AvMA Position statement in response to CJC request of 19.06.19

1. On 19th June, the claimant group were asked to set out their position in relation to the following specific issues:

    (i) The level of costs proposed for light track (LT) and standard track (ST) with an explanation/comments on the cost proposals

    (ii) The issues not agreed between the parties

    (iii) Your position on exclusions from FRC scheme which are not agreed

    (iv) Who pays for mandatory neutral evaluation (MNE)? The most recent proposal put forward by the defendant group is that parties share the cost of MNE equally with C being able to recover their costs from D if the MNE is in their favour

    (v) Fees payable for MNE. D proposes £1,000 for the cost of an MNE on liability issues only and £1,500 for MNE on liability and quantum and £500 on quantum issues only. Comments from the C group are invited.

Context

2. AvMA holds a unique position within the CJC working party. We do work closely with claimant clinical negligence lawyers, but we are not an organisation for lawyers. We are an independent charity; our primary objective is to improve patient safety and access to justice for people who have suffered avoidable harm in healthcare. Avoidable harm includes incidents where unintended/unexpected harm appears to have occurred as a result of errors or omissions in any kind of healthcare.

3. It is important to stress that the claimant group would have preferred wider terms of reference, which analysed the root causes of high costs in clinical negligence and the variety of ways in which costs can be reduced without damaging access to justice. Proposed terms of reference were submitted by AvMA, APIL and the Law Society which reflected this[1]. These proposals were rejected by the MoJ and DHSC.

4. It is also important to stress that the actual terms of reference for the working group have not yet been followed. Crucially, the working group has not conducted an analysis of to what extent, if any, the current proposed process represents an "improved process" to the current process or its likely effect on access to justice, let alone other processes which might have been explored. This, despite requests that this be conducted and assurances that it would be.

5. The claimant group has concerns about the serious risks for claimants' access to justice which the current process under consideration carries. We are also concerned that

[1] https://www.avma.org.uk/?download_protected_attachment=FINAL-ToR-Agreed-AvMA-TLS-APIL-30.11.17.pdf

insufficient attention has been given to the patient safety element of the terms of reference, and the process of the working group itself.

6. The process currently under consideration only emerged very late in the life of the working group. There has been insufficient time to give due consideration to it and the strict confidentiality rules attached to the working group has prevented the possibility of testing the ideas with the wider claimant community.

7. Long before the CJC working party was convened AvMA recognised the need and called for a bespoke process for clinical negligence claims valued at £25,000 or less. This was clearly set out in our response to the LASPO Bill in 2013.

8. As documented in our response to the DH consultation 2017, AvMA does not oppose fixed costs per se, however the costs applied to that grid of costs must be realistic and commercially viable to enable solicitors to undertake low value clinical negligence work properly at a profit.

9. Our primary reason for being included as a member of the CJC working party was to be able to contribute to the CJC working party's remit to consider how any new process will affect patient safety and learning.

(i) The level of costs proposed for LT and ST with explanation and comments on the cost proposals

Level of fixed costs proposed

10. It is not for AvMA to tell lawyers how they should run their business; we do not advise on what the correct level of remuneration should be. We are not going to comment on the figures proposed for either LT or ST, save to say that it is impossible to tell how experienced claimant lawyers will respond to the latest cost proposals.

11. [redacted]

12. To ensure claimants have access to good quality legal representation and advice it is important that claimant lawyers who have expertise and experience in running clinical negligence claims are prepared to work for the rates offered.

13. Clinical negligence is a complex area of law, the award of damages that can be achieved often has no correlation with the serious nature and/or complexities of a claim. Fatal claims are a good example of this, many people agree there can be no worse outcome than death, yet some fatal claims will only attract the statutory bereavement award, currently £12,980 and funeral expenses.

14. It is also important to ensure that lawyers who are prepared to do this work are not concentrated in niche geographic locations. The level of remuneration should be sufficiently

attractive for experienced lawyers across the country to undertake this work and to take whatever steps are necessary to achieve the right outcome.

Protection of client damages & access to justice

15. The proposed fixed costs scheme is intended to work with Conditional Fee Agreements (CFA). Unlike success fees which are ringfenced at a maximum of 25% of a client's general damages and past losses, shortfalls in costs that occur under a CFA are not similarly ringfenced. The scheme does not offer any protection for client damages.

16. The current proposed levels of fixed costs under both LT and ST are so low that it increases the likelihood that claimant lawyers will only take on those cases which they are almost certain will win. Each firm will have their own risk assessment to identify what they consider to be a viable case; cases will stand or fall at the first risk assessment hurdle based on their prospect of success. The effect will be that firms will almost certainly "cherry pick" cases.

17. This means that the more complex, low value claims which are time consuming, costly to prove and risky are going to find it harder to find representation. Lawyers will also be more attracted to the high value claims because of the proposed 40% costs award that is calculated on damages recovered.

18. If this scheme is introduced it will increase the risk that many low value claims will not be taken on by lawyers particularly if the issues are complex. The cost of proving those claims is going to be higher, those additional costs will not be recovered on a fixed costs scheme; lawyers will look to the client's damages to recover their shortfall in costs due under the terms of the CFA.

19. If claimant lawyers are forced to look to their client's damages to recover their costs this risks client damages being severely reduced or even wiped out altogether by their solicitor own client costs.

20. If this situation arises then it will cease to be in a client's interests to bring any sort of legal claim. It carries reputational risks for claimant clinical negligence lawyers. It will not help to address patient safety issues as the cases will no longer be captured by the litigation process. There will be no accountability for healthcare providers and no access to justice for the injured party.

Cases under settled

21. Lawyers taking on difficult to prove low value claims may also be forced to recommend their client accept low offers and under settle the claim. If the cost of continuing with the litigation to achieve reasonable settlement is fixed and where no effective sanctions are imposed then the actual costs of achieving an increased award of damages, will simply be payable out of the client's damages. In real terms, the client will have achieved an increased settlement with one hand but will have paid for the privilege of securing what was rightly theirs with the other.

An improved process

22. Forcing lawyers to operate in a way that risks them having to make significant deductions from client damages does not amount to an improved process. It will not meet the public's needs and requirements and will serve only to reduce access to justice.

(ii) The issues not agreed by the parties

Lack of effective sanctions

23. The current process does not include any real sanctions for penalising poor behaviours. As it stands, the level of costs proposed appear to us to be so low that they will not act as an incentive for defendants to extricate themselves from the litigation process and to resolve claims more swiftly.

24. We are mindful that the most recent National Audit Office Report of 2017 looked at what is causing the rising cost of clinical negligence claims. Paragraph 18 of that report noted the NHS Resolutions delay in resolving claims had increased from 300 to 426 days and that each extra day it took to resolve a claim resulted in an extra £40 costs per day on that is an extra £5,040 per case.

25. The reasons why the NHS Resolution has delayed in resolving cases has not been explored. AvMA, APIL and Law Society did draft suggested terms of reference for the CJC working party which included looking at why there were delays and any other factors that delayed settlement. In fact, this has not formed part of the working party's terms of reference, we consider this a missed opportunity.

26. Any new process must apply not only a fair and commercially viable rate to the fixed costs grid, but it must also have substantial sanctions to prevent the delays in resolving cases from occurring.

27. The status of the Part 36 offer within this low value scheme is not clear, we are mindful that the recent consultation on fixing costs in civil claims up to £100,000 (which does not exclude Clin Neg claims) proposes that indemnity costs should no longer be awarded on successful Part 36 offers. As an alternative, the suggestion is that indemnity costs should be replaced with an uplift of 35% on successful cases. There are risks with agreeing a grid of costs in this way without also being clear about what sanctions will be imposed to control behaviours.

28. Not only do we observe the rates to be very low, especially by comparison to the figures under discussion at the mediation but there are no sanctions to encourage defendants to resolve these cases as quickly as possible. On the contrary, the figures are likely to promote litigation as the defendants can now afford to run these cases further than they might otherwise have done in the knowledge that their own exposure to costs is fixed and their behaviours unchecked.

29. Claimant lawyers need to be satisfied not only with the process and the costs recoverable but with the sanctions imposed to manage poor behaviours. Sanctions have not been greed by the parties.

Preservation client damages

30. Please see our comments above. There needs to be protection for client damages especially where the claimant has been forced to pursue litigation because of failure to agree reasonable settlement at the earliest opportunity.

The effect of the proposals on the ATE market

31. ATE providers tell us that the ATE market for clinical negligence is very sensitive.

32. We have referred to how this process will mean that claimant lawyers will have to "cherry pick" cases, they will only take on the cases most likely to succeed. This may result in a swathe of more complex, low value claims risk not finding representation. In turn, this is likely to mean that a significant number of low value claims will cease to be brought.

33. If there is a reduction in the number of low value claims being brought and a corresponding reduction in the number of cases requiring ATE insurance, this is likely to influence the entire clinical negligence ATE marketplace. The effect is unlikely to be confined to low value claims and will ripple across all clinical negligence claims, regardless of value; the ATE premiums payable for all clinical claims will be affected, regardless of the value of the claim.

34. Work needs to be done with ATE providers to understand the extent to which, if at all, they can provide cover for the incidental cost of Mandatory Neutral Evaluation. We refer to our written comments on this circulated on 15.05.19 and whether the cost of a liability expert's response to an Evaluators request for clarification on a medical issue or issues might be covered by ATE insurance.

35. The CJC need to engage with ATE providers to understand this better. To our knowledge they have not done this and consequently the impact this scheme may have on ATE provision has not been established.

(iii) <u>Your position on exclusions from FRC scheme which are not agreed</u>

Fatal Accident Claims

36. As referred to above, most members of the public would agree that there is no worse outcome than death, these are the most serious cases.

37. There are particular sensitivities and time required to deal with bereavement cases, this alone makes them unsuited to a FRC scheme. The NHS Resolution commissioned a report entitled "**Behavioural insight into patient motivation to make a claim for clinical negligence"** published in August 2018. That report illustrates how important compassion is to claimants. (Para 4.2.1).

38. Death is the outcome for the victim. The effect of that death reaches and touches many other lives. Fatal claims are not suited to a quick, cheap process.

39. When the outcome is as final as death, claimants have a real and pressing need for healthcare providers to be accountable and to learn from their mistakes. Claimants are motivated to ensure so far as is possible that other families and loved ones do not have to suffer grief if it can be avoided.

40. Death in the elderly. There are very real issues with social care and negligence, an increasingly elderly population and the need for adequate funding for this vulnerable group needs to be carefully monitored. It is in the public interest that proper care and attention is given to the reasons why death has occurred in this group. This cannot be accommodated under a FRC scheme.

41. Suicides: Where death occurs at the hands of the state ie hospitals and mental health centres the need for proper investigation is particularly important. These cases are often complicated by the need to consider ECHR law.

42. Mental health provision is recognised as being in a state of crisis not least due to underfunding. As with elderly care there are public interest reasons for not including this category of case into a quick, cheap, scheme. The need for answers, recognition of how vulnerable groups have been treated and let down by the State and the need for change is often a driving force in these cases.

43. Another reason for excluding fatal claims from a FRC scheme is the impact this will have on recovering inquest costs. Generally, families are unable to secure representation for the inquest even where healthcare providers can. The existence of an unlevel playing field at inquest hearings is well recognised; the Chief Coroner has called for greater equality of arms at inquest hearings. One of the few ways this can be achieved now is by claimant lawyers being able to recover part of their inquest costs where there is a subsequent successful civil claim. If fatal accidents are included as part of a FRC scheme then it is far from clear who will bear the inquest costs and how they will continue to be recoverable.

44. A FRC is not able to offer an effective cost allowance for an inquest. Each inquest is unique to the circumstances of the deceased's death, the issues before the coroner and the length of time to be taken for the coroner to fulfil their duty to carry out a full, fearless inquiry.

Protected Parties:

45. Cases that involve issues of mental incapacity should not be included in a FRC scheme and should be excluded owing to the complex nature of taking instructions through a third party.

46. These cases require consideration to be given to the client themselves, their autonomy should be supported and promoted where possible. It takes time to take instructions in this sort of case and to ensure the client understands the process well enough to enable them to make informed choices.

47. In some cases, capacity may fluctuate, and this may be an added complication.

48. The type of clinical negligence cases involving children vary although instructions will be taken through a next friend which is usually more straightforward. There are some straightforward cases involving children that may be suited to a FRC scheme such as a green

stick fracture case. There will need to be a bolt on in these cases to cover the cost of court approval. However, not all cases involving children are that straight forward.

Secondary victim claims

49. If the primary victim claim is dealt with under FRC regime then it would be expected that the secondary victim claim would also fall under this scheme. If there is no primary victim claim brought under FRC then the secondary victim claim should be excluded.

50. We are mindful that many secondary victim claims are likely to need more than two expert reports on liability and will therefore likely fall outside the scheme.

51. However, the law around secondary victim claims is complex. These don't tend to be straightforward claims; careful consideration needs to be given to the facts of the case and the considerable body of case law, some of it conflicting needs to be considered. There is an increased need to discuss these cases with counsel to establish the viability of the claim an and the value.

52. AvMA consider it important that any figures that are currently being proposed by the working party are understood to be on the basis that the rates will not apply to any case that falls within the claimants list of excluded cases.

(iv) Who pays for mandatory neutral evaluation (MNE)? The most recent proposal put forward by the defendant group is that parties share the cost of MNE equally with C being able to recover their costs from D if the MNE is in their favour

53. AvMA clearly set out its position on Early Neutral Evaluation (ENE) in a paper entitled **"AvMA comments on Early Neutral Evaluation (ENE)"** this was circulated to the claimant group on 15.05.19. and a copy was sent to the Chair on 20.06.19.

54. The original proposal was that ENE would be used to determine quantum only issues, not liability. Our paper made it clear that in our view, if the process were to become mandatory, then there needs to be clarification on how ENE/MNE sits with a claimant's Article 6 rights.

55. In our paper we urged that the CJC obtain independent advice from leading counsel on whether using ENE or MNE as a substitute for a trial in the first instance offends Article 6, to date that advice has not been obtained or if it has, it has not been shared.

56. We note that the Chair considers that further consideration is needed on these points. [redacted]

57. We are unable to comment further on this until there is clarification around the Article 6 point. We refer to our paper and our concerns set out at paragraphs 18 – 22 inclusive.

58. We also said that there is a need to obtain confirmation from ATE providers that they will cover the costs of MNE/ENE. It is not clear whether an Evaluator will be able to seek

clarification of issues from medical experts and if they can, who will pay any additional costs incurred for the expert's response. To our knowledge, no enquiries have been made of ATE Providers to confirm their position. Very few claimants will be able to bear or contribute to the cost of ENE/MNE without ATE insurance. Even if ATE providers will cover MNE, the claimant will be responsible for paying the ATE premium.

59. MNE/ENE has not been used in this way before, there is no evidence that it has been used at all in any clinical negligence case, consequently this process must be treated with extreme caution.

60. The lack of evidence on how effective and fair MNE may be to claimants means that it is far from clear that this process can be part of an "improved process". Consequently, we are not able to give our support to it currently. [redacted]

61. We have not seen anything that alters the concerns we raised in our paper, there is still no further information on how the appeal from an Evaluator's conclusion might work – who will pay the cost of that appeal? What is the process for seeking an appeal? We do not think it right that the person evaluating the claim and forming a conclusion should be the same person to decide whether an appeal should be allowed. None of these points have been addressed since we raised them in May, we are unable to comment further without additional information or clarification being provided.

62. We are at a loss to understand why a claimant who has successfully appealed an evaluators decision on quantum must be able to beat the original award by a margin of 20%. It must be remembered that while lawyers refer to £25,000 and less as a low value claim, for many people these awards are a significant amount of money, which can make a significant difference to their lives.

63. By way of example, 20% of an award of say £15,000 is £3,000, that brings the total award up to £18,000 – that is a significant sum for an injured party. To put that in context, average yearly earnings in the UK are in the region of £29,000.

64. It is our view that to penalise a claimant for seeking and succeeding to recover what is rightly theirs because an evaluator did not arrive at the correct level of damages in the first instance is unjustifiable. The proposal will do nothing to improve defendant behaviour. AvMA does not support this approach.

65. It is far from clear whether the right to a fair trial under Article 6 would support the view that a trial judge was only entitled to consider the same evidence as was put before the evaluator. Independent advice from specialist leading counsel must be obtained to clarify this.

(v) **<u>Fees payable for MNE. D proposes £1,000 for the cost of an MNE on liability issues only and £1,500 for MNE on liability and quantum and £500 on quantum issues only. Comments from the C group are invited.</u>**

66. We refer again to our paper "AvMA comments on Early Neutral Evaluation (ENE)". Paragraph 3 of that document identifies that costs for ENE start at £3,000 plus VAT. That is a starting point.

67. ENE has not been used in clinical negligence claims; practitioners have no experience of it. It is far from clear to us how the figures referred to in question (v) have been identified, they do not bear any resemblance to the CEDR figures.

68. AvMA takes the view that generally, you get what you pay for. The proposal is a serious and significant departure from the usual course of litigation. There needs to be sound reasons why a clinical negligence barrister of standing would take on the role of Evaluator and do the job for less than what appears to be the going rate.

69. We understand that some of the bar have some experience in using ENE in personal injury claims, but we have not seen any detail. We do not know how ENE or MNE is used in those circumstances, what costs are charged, how the Evaluator has been chosen, what standards have been put in place to ensure the evaluator has enough experience to assess these cases. In any event we take the view that using MNE to assess a low value clinical negligence claim requires a different skill set to that employed to assess a personal injury claim.

70. We refer to our paper on ENE and the heading "The cost of ENE" paragraphs 35 – 40 inclusive. No further information has been made available to us on the costs of ENE and so beyond saying it needs to be piloted and evaluated we are unable to make any further comment on the cost of the process or how appropriate it is to introduce it to this scheme

<u>General Comments</u>

71. We have answered the questions specifically posed by the Chair however we do have other concerns.

Simultaneous versus sequential exchange expert evidence

72. In December 2017 we posed various questions of our lawyer service group. One of those questions invited comment on whether they would be prepared to unilaterally disclose their expert evidence to the defendants at an early stage in the process. The response was a resounding no.

73. However, there was more support for sequential exchange of expert evidence in circumstances where the reports could be disclosed on a without prejudice basis. It was generally felt that this would create an opportunity for cases to settle early if possible.

74. If the defendants chose not to resolve the claim at this time, they would be unable to refer to the disclosed reports later. This allowed claimant lawyers the opportunity to refine the expert reports in the knowledge that the defendants had been given the opportunity to resolve the case early on but chose not to.

75. It was generally felt that it was one thing for a claimant lawyer to take a view on whether to disclose a report early in the process in the hope of promoting early settlement, it was quite another to make this step mandatory.

76. AvMA recognises that early, unilateral disclosure of claimant expert evidence, can promote discussion on settlement. However, difficulties arise where defendant's start making counteroffers and negotiating with claimants in circumstances where they have not disclosed any evidence of their own. This creates an inequality of bargaining power; the defendant has seen the claimant's case and have the advantage of knowing the strengths and weaknesses of their own case.

77. The claimant has disclosed their evidence in good faith, but they are not in possession of all the facts. They have not seen the defendant's evidence and are unable to assess the possible strengths and weaknesses of their case, in the same way the defendant can. This can put the claimant lawyer at a disadvantage when negotiating; early disclosure of expert evidence in these circumstances can be detrimental to the claimant's position.

Patient safety:

78. Despite being a clear term of reference, this has barely featured throughout the process. The opportunity to introduce an innovative process has been lost through the failure to give this issue any real consideration.

79. The current position on patient safety appears to be based on the claimant lawyer setting out clear information on this issue in both the Letter of Notification (LoN) and the Letter of Claim (LoC). In response the defendant is to provide a commitment to patient safety and confirm learnings in the Letter of Response (LoR).

80. Setting out patient safety issues in the LoN (LT) or LoC (ST) is preferred to other possible options which have been discussed including that the expert be responsible for setting out the patient safety issues. In the latter case, the proposal was that the expert template report would include a specific section to allow them to identify and raise patient safety issues.

81. One of the difficulties with relying on the expert to set out patient safety issues in this way is that if the defendant accepts the claimant evidence and settles, there is no need for them to instruct an expert. Consequently, the defendants could avoid responding to the expert's patient safety concerns by making an admission. Similarly, in LT cases, by definition, no expert is to be instructed and so the opportunity to communicate patient safety concerns was lost at the outset.

82. However, even where the claimant sets out the patient safety issues in the LoN/LoC it is far from clear how the defendant will respond. It is our view, that organisations such as NHS Resolution (or equivalent organisations, MDU, MPS etc) need to take ownership and responsibility for actioning the concerns raised in the LoC/LoN. It is not enough to say that these organisations will provide a commitment to patient safety – that is not an action plan. That approach does not mean that the defendant organisations will investigate the issues, it does not enable them to demonstrate that they have learned lessons and set out how they have addressed those failings to prevent them happening again.

83. Steps need to be taken at the trust/healthcare establishment where the issue arose. However, the learning from litigation needs to be disseminated more widely to all trusts/healthcare providers across the country to reduce the likelihood of the same mistake repeating itself. Alternatively, where the same practices or procedures are being employed elsewhere that they can revise their approach before harm occurs.

84. The current proposals do not go far enough, and It is far from clear what the defendant obligations to respond is intended to be.

85. AvMA believes that more could and should have been done to address the patient safety issues.

86. Despite attempts to engage on this issue it has not been possible to get any real traction with either the DH, NHS Resolution or any of the other defendant organisations on this point. The stock response from these organisations has been to say that ***"all indemnifiers agree that patient safety and learning is important, however the difficulty is that indemnifiers cannot commit to imposing anything on the healthcare professional/Trust, who are outside their control."***

87. AvMA considers this response unacceptable, there has been a clear and disappointing failure by defendant groups to take ownership of this issue and to try and develop a workable solution.

88. Although the current proposal of setting out the issues in the LoN/LoR is better than nothing, the lack of commitment and willingness to invest in learning from litigation and to avoid or reduce the incidence of similar injuries arising demonstrates a cavalier approach that denigrates the importance of this issue.

89. There needs to be much more detail around what organisations are going to do and how they are going to action a response to the patient safety issues once they are reported to them. Simply reporting patient safety concerns without more concrete proposals about the nature of the action and response expected risks no action being taken at all.

90. The current proposals are too weak, they risk the reporting of patient safety issues simply being seen to be done, rather than it being seized upon as an opportunity to do something effective.

91. In our experience, patients want to know what the hospital has done to address the patient safety issues, they don't want mistakes repeating themselves and the same thing happening to someone else. For many patients this is as important as an award of damages.

92. AvMA has put forward its own suggestions on patient safety but these have never received a substantive reply from either the DH, NHS Resolution, or any defendant group. SCIL has also put forward patient safety suggestions, which have not been discussed either.

Expert Fees:

93. Currently the working party appears to agree that should be no change to the way expert fees are funded. We are content with that conclusion. We certainly do not support capping or any other alteration to expert fee on the basis that this will not reduce the expert fee, it will simply mean that the difference between what is charged and what is recoverable will be taken from client's damages.

Non recoverability ATE premiums:

94. The only part of the ATE premium that is recoverable relates to liability expert fees. Any additional cover is paid for separately by the client.

95. During the working party meetings there has been a focus on discussing whether ATE premiums for expert reports should continue to be recoverable. There was a view that this came within the remit of the working party on the basis that it fell within discussions on how expert reports should be commissioned.

96. We understand that the working party now agree and accept that there should be no changes to recovery of ATE premiums for liability expert reports.

97. For the avoidance of any doubt, AvMA cannot support a proposal that ATE premiums cease to be recoverable, to do so is to prevent claimants access to commissioning independent medical expert evidence on breach of duty and causation, they would be unable to have their case on liability investigated.

98. To alter the current status quo on recoverability of ATE premiums, without replacing it with some other means of enabling claimants to fund the investigative stage of their case is to prevent them from accessing justice. Most claimants would be unable to afford the cost of medical expert evidence on liability without ATE insurance being in place and the cost of the premiums being recoverable from the losing party.

Dated:26th June 2019

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