avma
action against medical accidents

RESPONSE TO CONSULTATION: <u>FIXED RECOVERABLE COSTS: Consultation on issues relating to the new regime (July 2023)</u>

<u>About AvMA</u>

1. Action against Medical Accidents (AvMA) is the national patients' charity for patient safety and justice. We provide free independent specialist advice and support to patients and families who have been affected by avoidable harm in any kind of healthcare setting. This provides us with a unique and extensive insight into the experience of patients and families following such patient safety incidents. We use this experience and our knowledge of the healthcare system to work with others to develop policies, systems, and practice to improve patient safety and the way that patients and families are treated following avoidable harm.

2. Although most of the people AvMA helps do not go on to make a clinical negligence claim, such claims are a vitally important option for many who need compensation to help cope with the implications of the injury or loss that has been sustained, and/or have exhausted other attempts to resolve their concerns and hold the organisation responsible for the injury to account. We have therefore always taken a strong interest in clinical negligence and have extensive in-house knowledge of how the system works. And because clinical negligence is a specialist area of law which we believe should only be undertaken by those with the right level of expertise, we operate a highly regarded accreditation scheme for specialist clinical negligence claimant solicitors and provide training for lawyers practising in clinical negligence. We get useful intelligence from the lawyers we work with and from medical experts on our extensive database. However, our primary focus is always on the needs of injured patients and their families.

3. AvMA welcomes the opportunity to respond to this consultation. We think it disappointing that the Ministry of Justice did not consult before issuing the SI 2023 No.572 (L.6) "The Civil Procedure (Amendment No. 2) Rules 2023. It is also disappointing that having now consulted, only 7 weeks have been allowed for the consultation instead of the agreed recognised practice that Government adopts of 12 weeks.

4. In our view there are two reasons why the Ministry of Justice (MoJ) should not be consulting on clinical negligence issues at all. First, government represented that clinical negligence claims valued at between £25,000 - £100,000 would not be subject to a Fixed Recoverable Costs (FRC) regime at all. We refer to paragraph 12 and 13 below for quotes and detail on the representations made.

5. Second, the Department Health Social Care (DHSC) has consulted on a bespoke FRC scheme for low value clinical negligence claims (LVCNC) valued up to £25,000. That scheme suggests a specific process designed for clinical negligence claims and recognises that a FRC regime is not suitable for certain types of clinical negligence claims which should therefore be exempt FRC regardless of value.

6. The difficulties of applying a FRC regime to a complex area of law such as clinical negligence is reflected in the fact that more than 15 months have passed since the LVCNC consultation has closed and there is still no indication of when the government will respond.

7. To ensure consistency of approach, the MoJ should at the very least have waited to see the DHSC response to LVCNC before considering including clinical negligence claims in the higher FRC band. That government has chosen not to wait is irrational policy making.

8. This consultation has a lens on FRC as it applies to claims valued at between £25,000 - £100,000. Amongst other things it seeks to refine its attempt to include clinical negligence claims in a FRC regime by clarifying that for a clinical negligence claim to qualify for the intermediate track and therefore a FRC regime, an admission of liability and causation must be made in the pre action protocol (PAP) period.

9. The consultation also seeks views on how inquest costs should be managed where there is a subsequent successful civil claim which falls into the FRC regime. No previous consultations, discussions or considerations have given to how inquest costs should be treated. Again, this appears to be irrational policy lacking in transparency.

10. It is AvMA's view that even with these proposed "refinements" the statutory instrument still lacks the detail required to properly accommodate clinical negligence claims and/or inquest costs. The inevitable consequence is that parties will have to revert to satellite litigation to seek clarity. The cost of that satellite litigation will be borne by the injured party, the claimant, and the costs will be deducted from the claimant's award of damages. This is unjust.

Protection for claimant damages

11. As the MoJ is aware, damages are awarded to a claimant on a restorative basis. Anything that diminishes the value of those damages must be avoided else it thwarts access to justice and makes a mockery of the Rule of Law. It is worth stating that damages are awarded to put the injured person back in the position they would have been if the negligence had never occurred. Damages are not awarded to cover the successful claimant solicitor's costs.

12. The first consultation on FRC in civil claims valued at £25,000 - £100,000 published in June 2019, stated: ***"Clinical negligence cases are generally excluded from the FRC proposals made in this consultation".***

13. In the response to this consultation further reassurances were given: ***"The government can confirm that the following category of case will be excluded categories from the expanded fast track at this stage: i. Mesothelioma and other asbestos related claims; ii. Clinical negligence cases." [see page 73, para 12.4]***

14. Those representations were relied upon by interested parties including claimant groups.

15. It is extremely disappointing that the consultation has not recognised or invited discussion about whether and how claimant damages might be protected. Consequently, were these proposals to be taken forward, the clinical negligence claimant who successfully demonstrates that the very high bar for proving negligence has been met, risks losing their award of damages to costs.

16. Currently, claimants who can prove clinical negligence can recover their costs on the standard basis. This does not mean that they will recover all their costs. There are already stringent checks and balances on whether the costs incurred are proportionate to the value of the claim. The courts look at whether the costs were reasonably and necessarily incurred. If the court is satisfied as to these requirements, then costs will be paid at a rate deemed acceptable by the costs judge or which is agreed between the parties themselves.

17. Currently, the rate broadly reflects a commercial market rate for the work done. While only a guide, the costs judge will be mindful of the Guideline Hourly Rate (GHR) which was last updated in October 2021: https://www.gov.uk/guidance/solicitors-guideline-hourly-rates

18. The GHR, unlike FRC recognises the value of experience and regional variations in overheads and costs. By comparison FRC is a blunt instrument which does not recognise any variation in the level of skill and expertise required in a case. The rate payable under FRC is a flat rate which offers no variation for the skilled and specialised practitioner, or the practitioner who is more experienced than others. FRC does not recognise the complexity of clinical negligence claims where a low value claim can be just as complex as a high value claim.

19. In failing to recognise the importance of expertise in this area and the importance of a commercially viable rate to reflect those skills it shunts the cost from the party who is responsible for the injury to the party suffering from the injury in this case, the harmed patient.

20. The FRC process artificially depresses the amount that can be recovered from the losing party. That will not prevent claimant lawyers from charging a commercial rate for their work. It simply means the cost burden shifts from the party responsible for the negligence, the injury and the costs over to the injured claimant. The shortfall comes out of the harmed patient's - claimant's - damages.

21. Part B of the After the Event (ATE) insurance premium also comes out of the claimant damages. The recent changes to Qualified One-way Costs Shifting (QOCS) now mean adverse costs orders can wipe out a claimant's award of damages. The net effect of this is that ATE, Part B insurance is now necessary rather than optional if the claimant wants to protect their damages.

22. Neither the LVCNC proposals nor these proposals offer any way for a successful claimant to protect their award of damages from being eaten up by legal costs. When Conditional Fee Agreements (CFA) were first introduced, the government recognised the importance of preserving the successful claimant's damages by preventing lawyers acting for them from wiping out their award by claiming excessive success fees. It did this by capping the success fee so that it could only attach to certain heads of damage (past losses and general damages).

23. Despite increasing the likely shortfall in costs which will occur by artificially depressing the market rate payable to claimant lawyers through the FRC regime, it does not offer the successful claimant any protection for their award of damages. It will create a situation where no matter how strong the claimant's case, if the defendant trust and NHS Resolution on its behalf fight the case hard, causing the claimant lawyer to do more work, then the costs will increase and be borne by the patient from their award of damages.

24. It is a basic legal premise that he who alleges must prove. The onus is on the claimant and injured party to prove their claim. On the face of it, difficult arguments over whether the legal test for negligence has been satisfied are removed by only allowing cases where there has been an admission of liability in the protocol period. However, the lack of a streamlined process ignores the fact that there can be and often are arguments over the value of the claim.

25. Difficulties on quantifying a claim can be caused by putting a claimant to proof as to their loss of earnings, particularly if the claimant is self-employed. Other common difficulties are around proving a claimant's loss of bonus or loss of promotion opportunities, or pension contributions. It is not uncommon for there to be dispute over prognosis for recovery and care costs. There are no protections or incentives to prevent or dissuade this sort of behaviour. For example, there are no opportunities for a claimant to drop out of the FRC regime where the defendant's make unjustifiably low offers of settlement. If the low offer is made by way of Part 36 offer, recent QOCS rule changes mean that a claimant may quite literally be scare mongered into accepting the low offer for fear of cost repercussions with accepting the Part 36 offer out of time.

26. There is a bitter irony in the fact that an injured patient, having successfully proven their case must then pay their lawyer for the benefit of demonstrating that the care they received from the paying party was substandard and caused them injury. The shortfall payment will be made from the claimant's award of damages and will be used to top up the difference between the commercial rate charged by their lawyer and the amount they receive from the defendants under the FRC regime. That rate is chargeable regardless of whether the claimant lawyer is addressing quantum issues only, or not.

Access to justice concerns

27. A FRC regime will almost certainly reduce the costs incurred by the NHS in settling clinical disputes, but it will do so by preventing injured patients from exercising their right to legal redress. There are few injured patients who will bring a claim, no matter how strong, if they will end up with a much-diminished award and in the worst cases wiping out their damages award and owing their solicitor money because the damages do not cover their obligations under the CFA.

28. This will mean that access to justice exists in name only. Injured patients will be reluctant to exercise their right to legal redress if there is a risk that there is nothing in it for them. Worse still, but equally possible is that they will end up recovering no damages but owing their lawyer's money because the shortfall in costs is so great.

29. Using this route to reduce the number of claims being made will also reduce the spotlight on repeated healthcare mistakes. It will reduce the need for the NHS and other healthcare providers to be accountable not just for the way they operate but for the amount it costs to properly compensate people who have received negligent treatment. It will also reduce the ability and the opportunity for the NHS to learn lessons and improve patient safety.

30. A streamlined process would have provided an opportunity for healthcare providers to include a step whereby they acknowledge and address the mistakes identified in the PAP process. Including clinical negligence claims into a FRC regime in this way completely misses an opportunity to identify a way of feeding learning back into the healthcare system.

31. Identifying mistakes and being committed to learning from them is the only way the NHS and other healthcare providers will improve. Those improvements will reduce the number of adverse incidents and incidences of negligence that occur, it will promote better patient safety and ultimately is the only realistic way of keeping costs down and offering better protection to the public.

32. There are several key motivators for injured people bringing a claim and litigation is for most people a daunting proposition and a last resort. However, the determination to get answers to what went wrong, the need to bring about change and so avoid others experiencing the same thing as they have done are powerful incentives.

33. It is true that many people bring claims because they need an award of damages to get them out of debt that may have occurred as a result of a loss of earnings caused by the negligent injury or similar but money on its own is a blunt instrument.

34. The current SI does not begin to address these difficulties or offer protections for the claimant's damages.

35. Even if there is an admission of liability and causation in a clinical negligence claim in the pre action protocol period, the SI offers no process by which quantum issues can be efficiently resolved.

36. Jackson LJ said r (Chapter 7, paragraph 3.1) in his "***Review of Civil Litigation Costs: Supplemental Report***" published in 2017: https://www.judiciary.uk/wp-content/uploads/2017/07/fixed-recoverable-costs-supplemental-report-online-2-1.pdf that "*..if recoverable costs are going to be fixed, the procedure must be streamlined, so that lawyers on both side do less work. It follows from this second point that only cases **suitable** for a streamlined procedure should be allocated to the intermediate track." [our emphasis in bold]*

FRC and suitable cases

37. It is far from clear that clinical negligence claims are ***suitable*** cases. A fundamental difficulty with clinical negligence is that complexity often has little or no bearing on value – a low value claim can be complex and therefore difficult and expensive to prove. The fact that the DHSC has taken more than 15 months to consider the responses to the LVCNC consultation is a strong indication of just how difficult it is to make FRC fit for complex, specialist claims like clinical negligence.

38. Even if there were an admission of liability and causation in the pre action protocol period, there still needs to be a streamlined process to ensure that quantum issues are correctly managed. The fact that each party seeks to rely on oral evidence from a maximum of two experts each, the trial is not expected to last more than 3 days, and the value of the claim does not exceed £100,000 is not a process, it is a qualifying requirement.

39. Draft Practice Direction 45, an early publication of fixed costs first made available on 20.04.23: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1151886/frc-cpr-pd-45-draft-early-publication.pdf

40. The tables do not appear to provide for fixed costs to be awarded in clinical negligence claims where there is an admission on the PAP period with quantum to be resolved. Although Table 14, rule 45.50 sets out the amount of fixed costs allowed in the intermediate track, this refers to stages of litigation; it does not address admissions on the PAP and any subsequent quantum only issues.

41. The minutes from the Civil Procedure Rules Committee dated 03.03.23 refer at paragraph 17 & 18 to FRC and the ***"necessary compromises required as part of the drafting process in order to achieve workable solutions to what are complex issues".*** While that note does not refer to compromises in the context of clinical negligence claims, that is what appears to have happened here. It should be noted that Jackson LJ did not talk about compromises being reached in order to make FRC fit claims, instead he referred to whether cases were suitable. Arguably, a case which must be compromised to fit a FRC regime, is not by its nature suitable.

42. There is no consideration as to what complexity band clinical negligence claims should be assigned to. Contrast professional negligence claims which are clearly referred for the highest level of complexity, category 4.

Cutting across work being done on LVCNC

43. CJC Costs Review Final Report published in May 2023 states at paragraphs 4.2 and 4.3 that it is not ***"part of the Working Group's remit to cut across the work being done relating to costs in clinical negligence cases…The working group has always been clear that it is tasked with considering the wider implications of the changes to FRC for the rest of civil justice system."***

44. Including clinical negligence claims into a FRC regime for civil claims valued £25,000- £100,000, does cut across the work being done by DHSC.

45. Consulting on how costs in inquest cases should be dealt with where a subsequent civil claim is subject to FRC, directly cuts across work being done by the DHSC in LVCNC.

46. The consultation on LVCNC suggested that fatal cases involving still births or neonatal deaths should be exempt FRC. Many of the responses to this consultation have said that there is no worse outcome than death and so all fatal claims should fall outside of FRC.

47. It is entirely possible that a clinical negligence claim where an admission of liability is made in the PAP period may be a fatal claim. It is equally possible that the admission was made following evidence heard at an inquest.

48. The DHSC has not yet responded to the consultation on LVCNC. After consideration the DHSC may well agree that all fatal claims should be exempt FRC. Consequently, this consultation leap frogs the DHSC response by pre-empting that fatal claims will be included in the FRC for claims valued up £100,000. That is irrational.

49. There should be no conflict between the stance which may be taken by DHSC and these proposals. The examples given illustrate how inevitable that conflict becomes by trying to include higher value clinical negligence claims into a FRC regime before the DHSC has responded to the responses to LVCNC.

50. This consultation is considering whether Part 8 CPR should be subject to a FRC regime. However, this too cuts across the DHSC work on low value clinical negligence claims in so far as there is still a question as to whether protected parties should be exempt a FRC regime in LVCNC.

51. It is distinctly possible that DHSC will accept that all fatal claims should be exempt FRC regime, as should protected parties. Given that, it is premature, inappropriate and irrational for this consultation to be considering how inquest costs should be managed and whether Part 8 proceedings should be subject to FRC.

52. There is no doubt that even if the amendments proposed in this consultation were to be approved, and incorporated into a revised version of the SI, it will still not offer a process by which quantum in clinical negligence claims can be determined and there is no mechanism for introducing fair and effective sanctions to control behaviours.

53. The difficulties highlighted here demonstrate the travesty of trying to include higher value clinical negligence claims into a FRC regime before there has been a response to the consultation proposals on low value claims.

54. Our response will be made public.

Questions for respondents: Please give reasons for your response

55. **<u>Fixing costs for Part 8 only claims – as affects clinical negligence claims:</u>**

56. Part 8 proceedings are used where a courts decision is required in a fairly straightforward issue such as, obtaining the court's approval of an infant settlement, or where the claimant is claiming in a representative capacity perhaps on behalf of a minor or someone under a disability.

57. Fixing costs for Part 8 only claims has not been dealt with in clinical negligence claims to date because no streamline procedure has been designed for this category of work.

58. There is no process for how clinical negligence claims valued up to £100,000 should be managed where the claim involves a child or person whose capacity is an issue even where there is an admission of liability made in the pre action protocol period.

59. Part 8 proceedings will need to be issued in clinical negligence claims involving children or any other case where the claimant is claiming in a representative capacity.

60. It is unclear whether Part 8 proceedings should even be considered for a FRC regime given that the current SI includes a provision at Rule 26.9 (10)(c) which says that *"A claim must be allocated to the multi-track where that claim is – (c) a claim for damages in relation to harm, abuse or neglect of or by children or vulnerable adults"*

61. The provision does not specify whether the reference to "harm" includes medical harm.

62. As referred to above, the DHSC Consultation on LVCNC which closed on 24th April 2022 will need to consider whether clinical negligence claims involving children or those under a disability should be exempt FRC regime. Pressing ahead with FRC in higher value claims without waiting for DHSC response will only create confusion and result in unnecessary and expensive satellite litigation, the cost of which will be borne by the claimant and injured party.

63. Given the need for consistency in approach to clinical negligence claims AvMA recommends references to clinical negligence claims being subject to FRC in the event of an admission of liability in the pre action protocol period be removed from the current SI. Given that this consultation clearly cuts across the work that DHSC are doing on low value claims, all clinical negligence claims should be allocated to the multi-track until DHSC has responded and a consistent approach can be identified. To not do so would be irrational policy making.

64. Inquest Costs: Providing for the recoverability of (a) inquest costs and (b) restoration proceedings

65. The fact that some inquest costs are recoverable if subsequently there is a successful civil claim is often the only way families can secure legal representation at a healthcare inquest. By contrast, the NHS and is invariably represented at inquest as are other healthcare providers.

66. Government is acutely aware of the stark inequality of arms that already exists between families/loved ones of the deceased and NHS Trusts at healthcare inquests. Clear reference was made to this at the recent Justice Committee report on the Coroner's Service: https://committees.parliament.uk/publications/6079/documents/75085/default/

67. While some families may be able to secure funding through the Lord Chancellor's exceptional funding provisions for legal aid, the financial eligibility requirements having recently been relaxed, but satisfying the merits test for legal aid remains problematic. The merits test requires a family to demonstrate that the inquest is an Article 2 inquest and/or that there are public interest issues which very difficult hurdles to clear.

68. The reality is that most families do not meet the legal aid exceptional funding criteria. Any provisions which risk further removing families access to justice at inquest must be carefully thought through in a considered and consistent way.

69. Question 10 of the DHSC LVCNC consultation asks, "Do you agree or disagree with the proposals on claims to be excluded from the FRC scheme and on the approach to protected party claims" The consultation proposals recognise that stillbirths and neonatal death cases should fall outside of a fixed recoverable costs regime. There is a body of opinion that says as there is no worse outcome than death, all fatal cases should be excluded from a FRC regime.

70. All fatal accident claims require a family's legal representative to show compassion and patience when taking instructions. It is irrational to consider how inquest costs should be approached in civil claims valued up to £100,000 when the DHSC itself recognises that in LVCNC certain types of death are not suited to a FRC regime.

71. The Civil Procedure Rules committee is effectively leapfrogging the outcome of the DHSC response by considering that deaths arising as a result of clinical negligence, even where there is an admission of liability in the Pre Action Protocol stage are suited to a FRC regime.

72. It is inappropriate and premature of the Civil Procedure Rules Committee to contemplate how inquest costs should be dealt with in a FRC regime when the DHSC has not given any further indication of how it intends to approach these cases.

73. Rather than consulting on how the CPRC should approach inquest cases this consultation should ensure that any clinical negligence claim involving a death and/or a claim under the Fatal Accident Act is exempt a FRC regime at least until the DHSC has given its view. That should be the case even if there is an admission of liability in the Pre Action Protocol (PAP) period.

74. Only by taking this approach can CPRC be confident that they are promoting a fair and consistent approach to inquest costs in clinical negligence claims and any FRC regime which may be introduced for low value claims.

75. The DHSC proposals in LVCNC recognises that some clinical negligence related deaths should be exempt a FRC regime even in low value claims. It is equally likely that this exemption may be widened to cover any death occurring because of clinical negligence.

76. Clinical negligence claims entering the intermediate track

77. The proposals made in this consultation and set out at paragraph 50 seek only to clarify that: *"… the rules on clinical negligence at rule 26.9(10)(b) [ref the statutory instrument 2023 No 572 (L.6) – The Civil Procedure (Amendment No 2) Rules 2023] should be tightened to make explicit that the early admission of liability must be made in the pre-action protocol letter of response".*

78. Even if this clarification were accepted it does not make the proposed fixed recoverable costs regime fit for including clinical negligence claims. This proposed wording fails to recognise that some of the clinical negligence claims which may fall

into the intermediate track may also be claims involving death and work undertaken as part of representation at an inquest. It may also involve cases where the claimant requires a representative to act for them, for example where minors are involved, hence Part 8 proceedings may be relevant to clinical negligence claims.

79. There is no streamlined process identified for lawyers to do less work on quantum in the settlement period when FRC will apply. Consequently, the same amount of work will be required in a FRC regime as outside of a FRC regime, but the claimant is nonetheless being penalised by fixed costs.

80. There are no provisions to control behaviours of either claimant or defendant parties and/or their representatives. There are no penalties for unreasonable litigation conduct built into the process. This was recommended by Jackson LJ in his 2017 supplemental review of Civil Costs (see chapter 7, para 5.14)

81. There is no clarity around how Part 8 claims relevant to cases where there has been an admission of liability in a clinical negligence claim should be treated. Jackson LJs supplemental report on Review Civil Litigation costs 2017 says (Ref Chapter 7, para 6.1) says that introduction FRC for claims issued under Part 8 CPR should in the first instance be controlled by cost management, he went on to say: "*It is first necessary to let the intermediate track and the proposed FRC for Part 7 claims bed in".*

82. There is no indication as to what complexity band should be applied to clinical negligence cases entering intermediate track. Contrast with professional negligence claims which are identified as falling into complexity band 4 - no specific reference is made to clinical negligence claims. Jackson LJ recognised at Chapter 7, paragraph 3.12 there would be need for a practice direction for the intermediate track to include specific guidance on assignment of bands. While there is guidance on assignment of professional negligence claims there is none for clinical negligence claims.

83. There is no indication of how clinical negligence cases which plead both Human Rights Act issues and allegations under domestic tort law should be managed. Human Rights Act claims are exempt FRC, but what about hybrid cases?

84. Even if the proposed amendments suggested in this consultation were included in this statutory instrument for FRC in civil claims up to £100,000 it remains a poorly through document which is not fit for the inclusion of clinical negligence claims even if the only issue is quantum.

85. All reference to clinical negligence claims being included an a FRC regime, regardless of whether an early admission of liability is made or not should be removed.

86. The MoJ should respect the DHSC process and consideration of FRC for low value clinical negligence claims.

87. It should not attempt to shoehorn clinical negligence claims into a regime particularly where it offers no streamline process, no incentives to avoid poor behaviour and no reason, justifiable or otherwise for acting contrary to its own clear and unequivocal representations that clinical negligence claims would be an excluded category for the purpose of a FRC regime.

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