CJC Pre-Action Protocol Consultation Questions – Nov 2021

Please note this document is provided to enable you to consider all the questions on the online form and prepare your responses**. All responses should be submitted through https://forms.office.com/r/ReAVrWvscB**

The consultation is open until 24 December 2021 at 10am.

Consultees do not need to answer all questions if only some are of interest or relevance. This form contains branching so you will be able to skip sections that you do not wish to respond to.

Answers should be submitted through the online form. Please note that responses are limited to 4,000 characters per question (around 650 words). Any individual question response longer than 4,000 characters will be cut off at 4,000 characters. If you want to supply any response not in text form please email cjc.pap@judiciary.uk for details on how to do so.

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We list who responded to our consultations in our reports. If you provide a confidential response

your name will appear in that list. If your response is anonymous we will not include your name in the list unless you have given us permission to do so.

Please let us know if you wish your response to be anonymous or confidential.

1. **Your response is**:
    - Public
    - ~~Anonymous~~
    - ~~Confidential~~

2. **Your first name**: Lisa
3. **Your last name**: O'Dwyer
4. **Your location (town/city):** Croydon, Greater London
5. **Your role**: Legal Director for patient safety charity.
    - ~~Judge~~
    - ~~Lawyer~~
    - ~~Insurer~~
    - ~~Paralegal/legal assistant~~
    - ~~Litigant~~
    - ~~Policy maker/civil servant~~
    - Other
6. **Your job title**: Director Medico Legal Services

7. **If relevant, whose interests to you predominantly represent?**
    - Claimants
    - ~~Defendants~~
    - ~~N/A~~

8. **Your organisation**: Action against Medical Accidents (AvMA)

9. **Are you responding on behalf of your organisation?** Yes.

    Our responses draw on our experience of clinical negligence litigation and the Pre Action Protocol for Resolution of Clinical Disputes (PAP RCD)

10. Your email address: lisa@avma.org.uk

Questions Relevant to all Protocols

11. **Do you agree that the Overriding Objective should be amended to include expressreference to the pre-action protocols?**
    - ~~Yes~~
    - ~~No~~
    - Other

    AvMA agrees that the stated overriding objectives in the Civil Procedure Rules could be improved if it referred to the importance of the Pre-Action protocol for the resolution of clinical disputes and the fact the parties are expected to comply with it.

AvMA does not agree that parties should be prevented from actioning their claim and if necessary, issuing proceedings simply because they have not complied with the PAP RCD.

Currently, the overriding objectives are described as a procedural code which enables the court to deal with cases justly and at proportionate cost. This gives Judges discretion to consider each case as it comes before them so they can assess significant issues such as whether the parties are on an equal footing and can participate in the proceedings.

Compliance with the PAP RCD can potentially improve equality of arms between the parties. This is facilitated by each party having sufficient understanding of the other's perspective and case to enable efficient investigation.

12. **Do you agree that compliance with PAPs should be mandatory except in urgent cases? Do you think there should be any other exceptions generally, or in relation to specific PAPs?**

AvMA is opposed to Pre Action Protocol Resolution Clinical Disputes (PAP RCD) ceasing to be a stand alone protocol specifically for the purpose of clinical negligence litigation. For reasons set out below, it would be detrimental for clinical negligence claims to be included under a generic PI pre action protocol.

AvMA agrees that much greater emphasis should be put on compliance with PAP RCD. AvMA considers that the most effective way of ensuring compliance if by scrutinising behaviours operating at the PAP RCD stage.

AvMA is concerned that if compliance with PAP RCD becomes mandatory it risks encouraging poor behaviour. This will occur through the tactical use of delaying disclosure and compliance with the protocol.

PAP RCD is potentially an effective and well drafted document which if adhered to could improve the opportunity for cases to resolve early. AvMA believes that it is in all parties interests that clinical negligence cases should be settled early, but not before proper and thorough investigation has been undertaken.

Currently, adherence to PAP RCD is not mandatory, neither is compliance to the protocol stage tested or examined by the court. This is a missed opportunity as undoubtedly compliance with PAP RCD would be beneficial.

The biggest weakness with the PAP RCD is that when a case concludes, insufficient attention is paid to the parties conduct and whether the case should and could have been resolved at an early stage without the need to issue proceedings.

The failure to hold parties to account for their noncompliance with PAP RCD means that parties who do not comply with the sensible and practical steps recommended are not held accountable for unnecessary and wasteful litigation and the associated costs that inevitably follow.

13. **Do you agree there should be online pre-action portals for all cases where there is an on line court process and that the systems be linked so that information**

exchanged through the PAP portal will be automatically accessible to the court (except for thosedesignated as without prejudice)?

- ~~Yes~~
- ~~No~~
- Other

AvMA is not able to comment on how an online portal system might affect a claimant in a clinical negligence claim as we have no experience of online portals or of low value PI claims.

However, by way of general observation, there does in principle appear to be merit in giving the courts access to information which was disclosed under the PAP RCD so the court can track the nature of the disclosure and form an early view on how open and honest parties have been with each other. We would support the court having access to this information but important safeguards such as specialist clinical negligence judges and docketing of cases should also be introduced.

Jackson LJ in his Review of Litigation Costs: Final Report: https://www.judiciary.uk/wp-content/uploads/JCO/Documents/Reports/jackson-final-report-140110.pdf

(Page 391, Chapter 39, Paragraph 4.2) said that he had "***received a clear message from court users and practitioners that (a) specialisation by judges and (b) docketing of cases to specific judges are welcomed. This promotes better and more consistent case management. It leads to savings of costs…It has also been urged upon me that costs are increased if (a) cases are passed between district judges during case management or (b) cases are managed by district judges who lack relevant expertise"***

He concluded at paragraph 4.4 that "***The thrust of this chapter is that, so far as possible, judges should not undertake work in fields in which they neither possess expertise nor are developing expertise"***

Clinical negligence is a very specific area of work which requires skills, expertise and experience. This is recognised by both claimant lawyers who seek to demonstrate their experience and expertise by reference to clinical negligence accreditation schemes (AvMA's panel membership was the first and is the longest running accreditation scheme). NHS solicitors are only instructed on NHS work if they are with an NHS panel firm. The High Court has for many years provided for designated, specialist clinical negligence Masters to help case manage this complex area of work – this has been of considerable assistance to practitioners and is an effective and cost effective way of managing these cases.

It is important that any information available to the court can be properly assessed so the information provided can be properly evaluated. The information needs to be given the weight it deserves within the context of the proceedings.

In clinical negligence cases, the duty of candour is an ongoing duty to be open and honest about any investigations and developments, it is uniquely supported by legislation https://www.cqc.org.uk/guidance-providers/regulations-enforcement/regulation-20-

duty-candour

Specialist judges should be familiar with this duty and be able to assess the information provided within the context of this duty as well as the PAP RCD and ongoing litigation generally. This is important because the claimant in a clinical negligence claim is often looking for much more than compensation, which for many is a blunt tool, they want answers, an apology and to prevent the same mistake being made.

While litigation cannot provide all these things, it is important that courts dealing with these claims understand and are aware of the background and statutory expectation which supports claimants quest to find answers. When these answers are not forthcoming claimants often resort to litigation to further their aims. Emotions run high in clinical negligence claims. These are just some of the important factors which sets clinical negligence claims apart from PI claims and why specialist judges are required.

While we are broadly supportive of the principle of a designated clinical negligence portal providing it is user friendly, intuitive and gives appropriate guidance as to how it should be used. A portal should ensure all users have easy to relevant information. Careful consideration needs to be given to safeguard claimants who do not have the benefit of representation.

Litigants in person for example are unlikely to understand or appreciate the importance of legal privilege and why they should not feel obliged to disclose any independent medical evidence they may have. The language used on the portals should be straightforward, and readily understood.

Litigants in person may be advised that ADR including mediation has potential benefits, which it can do - it can also be prejudicial to a litigant in person to enter into these processes unrepresented and without the benefit of legal advice and information. Litigants in person will not be able to assess whether any offer of settlement made at ADR represents a fair offer without recourse to at the very least, legal advice and information. A litigant in person will not be able to establish whether their injuries are likely to resolve or cause other long term health difficulties without the benefit of medical expert evidence.

Some litigants in person may not be confident with technology or may experience digital poverty which may prevent them from having ready and easy access to a portal.

If a portal system is to be used, then it is important that the portal is a designated clinical negligence portal and not a generic portal. To do otherwise would make what is already a complex area of law, even more complex and difficult to follow, it encourages confusion and mistakes. We make a similar point on the need for a designated clinical negligence pre action protocol - clinical negligence pre action protocol should not be included under the umbrella of personal injury PAP.

Portal systems should be optional. They should not be used unless parties are confident, they want to participate using technology and can confirm they have access to relevant technology.

AvMA would urge that use of a portal in clinical negligence claims is trialled before committing to this as a process.

14. **Do you support the creation of a new summary costs procedure to resolve costs disputes about liability and quantum in cases that settle at the PAP stage? In giving your answer, please give any suggestions you might have for how such a costs procedure should operate.**

    AvMA would be supportive of such a step in clinical negligence claims. Not only does it provide an early opportunity for specialist judges to assess whether the case should have been resolved sooner and possibly avoided litigation altogether, but it provides an opportunity to review the parties conduct and to identify if the PAP CD was properly executed and adhered to.

    It is outside of AvMAs expertise to comment on how the procedure should operate.

15. **Do you agree that PAPs should include mandatory good faith obligation to try to resolve or narrow the dispute? In answering this question, please include any viewsyou have about the proper scope of any such obligation and whether are there are any cases and protocols in which it should not apply.**

    According to paragraph 2.13 "Review of pre action protocol: Interim Report" a good faith obligation is intended to require that each party: "***meaningly engage with each other, with the benefit of having exchanged the key information and documents about their dispute as require by the protocols, with the aim of exploring whether a resolution is possible or alternatively, whether the issues in dispute can be narrowed"***

    The extent to whether parties have complied with this is a matter of fact which can only be determined by a judge reviewing the parties' conduct. It would be for a judge to identify whether parties have behaved in an open and honest manner. They would also need to assess whether sufficient information was provided by parties about their case at the earliest opportunity, that proper early investigation was carried out in a timely way to substantiate the parties' respective positions.

    These objectives are already stated in the PAP RCD to facilitate early resolution. Imposing a mandatory "good faith" obligation will not on its own improve and/or ensure adherence to PAP RCD. The duty to be open, honest, investigate concerns properly already exists for example, the statutory duty of candour, under the NHS constitution and complaints process. Currently, the failure to check for compliance and imposition of sanctions for noncompliance is what is missing.

    AvMA is supportive of the use of ADR as a means by which parties can resolve potential or actual litigious issues. However, ADR is only a fair process if there is equality of arms between parties. In part, this means that there has been full disclosure by both parties but is also means that there is fairness, including greater equality of bargaining power between the parties.

For example, a claimant who has only just instructed a lawyer or who is acting as a litigant in person is unlikely to have access to independent or any medical advice and or opinion. By contrast, a defendant hospital or trust is likely to have comparably ready and easy access to medical opinion and views by virtue of its budget and the nature of the staff it employs.

An invitation by a proposed defendant hospital to come to ADR at this stage may in fact be more tactical than done in good faith and with the aim of openly and fairly resolving the issues.

On one interpretation of the good faith obligation, a refusal by a claimant to attend ADR may be construed as them not acting in good faith. However, it is important that parties have the freedom to weigh up the situation according to the facts of each case. Parties should set out why they are not attending ADR at this stage. This may include the fact that some early ADR processes would not be cost effective at this stage and/or because there is a need for further disclosure and/or investigation into the claim so there is actual or at least increased equality of arms between parties.

Without there being a level playing field between parties, it is likely and indeed possible that ADR at this juncture is unlikely to be effective, fair, or appropriate.

PAP RCD is a well drafted document. It will become the effective and powerful tool to ensuring litigation is a last resort, if parties conduct during PAP phase is scrutinised. Checks need to be made that parties have done everything reasonable at the PAP stage to ensure PAP RCD has been implemented. Sanctions should be imposed for noncompliance with PAP RCD.

Currently, PAP RCD advises (para 1.7) that where a party fails to comply with the protocol, the court "may" impose sanctions. In practice, sanctions are not imposed, and this is a missed opportunity.

16. **Do you agree that, unless the parties clearly state otherwise, all communications between the parties as part of their good faith efforts to try to resolve or narrow thedispute would be without prejudice? Invitations to engage in good faith steps couldstill be disclosed to the court demonstrate compliance with the protocol, and offers of compromise pursuant to Part 36 would still be governed by the privilege rules in Part 36.**
    - ~~**Yes**~~
    - ~~**No**~~
    - **Other**

      Please see our above response on matters relating to imposing an obligation on "good faith".

17. **Do you agree that there should be a requirement to complete a joint stocktake**

report in which the parties set out the issues on which they agree, the issues on which they are still in dispute and the parties' respective positions on them?

Do you agree that this stocktake report should also list the documents disclosed by the parties and the documents they are still seeking disclosure of?

Are there any cases and protocols where you believe the stocktake requirement should not apply? In giving your answer please also include any comments you have on the Template Joint Stocktake Report in Appendix 6.

Yes. AvMA agrees that a stocktake would be a valuable and important addition to the PAP RCD. A stocktake should be a requirement

A stocktake report at PAP RCD stage is an important way of parties demonstrating how they understand each other's case. It is an early and important opportunity for parties to identify and be clear about the issues in dispute.

The extent to which parties can and do identify the issues in dispute will be determined by the level of disclosure each side has made available to the other.

AvMA thinks it important that following disclosure, parties can investigate further, should information available on disclosure cause them to reconsider or alter how they view their case. Given the specialist nature of clinical negligence claims, it is possible that a claimant lawyer will need to verify their position by seeking advice and/or clarification from an appropriate medico-legal expert.

The stocktake should list the documents disclosed by the parties. However, there should be no undue pressure on parties to disclose privileged information such as medical reports which have been obtained as part of this process.

By listing the documents disclosed, it will be apparent what information was made available to respective parties and the extent to which, this influenced their understanding of the facts in issue in the case. Understanding each other's case is a crucial part of being able to resolve it early or agree on what additional information may be required to facilitate resolution – this may be particularly relevant when the only issue in dispute is quantum. Parties should be able to identify the extent to which liability is in dispute.

Claimant clinical negligence practitioners frequently report being frustrated that their efforts to resolve cases early are thwarted. These efforts will often include claimant lawyers exercising their discretion to unilaterally disclose their medical evidence early. This is often done to encourage and facilitate early resolution. When these steps fail to result in even narrowing the issues such as admissions of liability and/or causation in appropriate circumstances, claimants are left with no alternative but to issue proceedings.

Currently, parties' compliance with PAP CD is not assessed at the first CMC. AvMA believes this could be a useful development.

A stocktake report would offer an opportunity for a judge to easily review the steps taken and the efforts made to resolve a case at an early stage. It would potentially give the judge the background to identify how reasonable it was for parties to proceed to issuing proceedings thereby enabling them to form a view on whether sanctions for failing to resolve early on should be imposed.

It may be that in complex matters such as a clinical negligence case, it would not be possible for a judge to assess compliance with PAP RCD at the first CMC, this may only become apparent later as further disclosure takes place. It is possible that a judge cannot form a conclusion on compliance with PAP RCD at the first CMC but this should not prevent it from being a consideration. However, it should be acknowledged that ultimately, this issue may need to be revisited at the conclusion of the case.

The stocktake report is also an opportunity for parties to be reminded of the issues apparently between them. This in turn can help to manage claimant's expectations and focus on the risks in the case.

The template stocktake report referred to at Appendix 6, was located at Appendix 4 together with revised draft text for general pre action protocol. On that draft text, AvMA comments on the core points as follows:

- **Parties must not start court proceedings without first complying with a protocol:** As stated above, we do not support mandating the PAP RCD but we do support greater scrutiny around compliance. We also support the use of sanctions for noncompliance. Mandating PAP RCD risks encouraging unwanted and negative behaviours whilst giving the remaining party no avenue to progress the claims. AvMA supports the use of the parties using their best endeavours to take the steps set out in PAP RCD, rather mandating full compliance with PAP RCD.

- **Compliance with the protocol should be mandatory**: We agree that parties should use their best endeavours to ensure compliance with PAP CD. Compliance should be scrutinised by the courts. The judge or Master at the first CMC should consider the extent to which the parties have complied.

  However, parties should not be prevented from issuing proceedings until full PAP RCD compliance has been achieved. There are many reasons why this would not be fair or reasonable in a clinical negligence claim. Excessive and prolonged delays with disclosure or in replying to letters of claim are common place in clinical negligence claims. It would be inherently unfair for a party to be unable to issue proceedings simply because of another party's continuous refusal and/or inability to provide full disclosure in a timely way. Indeed, this may well encourage tactical behaviour and is therefore to be avoided.

  There are times when issuing proceedings is the only mechanism by which a claimant can actively progress and achieve resolution. Slavishly following the

protocol until all steps have been completed, simply so it can be said that PAP RCD has been complied with risks encouraging negative behaviours. However, holding parties to account as to why they did not comply with the PAP RCD is likely to be far more effective, especially if sanctions are imposed for noncompliance.

PAP RCD is a positive and well-constructed protocol. Mandating it and preventing parties from moving to the next stage is not in the interests of justice. That situation risks parties being held hostage to fortune through no fault of their own and with no route to progressing the claim. It risks cases becoming "stuck" at this early stage of the process without recourse.

It is AvMA's view that it should be mandatory for the court to consider whether the parties complied with PAP RCD. In considering this the court should also be mindful of other steps to resolve the case which may have been taken prior to the PAP RCD stage. For example, where the claimant has put the proposed defendant on notice by raising concerns about their or their loved ones care early on. This might be through seeking answers via the healthcare complaints process, or where a negative serious incident report (or its equivalent) has been prepared by a healthcare provider. In the case of a death an investigation may have taken place as part of the inquest hearing. Equally, under the statutory duty of candour there is an ongoing duty to advise on the progress of any investigation being conducted by a healthcare provider.

- **The protocols are intended to encourage the early exchange of information between parties**: AvMA supports this. However in clinical negligence cases the courts need to look wider than just the use of PAP RCD. All of the steps referred to above, offer opportunities for cases to be resolved early on, before PAP RCD stage.

  The efforts made by the parties to find answers, seek redress and resolution through alternative processes such as complaints process should be listed. Likewise, reasons why the responses provided were considered insufficient and parties reverted to PAP RCD.

  These alternative processes are relevant as they provide opportunities to investigate, provide answers or offer admissions. These steps should also be considered when reviewing compliance with PAP RCD. The approach taken to the investigation of these forms of redress is likely to be relevant to a parties conduct.

  The stocktake report should include specific questions about other forms of redress explored, pre PAP RCD stage.

- **Litigation should be a last resort**: AvMA agrees with this

- **Good faith obligation**: AvMA supports the view that parties should always be acting in good faith. However, AvMA does not support the notion that not organising or engaging in dispute resolution demonstrates not acting in good faith.

  AvMA fully supports the use of ADR in appropriate circumstances. Whether circumstances are appropriate or not is influenced by whether parties have a level playing field. This means there has to be sufficient understanding of the matters in issue and disclosure of relevant evidence.

  Uniquely, in clinical negligence matters it is also important that information made available on disclosure can be considered and issues investigated further. This will often require a party or parties to seek advice on issues from an independent medical expert/s. This is critical to the process.

- **Stocktake:** AvMA is fully supportive of introducing a stocktake report which identifies the issues agreed on by the parties, the areas of disagreement, parties position on the issues in dispute and a list of documents disclosed at PAP RCD stage.

- **Stocktake report:** This should be completed once the parties in good faith believe they have exhausted their ability to comply with PAP RCD.

  Section 2 is entitled the good faith steps: while this helpfully sets out the key steps which may have been taken, the form ought to be amended to give parties the opportunity to comment on why a key step may not have been complied with.

  There may be good reason why a party has not complied with "all" PAP RCD steps. In particular, the early exchange of information may not be forthcoming within a reasonable period, or at all. In turn, this may have prevented parties turning to ADR such as mediation and Early Neutral Evaluation (ENE) – these processes are likely to be of little effect until parties are in possession of all the relevant information.

  Parties should not be held hostage to PAP RCD especially where the delay or noncompliance with PAP RCD is excessive or unreasonable and not within their control.

  The stocktake report should be amended to allow parties to set out why there has not been full compliance. It is important for this information to be immediately available to the court and the

reasons given readily assessed as it could influence the court's decision on imposing sanctions.

Section 2 should not ask if the defendant has joined any particular dispute scheme. It is well known that NHS Resolution operates a mediation scheme – it has both the funding and the structure to organise such a scheme, unlike claimants and or their lawyers. This question does not add anything to the stocktake process.

Likewise reference to an Ombudsman scheme. The Parliamentary Health Service Ombudsman (PHSO) is the second tier stage of the NHS complaints process. The question adds nothing to a clinical negligence stocktake.

Section 2 could usefully include specific questions about other forms of redress explored, pre PAP RCD stage. The Stocktake Report provides a good opportunity for parties to identify other forms of redress used to resolve the claim, for example the complaints process.

AvMA believes that listing the other forms of redress, is relevant to the efforts made, the opportunities and attempts to encourage early exchange of information and resolution

Section 3 – List of issues in dispute. We have no objection to this section. We suggest that a comment box is included, that will allow parties to raise particular issues or concerns under this heading. For example, a claimant may want to cross refer to a medical note or SIR which indicates an admission of liability which is subsequently denied.

Section 4 – disclosure. Agreed. This section may be improved by offering the parties an opportunity to comment briefly on the documents eg cross referencing to evidence contained within a document which may help to reduce or close the issues between them. For example, if a claimant has unilaterally disclosed their medical evidence, they may wish to point to the experts opinion on liability/causation.

Section 4B – documents requested but not yet disclosed. This section would be improved by including a section where the parties can set out the date it was first requested and any subsequent requests for it. It would also be useful for the parties to have a section where they can say why the document is relevant and required. Alternatively, the reasons for non-disclosure.

Section 4C – AvMA consider it relevant and prudent to include an

additional section on patient safety and in particular, lessons learned to date.

Many claimants' wish to achieve improvements to patient safety, prevent the same thing happening to another family/person. Healthcare providers could usefully identify what they feel they have learned from the proposed claimant's situation, what patient safety and learning issues are being investigated or are under consideration or what action has been taken in response to issues already identified. This would complement AvMA's patient safety letter suggestion (see below).

This section should include a requirement for healthcare providers to say what they are considering doing to improve things and when those improvements will be implemented.

AvMA has previously suggested that more could be done to learn from litigation and has recommended that a step be incorporated at the conclusion of the case that requires healthcare providers to send claimants a patient safety letter setting out what lessons have been learned. Patient Safety Paper - website.pdf

Section 5 – signed by the parties. Agreed

18. **Do you agree with the suggested approach to sanctions for non-compliance set outin general principles from para 3.26? In particular please comment on:**

AvMA does agree that the court should be able to impose sanctions for non compliance with PAP CD. AvMA would go so far as to say, the court should be expected to impose sanctions for non compliance.

a) **Whether courts should have the power to strike out a claim or defence to dealwith grave cases of non-compliance?**

The courts should not have the power to strike out a claim or a defence for noncompliance with PAP CD. Part of our reasons for this goes to the nature of clinical negligence litigation. Striking out a claim or a defence in these circumstances, simply means the matter will not be litigated. This is likely to be detrimental to improvements required for patient safety and for the need for healthcare providers to learn lessons.

It is in the public interest that claims alleging clinical negligence are litigated, if necessary. The court already has the power to strike claims out where there are no reasonable grounds for bringing a claim. If a clinical negligence claim can be struck out for noncompliance with PAP CD, cases risk being struck out because of a technicality, the merits of the case will not then be explored.

Claimant lawyers are unlikely to invite courts to use this strike out power, it is

highly unlikely to be in their client's interest to take this approach. This will therefore not be an effective remedy from a claimant perspective.

Clinical negligence is often about much more than compensation. It is about accountability, government bodies being made to tell the truth or understanding why their stance is incorrect.

Clinical negligence claims do not usually arise because of a mistake or breach of duty made by one healthcare provider. It is frequently about exploring system failures. It is often necessary to litigate or to be able to rely on the existence of a litigation process to enable the man in the street to hold a large organisation, like the NHS', feet to the fire and the truth to out.

Clinical negligence litigation can be about preserving taxpayers' money and breaking the cycle of events that can lead to healthcare organisations making the same mistakes time and again. Striking out a case because of noncompliance with PAP RCD will not enable these issues to be aired, it could in fact prove to be a benefit for defendant organisations as tactically it could be used to prevent scandals from coming to the public's attention.

b) **Whether the issue of PAP compliance should be expressly dealt with in all Directions Questionnaires, or whether parties should be required to apply to thecourt should they want the court to impose a sanction on an opposing party for non-compliance with a PAP?**

AvMA supports the suggestion that the directions questionnaire include a question on PAP RCD compliance. The use of a stocktake report, especially if parties are able to comment as suggested above, will give the judge/Master a quick and immediate overview of how parties have conducted themselves. Designated clinical negligence Masters are experienced in clinical negligence litigation and can reasonably be expected to form a fair view at this early stage. By contrast, judges/masters who are not experienced in this field may find decisions around compliance more difficult to call. There is a need for clinical negligence claims to be managed by judges and masters who are experienced in this field. The designated clinical negligence Masters in the High Court demonstrate how necessary and effective judges with experience can be.

The court should be able to impose a sanction of its own motion.

The court should have discretion to impose sanctions at this early stage and should be encouraged to give consideration and form a conclusion at this early stage. However, we can see that there may be circumstances when the court would have good reason to postpone their decision until proceedings have concluded. It is important that there is consistency of approach.

If a judge is going to postpone their decision until the proceedings have concluded, it is equally important that they reserve the case to themselves, this will encourage a consistency of approach and avoid work being duplicated.

Docketing was an important part of Jackson LJ proposals on civil litigation reforms

AvMA is equally supportive of the proposal that parties be able to formally apply to the court for sanctions to be imposed for noncompliance with PAP RCD at CMC stage. This would be a fairer and more effective tool, than enabling the court to strike claims out for noncompliance with PAP RCD.

c) **Whether the PAPs should contain a clear steer that the court should deal with PAP compliance disputes at the earliest practical opportunity, subject to the court's discretion to defer the issue?**

Please response to above question. This is about consistency of approach so that if a decision is deferred, the judge making that decision reserves the case to themselves. We agree that the court should have discretion to defer the issue if deemed necessary, but the reasons for that deferment should be made clear, so the issues to be revisited are readily identifiable.

d) **Whether there are other changes that should be introduced to clarify the court's powers to impose sanctions for non-compliance at an early stage of the proceeding, including costs sanctions?**

AvMA considers cost sanctions to be an effective tool and the court should have the power to make cost sanctions. There are numerous examples of how cost sanctions have proved to be a very effective way of helping parties to focus their minds on the issues. AvMA thinks of the benefits brought about by Part 36 offers and the severe cost sanctions that accompany a party's refusal to accept an offer which they are subsequently unable to beat

e) **Whether you believe a different approach to sanctions should be adopted forany litigation specific PAPs and, if so, why?**
AvMA believes that it is crucial for the courts to retain the PAP RCD and not to lump clinical negligence claims in with PI claims. They are two very different types of work, albeit bearing some similarity.

The PAP RCD has developed over the years and has been produced in collaboration with claimant and defendant lawyers. It is a well-crafted and appropriate document which will make a difference if the courts are willing to give due consideration to its compliance and impose sanctions for noncompliance, if necessary.

As described above, some of the sanctions suggested, such as striking out a claim for noncompliance with PAP RCD would simply be ineffective in a clinical negligence claim. The nature of this work is such that this could in fact prove to be a benefit for a defendant organisation who wants to avoid publicly rolling out potential/actual activity or scandals.

By contrast, a cost penalty would be an effective sanction. Even though clinical negligence operates a Qualified One-way Cost Shifting (QOCS) system it is still

possible to impose penalties on claimant's where necessary. Adverse costs orders can be made against a claimant under the QOCS principles. It should be possible for the courts to impose similar costs penalties against claimants for noncompliance with PAP RCD, should this be necessary.

Imposing a cost penalty on a defendant organisation in this situation should also be straightforward. The parties would therefore have equal access to recourse for noncompliance with PAP RCD if a cost penalty were imposed.

However, the cost penalty should be severe, as this fact will help parties focus on the importance of compliance with PAP.

19. **Do you agree that PAPs should contain the guidance and warnings about pre-actionconduct set out in paragraphs 3.8-3.13?**
    - **Yes**
    - **No**
    - **Other**

    We refer to response on generic PAP and reiterate that we consider it would be detrimental to include PAP CD under the umbrella of a personal injury PAP.

    PAP CD already clearly states that litigation should be a last resort. Paragraph 2.2 (f) PAP RCD says: **"The general aims of the protocol are – to enable the parties to avoid litigation…"**

20. **Do you think there are ways the structure, language and/or obligations in PAPs couldbe improved so that vulnerable parties can effectively engage with PAPs? If so, please provide details.**

    The information current included in the PAP RCD should be retained and presented as a standalone document used in conjunction with clinical negligence litigation. Amalgamating this document into a generic personal injury PAP with a designated clinical negligence section will create confusion for all court users and add nothing to the process.

    As previously stated, clinical negligence claims are inherently complex, the concepts are especially difficult for lay people especially those who are unrepresented. For many people, the notion that they are owed a duty of care, is foreign. Lay people do not tend to think in these terms.

    By contrast, liability issues in personal injury claims can be easier for lay people to grasp. For example, social norms dictate that if someone drives through a red light and as a consequence hits a pedestrian, the driver will be responsible and liable for injury and damage.

    The legal test for clinical negligence is complex, a two-stage test where it has to be shown that there was a breach of duty and that as a direct consequence of that breach

injury and/or loss has arisen. Many people, automatically trust doctors, it can be difficult for them to come to terms with the fact that trust has been broken. There are difficulties with understanding causation - the notion that a healthcare provider has accepted that they have done something wrong, but that no injury or loss has occurred as a result is difficult to reconcile. The fact that there is no punishment/penalty/damages for that "wrong" having occurred is hard for most lay people to understand.

Invariably, claimants bringing clinical negligence claims need to be represented, or at the very least have the benefit of advice, information and assistance to help them navigate this difficult legal test. There are some aspects of this area of law which are very challenging to explain in an easily digestible way, especially if representation is not available.

Lay people really do need to grasp a basic understanding of what this means for them and their litigation if they are to improve their engagement with PAP RCD.

Taking the above into account, the current PAP RCD is generally quite clear and user friendly. It is helpful that template letters are included.

PAP RCD would benefit from a glossary of commonly used terms. Words such as disclosure may be second nature to legal representatives but will be difficult for lay people to use. Even terms like, pre action will not be familiar to lay people – this could be example be substituted for an expression like "before you start litigation by issuing proceedings".

The PAP RCD does not signpost to organisations that may be able to assist. For example, a litigant in person may benefit from being signposted to AvMA and our free helpline, or our self-help guides. This will help unrepresented litigants

PAP RCD could be clearer about what a litigant in person can do, if they do not receive their medical records within 40 days as stipulated by paragraph 3.4.1 PAP RCD. Paragraph 3.7 does say that where there is a delay an application for pre action disclosure can be made. That probably does not improve a litigant in persons understanding of what they need to do next.

It is AvMA's view that unrepresented litigants are rarely going to be able to effectively engage with PAP RCD unless they have access to legal advice, information, and support. That is an access to justice and funding issue.

21. **Do you believe pre-action letters of claim and replies should be supported bystatements of truth?**
    - **Yes**
    - **No**
    - **Other**

AvMA has no objection to pre action letters of claim and replies being verified by a statement of truth. This simply goes to the authors genuine and honest belief that to the best of their knowledge the information contained is accurate**.**

22. **Do you believe that the rule in the Professional Negligence Protocol giving the court the discretion to impose sanctions on defendants who take a materially different position in their defence to that which they took in their pre-action letter of reply should be adopted in other protocols and, if so, which ones?**

AvMA is not familiar with the rules in the professional negligence protocol and responds to this question in terms of general principles only. Yes, the court should have the power to exercise their discretion to impose sanctions on a defendant who subsequently takes a substantially different view in their defence, to that set out in their letter or response.

However, the court should be fully satisfied that there is no good reason for the change in stance before it imposes sanctions. Should the court find no good reason, then the penalty imposed on defendant's who take this volte-face approach to the litigation without good reason should be severe. It could include awarding indemnity costs for work done up until the point of the change of approach.

23. **Do you think any of the PAP steps can be used to replace or truncate the procedural steps parties must follow should litigation be necessary, for example, pleadings or disclosure? Are there any other ways that the benefits of PAP compliance can be transferred into the litigation process?**

No. The PAP RCD should be used as a fact-finding opportunity so parties can resolve claims without the need for recourse to litigation. Should litigation be required, the well-established litigation procedures set out under CPR should be followed.

To suggest truncating the established steps of litigation is to risk the letter of claim and response being treated as a pleading. This would defeat the object of the PAP stage. In clinical negligence claims, no medical evidence is exchanged at this point. Typically, there are no conferences with counsel and expert at PAP RCD stage, using PAP RCD to replace the stages of litigation is to effectively morph the litigation phase into the PAP RCD phase.

The opportunity to resolve claims early currently afforded by PAP would be lost. Instead, PAP would effectively be used as a tool to restructure the litigation process altogether.

Questions specifically related to Practice Direction - Pre-Action Conduct

24. **Do you wish to answer questions about Practice Direction – Pre-Action Conduct?**
    - ~~**Yes**~~
    - **No**

This tends to be outside of AvMA's area of expertise. We do again refer to our comments on not losing a PAP RCD specific process.

25. **Do you support the introduction of a General Pre-action Protocol (Practice Direction)? In giving your answer please do provide any comments on the draft text for the revised general pre-action protocol set out in Appendix 4.**
26. **Do you agree parties should have 14 days to respond to a pre-action letter of claim under the general pre-action protocol, with the possibility of a further extension of28 days where expert evidence is required? In cases of extension, the defendant would still be required to provide a reply within 14 days disclosing relevant information they had in their possession and confirming that a full reply would be provided within a further 28 days. Claimants would have 14 days to respond to any counter claim. If you do not agree with these timeframes, what timeframes would you propose?**
27. **Do you think that the general PAP should incorporate a standard for disclosure, and if so, what standard? For example, documents that would meet the test for standarddisclosure under CPR 31, or meet the test for "Initial disclosure" and/or "Limited Disclosure" under Practice Direction 51U for the Disclosure Pilot. In giving your answer we are particularly interested in respondents' views about whether the standard should include disclosure of 'known adverse documents'?**

Questions specifically related to personal injury protocols

The sub-committee were very conscious, as a final point worth stressing, that there is a need for evidence to underpin any changes that might be suggested in response to the questions below.

28. **Do you wish to answer questions about the personal injury protocols.**
    - **Yes**
    - ~~**No**~~

29. **Do you agree that there should be a generic PI protocol that incorporates relevant general principles from the General PAP but also identifies PI specific objectives notapplicable to other litigation (Part A) with users being directed to a subject specific "Part B" rules for each specialist area?**
    - ~~**Yes**~~
    - **No**
    - ~~**Other**~~

    AvMA does not support the implementation of a generic PI PAP. Instead, practitioners should look to the PAP RCD, a long established and well drafted document that as evolved over a number of years with input from both claimant and defendant representatives. PAP RCD has been developed for the specific purpose of aiding the specialised area of clinical negligence litigation.

    Incorporating the PAP RCD into a generic PI PAP is not necessary, it will not benefit anyone or the courts. It will not improve the process for any party, it will only cause confusion and we urge that this proposal to be dropped. It is crucial for PAP RCD to be retained.

While clinical negligence and personal injury work share some common characteristics, they are very different. Some of those differences have been referred to above.

The PAP RCD recognises the nuances associated with this specialised area of litigation which risk being lost in a generic PI PAP. Issues such as the proposed claimant and defendant having ongoing relationships and obligations to each other to deliver treatment are unique to clinical negligence but less likely to be a pertinent feature of PI claims. The frequent ongoing need for parties to forge some form of relationship to enable future treatment to be carried out with any level of confidence, mutual trust and respect is important.

Other unique features of clinical negligence work include the fact that the vast majority of claims are brought against the NHS, a public body, funded by public money. Accountability is key.

Clinical negligence work is not the same as personal injury work. Fundamental differences include the complex legal test which has to be satisfied to bring a clinical negligence claim. The ability to prove liability is invariably dependent on third party, medical expert involvement and opinion.

The claimant's health will usually have been compromised in the first instance, which is why they sought medical opinion/investigation/treatment – condition and prognosis often not straightforward. Identifying the effect of negligence on a claimant's health will be specific to each client – it is very difficult to generalise in medical negligence cases.

30. **Do you agree that all PI protocols should include a good faith obligation more prominently in the introduction to try to resolve or narrow the dispute?**
    - Yes
    - ~~No~~
    - ~~Other~~

    Please see our response to question 15 above.

31. **Do you agree that all PI protocols should include an obligation to a complete a joint stocktake report/list of issues and should this be:**
    a) **before or after ADR, and/or**
    b) **filed with the Directions Questionnaire?**

    As referred to above, parties may consider ADR but may not engage in it at this early stage. We support the introduction of a stocktake report, which should be completed at conclusion of the PAP phase. There may be some merit in including the stocktake report when issuing proceedings, so this is available to the court at the earliest opportunity.

    Please see our more detailed comments on stocktake reports set out in response to question 17.

32. **Do you agree that any revisions to the Personal Injury Protocol need to be approached with great care to ensure workstreams for multi-track cases are clearly separated out from fast-track work? If so:**
    a) **How could there be effective~~,~~ referencing to and integration with the Serious Injury Guide where appropriate?**
    b) **How can the current protocol be updated to reflect moderately severe cases as well as catastrophic injury cases despite workflows for each being significantly dissimilar?**

    Currently this question does not really apply to clinical negligence claims as the vast majority are issued in multitrack owing to complexity. This would have to be revisited if this position were to change.

33. **Do you agree that there should be better integration of each protocol with the Rehabilitation Code? If so, should the protocol require a claimant to identify any rehabilitation they consider would be beneficial, with estimated costs if possible and should it require a defendant to supply reasons if they refuse, or fail to provide assistance with rehabilitation.**

    While AvMA supports the principle of a rehabilitation code, it is not routinely relied upon in clinical negligence claims as liability is all too often in dispute, early rehabilitation opportunities are lost as a consequence.

    Early interventions are key to improving outcomes in a lot of clinical negligence claims. Where early admissions are made, early rehabilitation interventions should be fully supported.

34. **Do you agree the transitional integration clauses for injury claims exiting fixed recoverable processes and slotting into the main injury protocol require greater clarity?**
    - ~~**Yes**~~
    - ~~**No**~~
    - **Other**

      AvMA is unable to comment as there are no fixed recoverable cost processes in clinical negligence claims. Should a fixed costs regime be introduced for clinical negligence this question will need to be revisited.

35. **Is there value in being more specific within protocols about the level of quantification work to be undertaken without a route map agreed with the other party and the timetable for commencing proceedings following an admission of liability?**
    - ~~**Yes**~~
    - **No**
    - ~~**Other**~~

    AvMA does not consider this to be of assistance in clinical negligence claims. The level and type of quantification work to be undertaken in a clinical negligence claim

will vary from case to case.

Where there is an early admission of liability, the parties are likely to be better off identifying the nature of the quantum issues to be investigated between them. There will be issues relating to condition and prognosis. While parties may dispute the type and number of experts required on liability, this tends to be more straightforward in quantum only issues. clinical negligence claims.

36. **Do you agree the management of disclosure pre-issue needs to be strengthened to encourage greater compliance with the protocol? Paragraph 7.1 of the protocol expects the claimant to identify which documents are relevant and why. Should there be equal obligations on defendants to give reasons why they consider a document is not relevant/why they will not disclose a document**?

The PAP RCD does not require parties to identify which documents are relevant and why. We refer to comments made in relation to proposals to introduce a stocktake report (see our response to question 17) and in particular our suggestion that Section 4B of the stocktake report would be improved by including a section where the parties can set out a description of the document required on disclosure, the date it was first requested and any subsequent requests for it. This section could usefully include why parties say the document is relevant and required and offer an opportunity for defendants to give the reasons for non-disclosure.

37. **Should the claimant's letter of claim state what medical records have been obtained and are available for disclosure and what medical records are still to be obtained?**

- ~~Yes~~
- ~~No~~
- Other

As can be seen from the templates attached to PAP RCD, there is already an expectation that parties provide an index of records obtained (Annex C). That expectation is clear from both the template Letter of Notification and the template Letter of Claim. The letter of claim makes clear that copies of the medical records will be provided and both letters set out details of medical records still to be obtained.

38. **Do you agree that a working group should be established, as a priority, to consider a specific protocol for abuse claims?**

- ~~Yes~~
- ~~No~~
- Other

We do not have the expertise to comment,

39. **Do you agree that a working group should be established to consider a specific protocol for foreign accident cases?**

- ~~**Yes**~~
- ~~**No**~~
- **Other**

No comment

40. **Should initiatives with third party organisations such as the expert witness communityand HMRC be considered to reduce delays in the resolution of injury disputes?**
    - ~~**Yes**~~
    - ~~**No**~~
    - **Other**

This would not be relevant in a clinical negligence claim. Medico legal experts act on their own, not as a community. Medical experts' opinions are expected to be independent and impartial. Medical Experts will act according to their own economic interests, this is about a fair hourly rate being payable in a timely way and in accordance with their terms of business. If the rates are not high enough, the experts will not do the work.

Medico legal work in clinical negligence claims is generally undertaken in addition to an experts own medical practice; they do not tend to operate as full-time professional medico legal experts. They do take note of any time limits imposed by the court under the standard order for directions. It is difficult to see what "initiatives" might effectively reduce delays experienced by experts producing their reports without impinging on the quality of their work.

41. **Should the personal injury PAPs deal with the question of what to do where a Claimantobtains medical evidence prior to issue but elects not to serve, and if so, what steps should be open to the Defendant?**

AvMA does not support changes to the PAP RCD which effectively seek to compromise the claimant's right to have simultaneous exchange of expert evidence.

A responsible, experienced clinical negligence claimant lawyer will be expected to carry out reasonable investigations prior to taking on a claim, even before the PAP RCD stage. That will often include obtaining some form of independent medical expert opinion on liability and causation from relevant expert/s in the appropriate field. This is the only way for claimant solicitors to identify whether there are reasonable prospects of a case succeeding and whether it is commercially sensible to enter into a CFA with their client.

It is important to appreciate that reports obtained at this early stage may be outline reports, that give a provisional view of the claimant's condition. They are likely to be sufficient for the purposes of establishing the likelihood of a claim, but are not likely to be disclosable. It must be in the best interest of all parties that reasonable investigation as to the merits of claim are explored at an early stage.

Early investigation in clinical negligence claims should be encouraged. It acts as a safety net by helping to filter out unmeritorious claims, these are weeded out at an early stage so they are not actioned. This saves the defence organisations the cost of having to investigate claims that have no real prospects of success. This is in the interest of the claimant firm's business, indemnity insurers and the claimant themselves so their expectations can be managed early on.

If claimants are expected to disclose their medical evidence prior to issue, it will simply serve to ensure that the opportunity to investigate, explore and discuss resolution of a case at PAP stage will be lost. It simply means the PAP stage will be treated as though parties are issuing proceedings. It will inevitably lead to claims being front loaded – full medical reports will have to be obtained, conferences with counsel and experts will take place prior to the PAP stage. The window of opportunity to explore the case will be lost and a litigious process brought forward.

Sequential exchange of expert evidence in a clinical negligence claim would be highly detrimental to claimants. It would enable defendants to see the claimants in full, it will not encourage defendants to carry out their own investigations in a timely way. The defendant expert's focus will be on replying and responding to the claimant experts views, not on examining the facts and forming an independent view on whether treatment provided fell below an acceptable standard of care and if so, what harm was caused as a consequence.

This would be a retrograde step for claimants and for patient safety generally. Instead of the defendant expert approaching a case based on what, if anything went wrong with this treatment. They will be looking at how a claimant expert has phrased their views and opinions and seeking advantage by attacking that rather than taking an impartial and independent view of the issues.

42. **Prior to commencement of proceedings by the Claimant should the Defendant be entitled to obtain a medical report on the Claimant if the Claimant does not disclose amedical report?**
    - ~~**Yes**~~
    - **No**
    - ~~**Other**~~

    Generally speaking no. It is for the defendant to consider the letter of notification, the letter of claim and to carry out their own investigations. As referred to above, defendant organisations are likely to have carried out their own investigations already, whether as a result of the complaints process, a serious investigation report, an inquest (if there is a death) or as per their obligations under the duty of candour.

    As part of the investigations on liability, defendants should be expected to obtain their own medical expert evidence before admitting or denying their position in the letter of response. If the defendant organisation admits liability and wants to establish condition and prognosis as part of efforts to identify

value of the claim and settlement then they should be entitled to obtain a medical report.

There is no point in obtaining medical evidence on a claimant in a clinical negligence claim at this early stage, unless there is an admission of liability. To allow this in a clinical negligence claim without an admission being made will only encourage poor behaviour, it risks this "entitlement" being invoked as a means by which the claimant feels harassed and or intimidated.

It may also encourage defendant's to avoid any form of investigation and simply move to exercising their "entitlement" to obtain a medical report.

It will not encourage parties to engage, it will almost certainly lead to an adversarial approach to PAP. PAP is an opportunity to resolve claims, if it is given an adversarial status, that opportunity is quite simply lost. That would be detrimental to the parties and defeats the object and purpose for which PAP was originally designed.

43. **Do you agree that the protocol should include provision that for the purposes of rehabilitation the claimant solicitors should give reasonable access for medical assessment when requested by the defendant insurer?**
    - ~~Yes~~
    - ~~No~~
    - Other

    This does not tend to apply to clinical negligence claims. If parties agree liability, condition and prognosis and quantum are likely to be the only remaining issues. The PAP RCD could include a provision that when an admission is made, defendants are obliged to consider making an interim payment at that early stage to facilitate rehabilitation and therapies that may improve the claimant's outcome.

44. **If you consider any change to the PI PAP expert evidence process in multi-track cases would be beneficial what would the new process look like?**

    AvMA does not consider this relevant to clinical negligence claims and offers no comment.

45. **Would an ability to have pre litigation court case management help dispute resolutionin multi-track personal injury cases?**
    - ~~**Yes**~~
    - **No**
    - ~~**Other**~~

    Please see our response to question 15 above. PAP RCD is likely to be a more effective opportunity to resolve disputes if the courts scrutinise conduct and

behaviours of the parties at the PAP RCD stage. This could be considered at the first CMC and failing that, at resolution of the claim.

Introducing a case management stage at PAP will complicate the arrangement. It will not achieve anything and will again encourage cases to be front loaded.

Questions specifically related to housing protocols

46. Do you wish to answer questions about housing protocols?
    - ~~Yes~~
    - No

Disrepair/Housing Conditions PAP

47. Do you agree that large corporate landlords should be required to publish an address to which pre-action protocol letters should be sent?
    - Yes
    - No
    - Other

Landlord Possession Claim PAP

48. Do you agree that the existing PAP should include information for landlords relating to the rules and procedure when a Defendant may lack capacity?
    - Yes
    - No
    - Other
49. Do you agree that the existing PAP should be amended to require landlords to file a checklist at court when issuing a claim, confirming compliance with the PAP and/or that the Claim Form or Particulars of Claim be amended to require the landlord to confirm compliance?
    - Yes
    - No
    - Other
50. Do you agree that the Landlord possession PAP should be extended to apply to possession claims brought by a private landlord (with the exception of claims brought under the accelerated procedure)?
    - Yes
    - No
    - Other
51. If so, do you agree that such a PAP should include information for landlords about the rules as to which bodies are authorised to conduct litigation?
    - Yes
    - No
    - Other
52. Do you agree that the existing PAP should apply to claims for possession on grounds other than rent arrears grounds?
    - Yes
    - No
    - Other

Mortgage Possession PAP

53. Do you agree that the PAP should be mandatory?
    - Yes
    - No
    - Other
54. Do you agree that the PAP should apply to all mortgage possession claims relating to residential property, including 'buy to let' mortgages?
    - Yes
    - No
    - Other
55. Do you agree that the PAP should be amended to require that occupiers are notified of steps taken under the Protocol that are likely to lead to a possession claim being made?
    - Yes
    - No
    - Other
56. Do you agree that the PAP should be amended so as to provide standard information to borrowers about the powers of the court?
    - Yes
    - No
    - Other
57. Do you agree that the PAP should be amended to require lenders to write to the borrowers to inform them of the time and date of the hearing and the importance of attending?
    - Yes
    - No
    - Other
58. Do you agree that the PAP should be amended to make reference to other forms of ADR available, such as the Business Banking Resolution Service.
    - Yes
    - No
    - Other

Questions specifically related to the JR protocol

59. Do you wish to answer questions about the judicial review protocol?
    - ~~Yes~~
    - No
60. Do you agree or disagree with the approach set out by the sub-committee in chapter 4?
61. Are there any other factors specific to judicial review that should be considered?
62. Do you agree or disagree that there should continue to be a separate and bespoke PAP for judicial review?
    - Agree
    - Disagree
    - Other

63. What elements of the proposed General Principles in Chapter 3 do you consider it is possible and/or desirable to include in the JR PAP?

Questions specifically related to the debt protocol

64. Do you wish to answer questions about the debt protocol?
    - ~~Yes~~
    - No
65. Do you support the introduction of a good faith obligation to try to resolve or narrow the dispute and the requirement to file a joint stocktake report, on condition that debtors have access to legal assistance to complete both requirements?
    - Yes
    - No
    - Other
66. Would you support aligning the time limits for responding to the Pre-action Letter of Demand to those suggested for revised general PAP (14 days with a right to extend for a further 28 days to obtain further information including legal advice)? What changes, if any, would you make to the rules on when litigation can be commenced?
67. Do you think the contents of the pre-action letter of claim should be more prescriptive and, if so, what content should be prescribed?
68. Do you think the language of the pre-action protocol should be made more user friendly and do you support changing the terms creditor and debtor to claimant and defendant?
    - Yes
    - No
    - Other
69. Do you support integrating the PAP for Debt claims into the MCOL portal (or any successor platform)?
    - Yes
    - No
    - Other

Questions specifically related to the construction and engineering protocol

70. Do you wish to answer questions about the construction and engineering protocol?
    - ~~Yes~~
    - No
71. Would you support aligning the time limits for responding to the pre-action letter of demand to those suggested for the revised general PAP (14 days with a right to extend for a further 28 days to obtain further information)?
    - Yes
    - No
    - Other
72. Do you support the retention of the referee procedure?
    - Yes
    - No
    - Other

73. Would you support the formal incorporation of a standard of disclosure and, if so, which standard?

Questions specifically related to the professional negligence protocol

74. Do you wish to answer a question about the professional negligence protocol?
    - ~~Yes~~
    - No
75. Would you support aligning the time limits for responding to the pre-action letter of claim to those suggested for the revised general PAP (14 days with a right to extend for a further 28 days to obtain further information)?

Questions specifically related to the proposed low value small claims track

76. Do you wish to answer a question about to the proposed low value small claims track protocol?
    - ~~Yes~~
    - No
77. Would you support the exclusion of the stocktake requirement and the inclusion of the good faith obligation to try to resolve or narrow the dispute in a new PAP for low value small claims case worth £500 or less?

Any other comments

78. Please include here any other comments you wish to make not covered by the questions already posed.