action against medical accidents

Registered charity Number 299123

RESPONSE TO

THE NORTHERN IRELAND FUNDING CODE:

A Consultation Paper on Proposals for
the Northern Ireland Funding Code

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Introduction

Action against Medical Accidents (AvMA) was originally established in 1982. It is the UK charity specialising in advice and support for patients and their families affected by medical accidents. 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 in England is not entitled to a clinical negligence franchise) and promotes good practice through comprehensive services to claimant solicitors.

Given AvMA's direct experience of clinical negligence, the focus of our response will be seen from this perspective. Whilst we accept that many of our comments may apply equally to other areas we wish to confine our comments to clinical negligence which falls within our own knowledge and expertise.

Our response comprises two sections:

- An overview
- Detailed comments and answers to questions for consultation which have implications for clinical negligence

Overview

The key question AvMA poses and addresses concerning the proposals is this: Is access to justice for the victim of a medical accident likely to be helped or hindered if the reforms proposed are implemented? AvMA has real concerns about any potential erosion of the rights of a person injured as a consequence of clinical negligence to receive appropriate compensation. Our conclusion is that the proposals as they stand would inevitably damage access to justice in the field of clinical negligence. We provide explanations as to why this would be the case, and where we can, make constructive suggestions of alternative approaches.

AvMA firmly believes that consideration should be given to improving access to justice in the field of clinical negligence rather than restricting it yet further. The LSC's own analysis shows "the volume of cases in Northern Ireland means that there is a relatively small practitioner base in this field of law."[1] It is now well established that it is a myth that there is anything resembling a 'compensation

[1] Access to Justice: Northern Ireland Legal services Commission, chapter 15, para 15.2

culture' amongst patients and their families. AvMA's own experience of directly helping thousands of medical accident victims each year is that people turn to the law only very reluctantly – usually as a last resort to get to the truth about what happened, or because it is the only route open to them to get the compensation they need to lead a reasonable standard of life after being injured.

This is not to suggest that recourse to the law should be the first or only means of seeking redress. AvMA shares the same belief as the LSC that legal action alone cannot provide the explanations, apologies and assurances which people want. We also believe that it is in people's best interests to explore more user-friendly approaches to dispute resolution than litigation. In our response to the chief medical officer's report '*Making Amends'* we made clear that we see positive potential for an approach such as an NHS Redress Scheme to provide an integrated approach to investigating medical accidents and offering compensation without recourse to litigation, provided there are a number of crucial safeguards. However, with the Redress Act not coming into effect in England until 2009 and complaints procedures still falling short on delivery, it is not appropriate at this stage to make any assumptions about what will be available or create extra barriers for people by forcing them to go through inappropriate procedures.

As stated above AvMA welcomes the view that public funding be employed for alternative mechanisms of redress other than litigation. However, it has not been customary for solicitors to assist clients in alternative mechanisms because the funding has not been there to do so. Whilst most solicitors encourage clients to make a complaint to hospital/clinic etc. as a pre-requisite to consider whether investigation is merited, in practice most clients have to navigate their way through the system alone. Some solicitors are prepared to act on a pro bono basis but work is unlikely to be extensive. The result is that an opportunity for early admissions/settlement of claims may be missed. The English experience of legal help is that, although legal help is available, in practice most solicitors do not avail themselves of it because of the cumbersome administration involved at very unprofitable rates. Hence, our concern is that if a balance is to be found, assistance for claimants must be adequately and effectively financially resourced.

AvMA also believes it is wrong to conflate the expense of litigation with the incentive for claimant solicitors to prosecute claims. This is to ignore the fact that resolving clinical disputes is a two-way process. We are made continually aware of cases where the defence do not concede that a mistake in treatment or management decisions was made until very late in the day. Responses to complaints are frequently less than candid and honest. Therefore, whilst we support alternative ways to resolve clinical negligence disputes as and when appropriate, it must be understood that in order to achieve resolution complainants/claimants need to be supported throughout the process. They must

have access to specialist advice and there needs to be realistic and appropriate funding to support it.

Many solicitors currently undertake filtering work on a pro-bono basis. Some do complaints and inquests pro bono. It is felt that this free work is not recognised by the LSC and will be lost if initiatives are not undertaken by the LSC to fund clinical negligence claims appropriately and aim to built up expertise in the area.

Questions for Consultation: detailed comments and answers

Question 1:

We do not agree with this proposal. It does not take into account the extra expense involved in pursuing clinical negligence cases. It also strikes us that changing the formula would work to the detriment of solicitors conducting cases in certain localities where the hourly rate is much higher. However, all this is to ignore the fact that the expense in running clinical negligence claims does not stem from lawyers alone but the large amount expended on disbursements in these cases due to the costs of medical experts. While it would be tempting to suggest that the LSC place a cap on the hourly rates allowed for experts, this would only have the effect of stopping the best and most sought after experts from acting for claimants rather than the defence placing the latter at an unfair advantage. It would lead to a situation where cases worth less than around £150,000 would not meet the cost benefit requirement, if one estimates the cost of a contested trial at around £40,000. Application of this rule would act as a driver to more cases being undertaken on CFAs - creating a ludicrous situation where costs would excessively outweigh damages. It also creates a perverse incentive for the defence to refuse mediation / ADR in legally aided cases as they will assume that legal aid will be limited to these processes alone.

Finally, we meet particular problems in our Advice and Information department in referring on fatal accident cases that many solicitors simply will not touch for the simple reason that the award of damages is likely to be “low” so that LSC funding will be refused. Our views with regard to the funding of fatal cases in England and Wales in particular are already known within the LSC. They have been documented in our response to the DCA consultation on *inquest funding* (www.avma.org.uk) Needless to say we feel immense disquiet at the prospect that meritorious claims of personal interest to the injured client but of public interest and concern also in the case of fatalities will not be pursued if a cost/benefit equation is simply and crudely applied.

Monitoring actual case outcomes as part of the LSC’s audit and compliance functioning may also not be appropriate in a clinical negligence context. Many cases start out with a view of damages that may either fall below or above the cost benefit threshold but involve substantial revision following causation

evidence. The latter may expand or contract the value of the claim depending on how far the injuries can be related back to the accident. It is most unusual for clinical negligence claims (other than "barn door" ones) to be rated as having 80% chance of success. We suggest the threshold is too high. Any case of 60% or greater ought to have a 1:1 ratio applied.

Question 2:

We do not agree. In a clinical negligence context, less than 1% of cases go to trial. It is therefore unrealistic to define prospect of success with no cognisance of the likelihood of a successful settlement. There are many reasons why a case will have a successful outcome which might not stack up if the case was tested at trial. For example, the defence might have made a payment in to court or offer of settlement. The claimant might have knowledge from defence that shows that they have no appetite for a trial etc.

It is notable that this test contrasts with the test in respect of "likely cost" where it is defined as costs to disposal of a case." The same test ought to be applied to the prospects of success.

Question 3:

It is welcomed that clinical negligence remains within scope for the time being. However, we are concerned about the possibility of this not remaining so in the medium to long term. This is very unsettling for those representing clients in this area. Clinical negligence is a specialism and training lawyers in this complex area of law underpins much of what AvMA does in its specialist panel work. At present only one Northern Ireland solicitor is an AvMA accredited specialist lawyer. This cannot be any reflection of the number of accidents that occur in hospitals in Northern Ireland. We have made a policy decision to focus more on our work in Scotland and Northern Ireland this year. Changes in funding might have the effect of undermining all this good work and learning as lawyers become disincentivised to take it on. We note that there are no immediate plans by the NI LSC to insist on panel membership as a pre-requisite to undertaking clinical negligence work in Northern Ireland. However, we believe achieving specialist status is an objective to work toward and we would be keen to collaborate further with the Commission in Northern Ireland in such a project as indeed is the case in England.

Further, it is noted that in paragraph 7.2 the commission gives top priority to, amongst other areas, proceedings against public authorities in cases involving serious wrongdoing. It is submitted that there is considerable overlap between this and clinical negligence. Pursuing claims against hospital trusts involves serious wrongdoing (affecting as it does life and limb). It allows hospital bodies to learn to face up to mistakes and take responsibility, as well as affording opportunity to learn from error and improving patient safety.

Question 4:

We have no comment to make about this as it is an area outside of AvMA's expertise.

Question 5:

We agree provided that the monitoring of case outcomes takes into account the issues that relate to clinical negligence where the impact of causation evidence can revise quantum assessments radically (downward).

Question 6:

We have no comment to make about this as it is an area outside of AvMA's expertise.

Question 7:

We have no comment to make about this as it is an area outside of AvMA's expertise.

Question 8:

We have no comment to make about this as it is an area outside of AvMA's expertise.

Question 9:

We have no comment to make about this as it is an area outside of AvMA's expertise

Question 10:

We do agree

Question 11:

We have no specific comments to make about this save that we would agree that a public interest advisory panel, modelled we presume like the one for England would assist in this area.

Question 12:

We have no suggestions to make but regard it as inappropriate for the LSC to shift funding responsibilities for public interest cases on to the voluntary sector

where funds are limited. This would have the effect of diverting much needed revenue used to help fund front-line services such as advice services (which AvMA, in particular, provide to the public at no cost to clients).

Question 13:

See response to Question 11 above.

Question 14:

Very few clinical negligence cases are ever contested at trial. Most firms settle cases following round the table discussions with their opponents. The courts In England have the power to ensure that ADR is considered and take into account any unreasonable refusal to enter into ADR in making decisions about costs. A safeguard such as this seems sensible. A further safeguard might be to require an offer of mediation or negotiation to be made in letters of claim and provide the LSC with copies of this and of the response before being awarded further funding for a case.

AvMA is an advocate of alternative dispute resolution (ADR) where appropriate. However, AvMA remains concerned that so many cases still settle too late on in the process. Mediation or ADR cannot work if the claimant does not have enough ***information*** to assess the strength and value of the claim. Therefore we do not agree that ADR can be attempted, on the whole, before funding for representation for court proceedings could be granted (i.e. after investigative help).

While ADR may be effective in circumstances prior to exchange of medical evidence (e.g. breach of duty or liability conceded) AvMA is opposed to the idea of compulsion implicit in the paper. We are disappointed by the lack of progress in the joint AvMA / CEDR / NHSLA project originally funded by the LSC in England. The project envisaged the provision of training for all stakeholders who might be involved in mediation in clinical negligence cases. We remain committed to the exercise but are pessimistic about the LSC recognising that it ought now to finally attract the support it needs. Another part of the same project would provide clinical negligence-specific training and accreditation for mediators. The wider availability of true specialists would both improve confidence on the part of people who might use mediation, and should also help make the costs of mediation, which are currently very high, more competitive. As stated before, despite widespread support for the project we are disappointed that it has not been pursued beyond the feasibility study funded by the LSC and despite the intentions of the Department of Health referred to in Making Amends[2]. We would be very willing to discuss our experience of mediation in England and Wales further (as indeed we have done for the Scottish executive), for example.

[2] Making Amends, page 96, para23-24

Until such training takes place we remain guarded about a process that might well be effective and fair but appropriate safeguards need to be in place prior to whole-scale endorsement. Moreover, it takes more than the claimant to reasonably accede to or decline ADR. The LSC in England's own data[3] reveals that in most cases mediation did not occur because the offer to mediate was declined by the defence.

If, as the LSC proposes, certificates are limited to pursuing ADR we are worried about otherwise perfectly meritorious claims being abandoned because the defence tactically refuse ADR knowing that funding will be withdrawn (as, we are informed, is currently the case).

Question 15:

We believe that it would be premature to amend the code to force claimants to go through a complaints procedure first. Specialists in clinical negligence are more than able to identify when it would be in the client's best interests to use the complaints procedure first, and often this is the course taken – especially when AvMA advise clients. However, the current complaints system is not geared towards identifying the issues that directly inform decisions about the merits of a compensation claim. In fact, the procedure specifically excludes such matters and concentrates solely on seeking to resolve dissatisfaction. If a complainant signals his/her intention to seek compensation they can even have the shutters brought down on their complaints investigation. Complaints can take a long time to complete, and AvMA are aware of some cases that have fallen outside limitation because of delays due to the complaints procedure being completed. Huge investment in staff and training may be necessary to enable hospitals/clinics etc to investigate complaints more thoroughly and speedily, and to deal with the extra complaints the proposal might result in. If a claimant and their specialist adviser are sure that the best course of action is to proceed to litigation, then to force people back to the complaints procedure will be perceived as yet another obstacle being put in the path of accessing justice. It would have the effect of wearing some people down to the point where they cannot cope with the prolonged stress of starting all over again with what is a completely different procedure.

If the decision is taken to require people to use a complaints procedure before qualifying for legal aid, we would suggest that the limitation period must be extended. However, we also recognise that the effect of delays can be detrimental to the defence as well as the claimant. If limitation periods are extended there may be difficulties with formulating a defence or a claim if witnesses cannot be traced or memories fail. There may be problems in locating key documents. Circumstances when it would ***not*** be appropriate to require people to have used the complaints procedure include:

[3] ibid

- where both sides agree it would make more sense to deal with the issue through the legal route
- where the Trust/clinic etc has brought an end to the complaints procedure because of the complainant's intention to take legal action
- where the complaints procedure can be demonstrated to have taken an unreasonable length of time
- where the hospital etc can be seen to have been less than fully honest about the incident already, or where reasonable doubts exist about the objectivity with which the hospital will be able to investigate itself
- where there is danger of getting close to or exceeding the limitation period (unless, of course, limitation is extended whilst the process is going on).

Question 16

Please see response to question 14 above.

Question 17

We do not accept that it is appropriate for funding to be refused or deferred in the light of the resources available to the fund and likely future demand on resources. We recognise the pressure on the LSC budget. However, for the reasons stated above we find it iniquitous that largely because of the huge cost of funding other cases, potential claimants in clinical negligence cases should find access to justice even harder to achieve. Clinical negligence is an area where there is strong evidence that there is a very small amount of litigation (and reducing), given the scale of medical errors. The LSC has not made any suggestions of evidence of poor practice, and there is not a substantial amount of savings that can be achieved from the proposals relating to clinical negligence.

Question 18:

There may be a role for a Special Cases unit. However the experience for solicitors in England has been vexed with the LSC applying a very heavy hand as well as overly-interventionist role that results in top-heavy administration, burdening lawyers with additional work (for which ultimately they often cannot be reimbursed) and frustration with the effect it has on slowing down progress of cases. The LSC in England are devising methods for reducing the burden for both the LSC and lawyers. The LSC in N. Ireland, we hope, will be engaging with the LSC in England to learn from them.

Question 19:

This mirrors the situation in England.

Questions 20-25

We have no specific comments to make about judicial review other than those more generally stated elsewhere.

Conclusion

We hope that our observations and comments will be seen as useful. AvMA is a strong advocate of public funding to promote access to justice and generally supports the aims and objectives of the LSC. We enjoy a constructive relationship with the LSC in England and would welcome engagement with the LSC in Northern Ireland as well. Should there be any issues arising from this paper or otherwise that the LSC requires further clarification on, we would welcome the opportunity to develop or discuss them further.

Fiona Freedland
Legal Director
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