules

Question 43: Do you agree with the proposal to introduce a Supplementary Legal Aid Scheme? Please give reasons.

Please see our response to question 3. We maintain our opposition to the removal of clinical negligence from scope. If contrary to our primary position, clinical negligence is taken out of scope and a general scheme is adopted of a levy on general damages in all publicly funded damages cases where there was such a claim (as to which we have commented above), then subject to extensive discussion and safeguards we may support the introduction of a SLAS. The overriding principle of our approach to clinical negligence litigation is that the process should not hinder access to justice for claimants, that claimants should receive the damages to which they are due without deduction and that there should be equality of arms with claimants not disadvantaged by lack of access to the best legal advice and expert evidence because of lack of funds.

Question 44: Do you agree that the amount recovered should be set as a percentage of general damages? If so, what should the percentage be?

We agree this is one way of funding a SLAS. But there are other ways of providing such funding that do not seriously deplete a claimant's damages while providing the contribution to the SLAS

We have made our suggestions for a SLAS at 3 above.

Governance and Administration

Question 45: The Government would welcome views on where regulators could play a more active role in quality assurance, balanced against the continuing need to have in place and demonstrate robust central financial and quality controls.

This is generally a matter for private practice. We have no comment save to say that in clinical negligence, the system of requiring firms to hold a quality standard and for supervisors to have panel membership (of AvMA or Law Society) has led to an improvement and greater consistency of the service provided to clients

Questions 46 – 48 are applicable to private practitioners

Impact Assessments

Question 49: Do you agree that we have correctly identified the range of impacts under the proposals set out in this consultation paper? Please give reasons.

The range of the impacts we are considering is limited to clinical negligence and the proposal to remove clinical negligence from scope.

We would suggest that the range of impacts should include the effects of the Legal Aid reforms on lower value cases and the options for alternative sources funding for these cases in particular but due consideration should be given to all cases that are legally aided currently.

We are aware that the LSC has data on the percentage of cases in several of the categories of clinical negligence cases ranging from birth related injuries to orthopaedic cases.

The impact of removal of Legal Aid from each of these categories and the effects of alternative sources of funding on each of these categories should form part of the impact assessment especially to address the access to justice issues.

We would also suggest that due consideration should be given to the impact of providing Legal Aid funding for disbursements only.

As the proposal is to remove clinical negligence from scope a wider range of impact assessment should be considered.

Question 50: Do you agree that we have correctly identified the extent of impacts under these proposals? Please give reasons.

LSC client data forms the backbone of the data on which the proposed reforms are based.

With regards to clinical negligence being removed from scope there will be a substantial impact on ill and disabled people and in particular children given that almost 100% of children claims are currently funded by Legal Aid.

To fully understand the extent of the impact of the proposals on claimants due consideration has to be given to clinical negligence cases that will not receive Legal Aid under the new proposals and whether they will receive alternative sources of funding namely under CFA's, and whether providers will be able to provide services under the proposed alternative sources of funding.

The extent of these impacts have to be considered on lower value claims, in particular and on the range of cases from failure to diagnose to cerebral palsy.

The impact assessments of implementation of the new proposals is particularly limited in allowing any conclusions to be drawn as only those matters that currently receive Legal Aid has been considered and not whether those cases would be able to have access to justice under the alternative funding schemes proposed and the impact of that implementation.

Question 51: Are there forms of mitigation in relation to client impacts that we have not considered?

We would suggest that proposals to leave certain categories of cases within scope rather than the removal of all clinical negligence cases would certainly mitigate the impact of these reforms on clients. The expectation that exceptional funding will mitigate the impact on clients with clinical negligence claims is unrealistic.

Proposals addressing the costs of clinical negligence litigation rather than passing the burden of the costs to claimants should be considered, e.g. LSC funding of disbursements.


The CFA costs recovery reforms recommended by Sir Rupert Jackson were explicitly on the understanding that Legal Aid funding for clinical negligence matters should remain. To suggest implementing Sir Rupert's reforms in conjunction with significant cutbacks to the availability of Legal Aid is unsupportable and misjudged in our opinion


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