RESPONSE TO CONSULTATION:

CONSULTATION ON EXTENDING FIXED RECOVERABLE COSTS (FRC): HOW VULNERABILITY IS ADDRESSED

20th June 2022

About AvMA

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

Although most of the people AvMA helps do not go on to make a clinical negligence claim, such claims are a vitally important option for many who need compensation to help cope with the implications of the injury or loss that has been sustained, and/or have exhausted other attempts to resolve their concerns and hold the organisation responsible for the injury to account. We have therefore always taken a strong interest in clinical negligence and have extensive in-house knowledge of how the system works. We accredit specialist claimant solicitors and provide training for lawyers practising in clinical negligence. We get useful intelligence from the claimant lawyers we work with and from medical experts. However, our focus is always on the needs of injured patients and their families

Questions for respondents: Please give reasons for your response

(i) Do you agree that the Governments proposals (as outlined in paragraph 15) is the right way to address vulnerability within FRC?

Paragraph 15 reads: "MoJ now considers that vulnerability in respect of parties and witnesses under the extended FRC regime should be addressed on the following basis:

i. It is a judicial decision to determine whether or not the vulnerability gives rise to sufficient extra work to justify, exceptionally, an additional amount of costs;
ii. There needs to be a threshold, which is proposed to be 20% in line with existing provisions additional work caused by the vulnerability;
iii. The procedure by which people can establish a vulnerability uplift needs to be clear and simple; and

iv. The process needs to be retrospective (as with the assessment of costs generally), not prospective: the judge needs to be satisfied that sufficient extra work has been incurred, not that it may need to be."

Paragraph 8, of this consultation refers to Practice Direction 1A which was introduced in April 2021. PD1A deals with the participation of vulnerable parties or witnesses. The overriding objective is stated at paragraph 1, to be that ***"parties are on an equal footing and can participate fully in the proceedings, and that parties and witnesses can give their best evidence. The parties are required to help the court to further the overriding objective at all stages of civil proceedings."*** Paragraph 4 then sets out factors ***"which may cause vulnerability"*** and paragraph 6 states ***"The court with the assistance of the parties, should try to identify vulnerability of parties or witnesses at the earliest possible stage of the proceedings"***

AvMA is not aware of any feedback on PD1A and how this is operating in practice. Subject to any feedback being made available it occurs to us that PD1A potentially already adequately deals with the question of vulnerability and does not need further explanation of factors that need to be considered when assessing vulnerability.

AvMA notes that the PD1A recognises the importance of vulnerability being defined early in the proceedings. That should remain the case. AvMA is concerned that paragraph 12 of this consultation seeks to distinguish between a vulnerable client whose vulnerability requires extra work and a vulnerable client where their vulnerability does not automatically generate exceptional work. That appears to us to be an artificial distinction.

AvMA is concerned that the artificial nature of this distinction will only serve to create uncertainty for both vulnerable clients and those considering acting for them. It would appear the sole purpose of introducing this distinction is to reduce the costs payable to those representing vulnerable clients under a fixed recoverable costs regime; identified as "***inappropriate additional costs***"

Paragraph 14 (i) of this consultation makes clear that what is being proposed is an uplift for lawyers acting for vulnerable clients in "***exceptional cases***" only.

Generally, government has stated that the benefits of fixed costs is the certainty it brings. If these proposals are introduced, it will only create uncertainty.

PD1A, is clear. If a claimant can be shown to reasonably meet the criteria set out in this practice direction then it should be acceptable for the lawyer representing them to rely on this. This is a determination which needs to be made at the outset, when the client first meets the lawyer representing them.

It is of concern, that paragraph 15 (iv) refers to the question of vulnerability being retrospective, not prospective. Lawyers acting for vulnerable clients will be

extremely cautious taking their cases on if the issue of vulnerability can only be determined at the end of the process.

The risks for lawyers taking on clinical negligence cases are already considerable. AvMA refers to its response to the government's consultation on "fixed recoverable costs in low value clinical negligence claims": https://www.avma.org.uk/wp-content/uploads/AvMA-response-to-Fixed-Recoverable-Costs-consultation-Apr22.pdf We draw attention to our response to Question 8 of that consultation relating to protected party claims. Protected parties are by their nature a vulnerable group of individuals who readily meet existing PD1A requirements, it illustrates that this practice direction appears to be more than adequate and does not need further amendment as proposed here.

In our response to question 8 we have expressed concerns that the complexities involved in acting for a protected party cannot be overcome with a proposed bolt on fee of £650. That such an approach will simply result in this group of people finding it difficult to secure legal representation. To suggest that "***any vulnerability mechanism should only allow for an uplift in those exceptional circumstances in which it is clearly merited"*** (paragraph 14 (i)) and that this determination would be retrospective only increases the likelihood that this cohort of people will find it even more difficult to find representation.

Vulnerable clients need careful and sensitive management, that requires time which inevitably means these types of cases are more costly. If that time cannot be recovered because the nature of the client's vulnerability is not considered "exceptional" enough then the lawyer will be out of pocket. Alternatively, the short fall in costs will be deducted from the vulnerable client's damages which is detrimental to them.

If the vulnerability is caused by the injury consequent upon the negligence, then the claimant should be able to recover for this. If the claimant was vulnerable when the negligent injury occurred, then the principle that the tortfeasor takes their victim as they find them is relevant. Either way, there is no reason why a vulnerable claimant's damages should be reduced, or that the fees reasonably incurred by the lawyer representing them should not be payable.

AvMA agrees that any vulnerability uplift needs to be clear and simple. These proposals are not clear and simple. In practice they will be very difficult to apply. Lawyers will already be cautious about representing claimants on a FRC regime, especially given the rates proposed. If in addition they cannot be confident, that the client they treat as vulnerable will be considered vulnerable at the conclusion of the case they will be even more cautious about providing representation.

It is noted that the government has yet to publish its response to the consultation on FRC in low value clinical negligence claims. To that end, AvMA considers this consultation on vulnerability to be premature. Arguably, the nature of clinical negligence claims where individuals have been let down by one profession (the medical profession) already makes clinical negligence claimants potentially vulnerable.

AvMA believes the question of vulnerability needs to be addressed and/or revisited within the context of clinical negligence litigation only once it has been confirmed that a FRC regime is to be introduced. AvMA has responded to this consultation because we consider the issue of vulnerability to be key to clinical negligence claims and because the MoJ in publishing this consultation at this time have not made it clear that the definition would and should be revisited within the context of clinical negligence claims, if a FRC regime is introduced for this group of claims.

(ii) If not, do you have an alternative proposal?

AvMA agrees that any vulnerability uplift needs to be clear and simple. We suggest that one way of doing this is to maintain the status quo and allow practice direction 1A more time to bed in. It was only introduced in April 2021; it is unlikely that many cases on vulnerability have concluded yet.

The issue of whether PD1A is appropriate for clinical negligence claims which may be subject to a FRC remains to be seen. We suggest that if a FRC regime is introduced for clinical negligence claims that the issue of vulnerability be reviewed after a reasonable period, say 2 years after any FRC regime is introduced. This will allow sufficient time for any problems to arise and for more practical solutions to be found.

It occurs to us, that any case meeting PD1A definition of vulnerability could be certain of a minimum of 20% uplift, with the ability to exceed this uplift according to the facts of the case and complexities involved. We also consider that factors such as the defendants conduct should be relevant considerations.

Increasingly, the concept of secondary harm is being realised. This is where injured patients who have sustained injury because of clinical negligence and who then must overcome persistent denials, and their claim being defended, only for it to settle subsequently experience a type of secondary harm. Not only should lawyers acting for these vulnerable claimants be entitled to an uplift of more than 20% but the client should also be entitled to an enhanced award to reflect the additional harm felt by the way in which the allegations were dealt with.

(iii) Do you have any drafting comments on the draft new rules?

It is staggering that proposed new rule 45.XY (2) can even suggest that the claimant's lawyers be at risk at receiving even less than the low sums proposed under the current FRC for clinical negligence claims simply because they sought and failed to secure an uplift on FRC rates for a vulnerable client.

If the MoJ really do believe that vulnerable people have a right to have their claims being heard, then they need to offer incentives for lawyers to represent people who fall within this category. This proposal means that all the risk is carried by the claimant and/or their lawyer. That flies in the face of PD1A and the overriding principle that parties are put on an equal footing.

AvMA believes that this suggestion simply compounds concerns that vulnerable people will be less likely to secure representation. A provision such as this will deter lawyers even further from acting for vulnerable claimants.

AvMA considers that those with a physical or mental disability are much more likely to be affected by this proposal than those who are not. As such we suggest that this proposal is more prejudicial to those with protected characteristics under the Equalities Act.

We note, no impact assessment has accompanied this consultation – the government needs to produce that.

Please see also our response to question 16 re the equalities impact assessment referred to in FRC in lower value clinical negligence claims consultation 2022.

(iv) Should any new provision in respect of vulnerability apply to existing FRC, which generally cover lower value PI (please consider in the context of paragraph 20 above)

No response. AvMA is only able to comment on likely effect of these proposals on clinical negligence claimants and/or their lawyers.

(v) Do any changes need to be made to the arrangements for disbursements for vulnerability in FRC cases?

This question needs to be revisited if a FRC regime is introduced for low value clinical negligence claims. It is premature and inappropriate to respond to this question at this stage.

Lisa O'Dwyer
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