AvMA's Response to

Ministry of Justice Consultation on

Extending Fixed Recoverable Costs in Civil Cases: Implementing Sir Rupert Jackson's proposals

The Consultation begins on 28th March 2019

The Consultation ends on 6 June 2019

About AvMA

Action against Medical Accidents (AvMA) is the UK charity for patient safety and justice. Established in 1982, AvMA provides specialist support and advice to people who have been affected by lapses in patient safety. AvMA works in partnership with government departments, health professionals, the NHS, regulatory bodies, lawyers and other patients' organisations to improve patient safety and the way injured patients and their families are treated following lapses in patient safety. AvMA also accredits specialist clinical negligence solicitors so that injured patients or their families have access to the best quality legal advice if they need it. Consequently, AvMA is uniquely well positioned to respond to this consultation from the perspective of the people who would be affected by the proposals.

Executive Summary of our response

We believe that despite the MoJ consultation stating that ***"clinical negligence cases are generally excluded from the FRC proposals made in this consultation"*** insufficient detail has been provided about when clinical negligence claims will be included.

AvMA considers that the criteria for extending the fast track and the discretion to include cases even where they do not meet the revised fast track criteria will mean that in practice clinical negligence claims will be included.

The MoJ's use of the word "***generally***" will not prevent clinical negligence cases from being included. The risk of clinical negligence claims being included in the fast track exists where a case meets the intermediate track criteria. The risk of inclusion is increased given the courts ***"residual discretion"*** to allocate ***"any case***" (including clinical negligence cases) where it is considered "***advantageous in promoting access to justice***".

AvMA believes that contrary to Jackson LJ intention that only a ***"minority***" of clinical negligence cases be included, a great number of cases with damages valued at £100,000 or less risk being included in the expanded fast track. This has implications for access to justice, particularly as the consultation does not offer any suggestions on how to control one of the fundamental causes of spiralling costs, defendant behaviour.

It has also failed to consult with insurers on what effect an expanded fast track will have on After the Event (ATE) insurance cover for clinical negligence claims

Threat of access to justice

- The proposals will drive accredited specialist solicitors out of clinical negligence.
- Clinical negligence claims with a value of £100,000 or less will become less commercially viable for experienced claimant lawyers to take on.
- The reduction in lawyers willing to take these cases on will result in claimants being unable to find representation.
- Even if a claimant were to find a solicitor and manage to win their claim, they would inevitably be required to pay a significant amount from their damages to meet legal costs which currently are largely met by the losing negligent defendant.
- Claimants and claimant lawyers will be forced to accept offers to settle which do not reflect the true value of the claim because the cost risk of continuing to fight the case will not be worth the difference in the award.
- The proposals are prejudicial to claimants as their damages are not protected from their lawyer's costs.
- No work has been done to explore what effect, if any, an expanded fast track will have on the provision of ATE insurance in clinical negligence claims.

Threat to patient safety

- Many patients and their families would no longer be able to challenge healthcare providers through the legal process when there have been inappropriate denials of mistakes or liability.
- This would mean a lost opportunity for healthcare providers and the NHS to learn lessons for patient safety from cases they had wrongly defended.
- If implemented, the proposals could further encourage a 'deny and defend' culture amongst healthcare providers rather than the desired 'open and fair' culture.

Questions

Chapter 3: The Fast Track:

1. Given the Government's intention to extend FRC to fast track cases, do you agree with these proposals as set out? We seek your views, including any alternatives, on:

(i) the proposals for allocation of cases to Bands (including package holiday sickness);

AvMA does not consider clinical negligence claims to be suited to the fast track or the proposed FRC bands – see comments below.

AvMA looks to claimant clinical negligence practitioners responding to this consultation to comment on the proposed band allocation and the fees allowed within those bands.

Package holiday sickness claims falls outside of AvMA's area of expertise.

(ii) the proposals for multiple claims arising from the same cause of action;

Clinical negligence claims involving multiple claimants or defendants are certainly not suited to the fast track owing to the complexity of managing multiple claimants.

In clinical negligence claims consideration must be given to the individual nature of each claimant's health, inherent risk factors and unique conditions which can result in injuries being exacerbated, these are complex claims which cannot be accommodated by a standard percentage-based supplement for each additional claimant. Clinical negligence claims involving multiple parties are not suited to the fast track or FRC banding.

(iii) whether, and how, the rules should be fortified to ensure that (a) unnecessary challenges are avoided, and (b) cases stay within the FRC regime where appropriate; and

There needs to be a clear statement that clinical negligence claims are exempt the proposed, expanded fast track other than in exceptional circumstances otherwise by agreement of the parties.

Jackson LJ did not envisage clinical negligence claims being included in either the intermediate track or the fast track, but the language used is lose and open to interpretation. For example, in relation to the fast track Jackson LJ says: "***Clinical negligence claims will not generally fall within the parameters of the fast track"*** the use of the word "***generally***" in this context suggests that some clinical negligence claims will be included.

In relation to the intermediate track, Jackson LJ says: "***a minority of clinical negligence claims with a value between £25,000 - £100,000 might be suitable for the intermediate track".***

Contrary to Chapter 5, paragraph 2.2 and the MoJ's footnote 99, Jackson LJ said: ***"…a minority of clinical negligence claims with a value between £25,000 - £100,000 might be suitable for the intermediate track. <u>A good example</u> of such a case may be one where the defendants admits breach and causation in the protocol period and all that remains are relatively straightforward quantum issues…"*** [my underlining]. The MoJ have interpreted this as clinical negligence claims will not generally be included ***"<u>Unless</u>… both breach of duty and causation have been admitted at an early stage"*** [my underlining]

There is a very real difference between providing an example of the type of clinical negligence case that *"might"* fall within an intermediate track and saying that clinical negligence cases will not usually fit the criteria *"unless"* breach of duty and causation have been admitted at an early stage.

At chapter 5, paragraph 2.5 of this consultation the MoJ propose that in addition to the intermediate track criteria identified ***"the court should have a residual discretion to allocate any case as an intermediate***

case, where it is considered advantageous in promoting access to justice"

Any residual discretion needs to be carefully defined, factors that the court should consider when exercising this discretion need to be clearly set out.

A residual discretion to allocate any case as an intermediate case, is open to wide interpretation. What does this really mean?

- Does the residual discretion mean that even if more than four experts in total are required to give oral evidence that the court can allocate the case to the fast track?

- Does it mean that where a trial estimate is longer than three-days that the case can still be allocated to the fast track?

If the answer to either or both of the above questions is yes, or possibly, then this increases the chances of clinical negligence claims with a value of up to £100,000 being referred to the fast track, unless the MoJ specifically excludes them or states that this category of case will only be included in exceptional circumstances.

Failure to clarify this will result in an increased risk that clinical negligence claims will be allocated to the fast track regardless of whether they are suited to this track or not, the consequence will be satellite litigation. It will likely follow that Court Applications will be made challenging the decision to allocate clinical negligence cases to the fast track, notwithstanding the fact it meets the apparent criteria.

Applications will be made by lawyers seeking to show Part 26.8 applies and that in particular, the court needs to have regard to amongst other things: the likely complexity of the facts, law or evidence; the amount of oral evidence that may be required - even where a clinical negligence case can be restricted to oral evidence from four experts, oral evidence may be required from numerous witnesses of fact including doctors and/or nurses attending on the claimant at the relevant time, the claimant

and any other witnesses that can give first hand evidence of the facts alleged by the claimant.

Other issues may include the importance of the claim to people who are not party to the proceedings; the views expressed by the parties; the circumstances of the parties and so forth.

(iv) Part 36 offers and unreasonable litigation conduct (including, but not limited to, the proposals for an uplift on FRC (35% for the purposes of Part 36, or an unlimited uplift on FRC or indemnity costs for unreasonable litigation conduct), and how to incentivise early settlement.

The consultation is not precluding clinical negligence claims from the proposed fast track. Although the language suggests that very few cases are expected to be caught, for the reasons set out we query whether that is what would happen in practice.

When considering amendments to the rules around Part 36 offers we point to the fact that they are a powerful incentive and tool to promote settlement. They work. The current terms of a Part 36 offer focus the mind, indemnity costs are a powerful incentive to settle claims. Where a party has pitched their offer carefully, sensibly and well that should be recognised.

We agree with Nicolas Bacon QC (one of Jackson LJ's assessors) two key points on this issue; first, cases on indemnity costs are not clogging up the courts with detailed assessments. Second: Why shouldn't a client be entitled to be recompensed for their actual legal spend, rather than fixed costs, particularly where a party has misconducted themselves or caused a party to incur costs unnecessarily because an earlier offer should have been accepted.

There is no evidence that a percentage uplift, whether it be 30%, 35% or 40% will be equally effective.

Chapter 4: Noise Induced Hearing Loss:

2. Given the Government's intention to extend FRC to NIHL cases, do you agree with the proposals as set out? We seek your views, including any alternatives, on:

(i) the new pre-litigation process and the contents and clarity of the draft letters of claim (and accompaniments) and response.

(ii) the contents of the proposed standard directions, and the listing of separate preliminary trials.

AvMA is unable to comment, Noise Induced Hearing Loss claims falls outside of our area of expertise.

Chapter 5: Intermediate Cases:

3. Given the Government's intention to extend FRC to intermediate cases, do you agree with the proposals as set out? We seek your views, including any alternatives, on:

(i) the proposed extension of the fast track to cover intermediate cases;

If the fast track were to be extended to capture those cases originally identified by Jackson LJ as meeting the criteria for his proposed "intermediate track" then some clinical negligence cases would be included in the fast track.

Jackson LJ did not see clinical negligence claims generally meeting the criteria for intermediate cases, neither did he see this category of claim being suited to the fast track. As discussed above, allowing the court a residual discretion to allocate any case where it may be advantageous to promoting access to justice increases the risk of clinical negligence cases being allocated to the fast track.

Jackson LJ was clear in his Review of Civil Litigation Costs: Supplemental Report July 2017 that clinical negligence claims should

not generally fall within either the fast track or his proposed intermediate track. At Chapter 5, paragraph 5.15 of that report he said:

"Clinical negligence claims will not generally fall within the parameters of the fast track. They are more demanding than other forms of personal injury litigation and require more complex pre issue investigation…The only clinical negligence claims which would fall within the fast track fixed costs scheme proposed in this chapter are those where (a) breach and causation are admitted in the pre action protocol letter of response and (b) the value is less than £25,000"

At chapter 5, paragraph 5.3 he was unequivocal in his view that:

"Any case of particular complexity does not belong in the fast track at all"

Regarding the Intermediate Track, chapter 3, para 2.9 (iv) of Jackson LJ 2017 report says:

"Finally, it should be noted that the assumptions and directions that came in with the budgets made clear that the great majority of clinical negligence cases in our sample would not be suitable for allocation to the new track proposed in chapter 7…"

And at chapter 8, para 5.5 he envisaged that only:

"…a minority of clinical negligence claims with a value between £25,000 - £100,000 might be suitable for the intermediate track. A good example of such a case may be one where the defendants admits breach and causation in the protocol period and all that remains are relatively straightforward quantum issues…"

For the avoidance of any doubt, if the MoJ does extend the fast track as suggested in this consultation, the complex nature of clinical negligence claims is such that they should be specifically excluded from the fast track other than in exceptional circumstances or unless the parties agree

to the case being allocated to the fast track at the outset. It is noted that this consultation states at paragraph 1.6 that

"clinical negligence cases are generally excluded from the FRC proposals made in this consultation paper".

Given that, and if there is an extension of the Fast Track as proposed then it would be in line with MoJ's own approach for clinical negligence cases to be excluded unless agreed by the parties or there were exceptional circumstances.

(ii) the proposed criteria for allocation as an intermediate case and whether greater certainty is required as to the scope of the track;

Greater certainty is required as to the type of case to be included, hence the recommendation that clinical negligence claims be specifically excluded alternatively, only included in exceptional circumstances.

Jackson LJ's criteria for intermediate track is set out at Chapter 5, paragraph 2.1 of the consultation document. Essentially, the criteria for intermediate track cases was intended to be: (i) damages claimed do not exceed £100,000, (ii) maximum of two experts to give oral evidence for each party (total four experts giving evidence); (iii) a trial is not expected to last more than three days.

The proposal that the court have residual discretion to allocate "any" case where it is considered advantageous in promoting access to justice gives the court discretion to include cases that do not meet the intermediate case criteria. This substantially increases the risk that clinical negligence cases valued up to £100,000 could and would be allocated to the fast track.

Jackson LJ offered one example of where a clinical negligence claim might be suited to the intermediate track, that is where a defendant accepts breach and causation in the protocol period leaving only "*relatively straightforward quantum issues*". It is accepted that such a case may be suited to an intermediate track approach.

However, cases where a defendant admits breach of duty but not causation might also be fall into the intermediate case category. If the case was valued at £100,000 or less and required say, one expert on causation and one on condition and prognosis, or even two experts on causation and no condition and prognosis expert then it would, according to the MoJ's proposed criteria, be eligible for the fast track.

The fact that the case is likely to raise complex medical issues on causation is likely to be lost especially if the court is allocating the track as it does in fast track cases. The specialism and experience to recognise a clinical negligence claim would not be available in the county court in the same way as it is in the High Court, the same docketing arrangements do not routinely exist.

If this were to happen, then it would be incumbent on the opposing party (most likely the Claimant) to take out an application and argue that the case should be allocated to the multi-track. That application carries with it a risk that if the judge finds against the applicant that they will incur penalty costs for bringing the application – the consultation proposes, £300.

The risk of that cost being incurred would most likely fall to the claimant/patient themselves, unless ATE insurance can be obtained to cover the risk. It is not clear, what if any consultation has been undertaken by the MoJ with ATE providers to consider whether ATE insurance could cover this risk. Similarly, whether these proposals would affect current ATE models in clinical negligence.

The risk is more likely to fall to the claimant/patient as tactically it would be advantageous for defendant organisations to keep the claimant in a fixed costs regime. In turn, this is likely to encourage poor behaviour from the defendant, such as delays in settling and resolving claims. This would be further encouraged if part 36 offers cease to carry the risk of indemnity costs.

Access to justice would likely be compromised unless clinical negligence claims are stated to be unsuited to the fast track other than in exceptional circumstances. Claimant solicitors will be reluctant to take the risk that demanding cases, requiring complex investigation may be included in a fast track process where the claimant can only recover fixed costs. The risk is increased if the power of the part 36 offer has been diluted. The process becomes weighted against the claimant, who already has the burden of proving the claim.

Clinical negligence cases are wholly unsuited to a fast track process and to fixed costs; fixed costs are unable to reflect the complex nature of these claims; proportionality is a better tool for managing the costs in complex cases. This fact was recognised by Jackson LJ when he said the only clinical negligence claims that would be suited to a fast track fixed costs scheme would be ones where the value was less than £25,000, and where breach and causation were admitted in the pre action protocol letter of response. It is notable that to date, no fixed costs scheme for low value claims ie £25,000 or less has been produced.

Currently, “intermediate cases” would typically be issued in the High Court where they benefit from being assigned to designated clinical negligence masters who understand these cases and who are experienced in dealing with them.

When the county court receives a defence to a case which meets the fast track criteria, the usual procedure is:

- The court officer will provisionally decide which track is most suited to the claim.
- When the court allocates a case to the fast track, the court will give directions for the management of the case
- The court sets the timetable for the steps to be taken between the giving of the directions and the trial
- The court fixes the trial date (usually 30 weeks from giving the directions)

Contrast this approach to the current approach where High Court Masters are “docketed” and use their expertise and experience to allow model directions (drafted for the purpose of managing clinical negligence cases) to be used as a basis for discussion.

These directions allow the court and the parties to be flexible and to look at each case on its own facts and issues. They also actively promote the use of Alternative Dispute Resolution to bring about early settlement of cases where possible.

These directions carefully manage the exchange of expert evidence and witnesses of fact and have evolved for the purposes of streamlining clinical negligence claims which are by their nature complex.

(iii) how to ensure that cases are correctly allocated, and whether there should be a financial penalty for unsuccessful challenges to allocation;

If clinical negligence claims are not specifically excluded from the fast track or stated to be included only in exceptional circumstances as AvMA suggests, no financial penalty should be applied in the event of an unsuccessful challenge to allocation.

If it is accepted that clinical negligence claims are not intended to be in the fast track, the parties must be free to put their case to the court for further consideration without fear of incurring cost penalties. This is particularly true given that clinical negligence cases wrongly allocated to the fast track give a tactical advantage to the defendant in whose interest it is to press for fixed costs to apply, even if it is inappropriate.

(iv) whether the 4-band structure is appropriate, or whether Bands 2 and 3 should be combined, given the closeness of the proposed figures: if you favour combining the bands, we welcome suggestions as to how this should be done; and

AvMA will look to the responses offered by practising claimant clinical negligence practitioners on this issue.

(v) whether greater certainty is required regarding which cases are suitable for each band of intermediate cases.

AvMA will look to the responses offered by practising claimant clinical negligence practitioners on this issue. The complex nature of clinical negligence claims is such that any cases included in the fast track should be allocated to Band 4 or the band considered to be most appropriate for complex cases.

Chapter 6: Judicial Review:

4. Do you agree with the proposal for costs budgeting in JRs with a criterion of 'whether the costs of a party are likely to exceed £100,000'? If not, what alternative do you propose?

AvMA is unable to comment, costs budgeting for judicial review cases falls outside of our area of expertise.

Chapter 8: The Next Steps:

5. We seek your views on the proposals in this report otherwise not covered in the previous questions throughout the document

Our responses pertain to clinical negligence claims only and our views on the proposals are set out in our responses.

Chapter 9: Impact

6. Do you have any evidence/data to support or disagree with any of the proposals which you would like the government to consider as part of this consultation?

AvMA does not accept the governments assumption at paragraph 34 of the Impact Assessment that:

- ***"the overall willingness of claimants to bring a claim would remain unchanged"***
- ***"There would be no aggregate impact on claimant lawyers' willingness to take on cases.*** We add that clinical negligence claims

should only be handled by lawyers with expertise and experience in this field, the government should not encourage inexperienced lawyers to enter this market. We point to the effect of personal injury lawyers entering the clinical negligence market in the immediate post LASPO 2013 phase; this resulted in increased number of claims and cost to the NHS LA (now NHS Resolution) in handling those claims.

- ***"Claimant lawyers would set their legal fees equal to the FRC being proposed for each case type.***
- ***"Claim settlement outcomes would remain the same"***

Fixed Recoverable Costs (FRC) only limit the amount of money recoverable from the losing party, they do not limit the amount of money that can be charged by a solicitor to their client. FRC sit alongside Conditional Fee Agreements (CFA). Since the reduction in availability for legal aid, CFA's are now the most common way of funding clinical negligence litigation as between a claimant and their lawyer.

CFA's do not restrict the amount a solicitor can charge their client. Where a solicitor charges a success fee on their CFA, the success fee may be as much as a 100% however the amount the solicitor can recover from damages is ringfenced at 25% of the award for general damages and past losses.

Costs payable by a client to a solicitor under the CFA may be recovered from the client damages. If a solicitor charges say £250/hour in their CFA but only recovers the equivalent of £90/hour on a fixed fee from the losing party, the client remains liable for the difference, in this example, that is a shortfall of £160/hour. This is not ringfenced. That shortfall will likely come out of client damages. It is feasible that an award of damages could be very much reduced or even wiped out by the actual costs of litigation.

There is no evidence that claimant clinical negligence lawyers can or will set their legal fees equivalent to the FRC proposed in clinical negligence claims.

FRC ignores the fact that the costs and time spent to achieve a fair outcome is dependent on several factors outside of the claimant's control. These include the complexity of the case as well as defendant behaviour and conduct. For

example, a defendant can deliberately avoid settling a meritorious case at the earliest opportunity with the intention of pushing a claimant through the court system in the hope that the claimant gives up their claim.

Each stage of the litigation process incurs more costs which under the terms of the CFA the claimant is responsible for. The case may settle just before trial by which time considerable costs have been expended by the claimant. Those increased costs carry with it an increased risk that the claimant's award of damages will be reduced and possibly even wiped out altogether to cover the shortfall in costs which FRC leaves.

The defendant's obligation to contribute to the claimant's costs remains fixed at the levels determined by the FRC regime. The defendant is not at risk of paying the claimant's full solicitor client own costs incurred, even though the defendant party deliberately pressurised the claimant into litigating by failing to make a reasonable offer of settlement early on.

Claimant lawyers may have to settle claims for less than they are worth as the risk of incurring further costs and going to trial are too great. That risk is increased by the fact the claimant will only recover fixed costs. Lawyers will have to take a view on the risk/benefits of accepting an offer which is less than the value of the claim, or incurring costs that won't be recoverable from the losing party but will be deducted from the client's damages; damages will be agreed at less than their full value as a result.

If solicitors are unlikely to recover their costs from the losing party in a clinical negligence claim and are expected to look for any shortfall from their client, then there are real reputational risks for lawyers. Those reputational risks together with the difficulties of managing defendant tactical behaviour of deny and defending claims, thereby increasing the claimant's costs are likely to result in lawyers avoiding these claims.

Fixing the costs recoverable from the losing party does not control the costs of litigation, it does not ensure that costs are proportionate or predictable, it simply controls the amount that may be recoverable – that is very different.

To control the costs of litigation the government will need to address both defendant behaviours and ensure that client damages are protected.

If the government does interfere with the terms of the CFA and recoverability of costs, then there is a real risk that clinical negligence claims will cease to be commercially viable and therefore unattractive to lawyers; experienced lawyers will refuse to do the work. That creates an access to justice issue as clients will not have lawyers willing to represent them even if they wish to bring a claim.

If the government does nothing to protect clinical negligence client's damages, the risk to the claimant of having their damages reduced or wiped out is likely to put them off seeking redress and creates an access to justice issue. The willingness of claimants to exercise their legal rights and bring a claim will change if they are unlikely to recover any or a substantial part of their damages.

If claimants cease to bring claims this will also affect patient safety. Problems within trusts will remain hidden and allowed to perpetuate causing continuing risk of and actual injury to the public. It will not encourage learning. The loss of this information will be detrimental to the health service, service users and the public alike.

The impact assessment refers to making legal costs proportionate in low-value civil litigation (cases up to £100,000 damages). The government does not offer any evidence for the basis upon which they have decided an award of £100,000 damages is low value. Indeed, in our experience, from our helpline calls and case work, members of the public consider £100,000 a great deal of money.

The only certainty that FRC offers is to the defendant, not to the claimant. Contrary to the impact assessments statement, they do not "provide both sides with certainty as to the costs of the case".

We are concerned that the MoJ has not consulted with After the Event (ATE) providers on the effect FRC might have on ATE policies. If clinical negligence claims begin to enter the fast track how might this affect ATE providers ability to continue to offer ATE insurance for clinical negligence claims?

Not only does this create an access to justice problem but if a swathe of cases under £100,000 are no longer brought, it also reduces the size of the clinical negligence market. This factor alone will affect the availability of ATE insurance and the cost of premiums throughout the entire clinical negligence ATE market.

AvMA understands from its discussions with ATE providers, that any reduction in one area of the clinical negligence market will affect all clinical negligence cases, not just those valued under £100,000. The reduction in volume of cases alone may prove fatal to the continuance of the ATE market in clinical negligence.

The Government and its agencies need to involve the ATE industry in a dialogue on how the proposed changes to the fast track will affect the ATE market. There is no evidence from the impact assessment that this group has been engaged. If clinical negligence claims are going to be included in the fast track process even if is only a "minority" of claims, then it is imperative the government does this.

We have repeatedly made the point that if clinical negligence cases are to be excluded from the fast track process and FRC other than in exceptional circumstances this must be clearly stated. This is the only way the government can ensure that unsuitable cases are not brought into scope.

Chapter 10: Equalities Statement

7. What do you consider to be the equalities impacts on individuals with protected characteristics of each of the proposed options for reform? Please give reasons.

If the extended fast track is intended to capture some clinical negligence cases, we consider it necessary for certain types of case to be specifically exempt the fast track process. Cases involving claimants with mental capacity issues; the elderly and fatal accident claims (in particular stillbirths, neonatal deaths and death of any minor) should be excluded from the fast track process.

These cases are often of great personal and often public interest significance however they are usually complex and time consuming. Applying fixed costs to

them would mean that claimant solicitors would be unlikely to represent claimants in these serious cases.

If these cases were to be included in a fast track scheme, then these groups are more likely to struggle to find representation because of the additional time and sensitivities around handling these claims. Those with the protected characteristics of age (elderly), mental disability, and pregnancy, maternity and being female are therefore more likely to be adversely affected by access to justice problems because of the complexity of the cases.

This consultation lacks any detail on what data is available to government and the MoJ, to form the conclusion that groups with protected characteristics will not be affected. What we do know from the Equalities statement summary is that ***"limited data is available"*** nonetheless, despite this the government has assessed that the "***proposals are not directly discriminatory"*** and would not result in people being treated less favourably. AvMA is not satisfied by that conclusion.

8. Do you agree that we have correctly identified the range of impacts under each of the proposed reforms set out in this consultation paper? Please give reasons.

See our response to Question 6 above.

9. Do you agree that we have correctly identified the extent of the impacts under each of these proposals? Please give reasons and supply evidence as appropriate

See our response to Question 6 above

10. Are there forms of mitigation in relation to impacts that we have not considered?

See our response to question 7 above.

About you

Please use this section to tell us about yourself

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If you are a representative of a group, please tell us the name of the group and give a summary of the people or organisations that you represent.
