# SUBMISSIONS TO CIVIL JUSTICE COUNCIL ON

# "ADR AND CIVIL JUSTICE – QUESTIONS FOR CONSULTATION"

**15TH DECEMBER 2017**

## Brief Introduction to AvMA

1.1. Action against Medical Accidents (AvMA) was originally established in 1982. It is the UK patient safety charity specialising in advice and support for patients and their families affected by medical accidents. Since its inception AvMA has provided advice and support to over 100,000 people affected by medical accidents.

1.2. AvMA offers specialist services to the public, free of charge. AvMA's specialist services are its Helpline, pro bono inquest service and advice and information services.

1.3. Through our work we have observed how the public are driven by the need for the truth about what has happened in relation to an incident or a death and to ensure that lessons are learned so that future mistakes are prevented.

1.4. The demand for our services invariably outstrips what we can supply and has generally increased, not diminished in recent years.

## 2. Executive Summary

2.1. We believe that the term ADR is too broad and encompasses a number of ways of resolving civil litigation disputes, both before and after the issue of proceedings.

2.2. ADR might include the use of mediation, round table meetings, telephone discussions as well as arbitration and other alternatives to litigation. The term ADR should be avoided and the more specific alternatives should be referred to so as to identify the forum or skills intended to be used.

2.3. The generic use of ADR means that it is difficult for practitioners to identify whether it has been employed or not.

2.4. The cost of some forms of ADR such as mediation and arbitration, whilst undoubtedly powerful tools are also expensive tools. At a time when clinical negligence litigation is dictated by proportionality lawyers will, naturally and understandably, be more circumspect about incurring additional costs by entering into processes, such as mediation.

2.5. There is a great deal of concern about identifying the most appropriate time to mediate. Generally, it is thought that mediating before you have obtained your medical evidence is not appropriate.

2.6. Where parties have obtained their own independent medical evidence they can usually resolve issues without the need for formal mediation.

2.7. In clinical negligence claims, if NHS organisations and the NHSR have both done their job properly and carried out robust internal investigations, met their obligations under the complaints process and NHS constitution and/or obtained independent medical evidence at the time of signing off

the Letter of Response, then the issues should be clear and there should be no need for ADR, the matter should simply be resolved or turned down.

## 3. Background to AvMA's Response

3.1. In preparing these written submissions we have been particularly mindful of the focus on the use of ADR in the Civil Justice System. AvMA does not issue proceedings or conduct litigation and so to that extent our experience is limited.

3.2. AvMA does operate an accreditation scheme for specialist clinical negligence lawyers and has access to information on litigation and associated processes through this and other related resources. That information has helped inform our response to this consultation.

3.3. It is our experience that whilst Round Table Meetings (RTM) and negotiations generally are used widely in clinical negligence litigation, other forms of ADR such as mediation are not. This largely remains the case despite the NHSR's recent incentive to promote mediation. This is also in the context that AvMA has received feedback from claimant lawyers where offers to mediate have not been taken up by defendants.

3.4. The NHSLA's mediation pilot (July 2014 - March 2016 focusing on elderly care and fatal claims) has been described by the NHSLA as 'successful'. However, this represents a real missed opportunity in that there appears to have been no published independent analysis of the pilot scheme in terms of a detailed analysis of the appropriateness of the outcomes achieved, the type of costs involved, a review of the feedback from participants including the benefits as well as potential drawbacks, which would evidence the basis on which the pilot was deemed successful and to highlight where changes might be needed. This could potentially have been persuasive in terms of sharing learning from the pilot as well as being able to demonstrate when and how mediation might benefit all parties in a clinical negligence dispute.

3.5. AvMA believes that mediation has the potential to offer benefits to patients and their families that goes beyond a simple financial settlement and which the legal process is not otherwise equipped to deliver. It does however also have the potential to cause further harm as well as adding to overall costs, if not utilised at the right time and if defendants do not have the appropriate authority or willingness to negotiate. This is why it is important that lessons are shared which evidence how and when mediation can be used to best effect in clinical negligence disputes.

## 4. Making ADR culturally normal

4.1. The answer to this question depends what you mean by ADR. It is culturally normal in clinical negligence litigation to try and resolve cases without recourse to litigation. The clinical negligence pre-action protocol encourages and expects this approach.

4.2. The use of RTMs is common place in clinical negligence work. However, we often hear reports of NHS Trust representatives attending RTMs without any or sufficient authority to settle cases. This approach undermines attempts at settlement and can make an RTM appear futile. In turn, this dilutes the potential power of the ADR process. AvMA has seen similar examples in the context of mediation which again undermines trust in the benefits of the process.

## *5.* Encouraging ADR at source and Low value cases/Litigants without means

5.1. ADR is a powerful tool but in our view it relies on three key aspects being present.

5.2. First that there is equality of arms in the process; this requires that the claimant has access to independent legal advice prior to deciding on mediation.

5.3. Without independent legal advice being made available, a claimant cannot possibly understand all of the options open to them. They are also potentially disadvantaged from knowing what the value of the claim is.

5.4. The second key issue is that ADR needs to be both seen to be fair and actually be fair in practice. Unrepresented claimants may attend an ADR process without access to key documents; for example, key witness statements, independent medical reports which may have been obtained by NHSR and so forth. There should be disclosure of documents between the parties, prior to any ADR being entered into. It is also the case that very few claimants would be in a position to challenge often highly complex arguments on causation when faced at mediation with professional advisors on the opposing side.

5.5. A third important issue is that the ADR process must be voluntary. Without parties being mutually willing to come to the table and resolve issues the ADR process risks becoming no more than another step in the litigation process.

5.6. Our views on the need for ADR to be voluntary do not sit comfortably with a cost sanction being imposed for not using the process. However, the reasons for not utilising ADR should be clearly set out in writing prior to proceedings being issued. The reasons should be factors taken into account by a costs judge at the conclusion of the case if there is an issue over the costs to be awarded.

5.7. The NHSR has identified that one of the key driver of costs is the expansion in the number of much smaller cases. However, the NHSR has not suggested that the increase in the number of lower value claims being made is down to spurious claims being made. It is worth noting that claimant solicitors will only be paid for cases where they have successfully proved the claim, it is not in their financial interests to bring claims that are lacking in merit.

5.8. If improvements were made to both the complaints and early investigation processes this would enable trusts to identify cases where negligence occurred at the earliest possible opportunity. NHS organisations and other healthcare providers need to ensure effective systems are in place that would ensure that where appropriate, cases are settled at this early stage. This would avoid the need for litigation and lessons could be learned as soon as possible to prevent a repetition of the incident.

5.9. If there is a genuine commitment to capturing incidences at the earliest opportunity, resolving claims as soon as possible, as well as being open, honest and transparent and making changes which will safeguard other patients, this will require a commitment to improving the complaints process and other investigations at this level. Improvements to these processes would be tantamount to a form of ADR in that they would not require litigation.

5.10. Some forms of ADR such as mediation are inherently expensive. There are additional difficulties with knowing when it is appropriate to mediate. Reducing the cost of those ADR process is crucial in making them fit for low value claims. We note this point was made by the CJC in their report.

## 6. Encouraging ADR when proceedings are in contemplation

6.1. We consider it important that parties are able to demonstrate that they have exhausted every option open to them before contemplating the issue of proceedings. This should not be limited to ADR.

6.2. More emphasis should be placed on how robust an NHS Trust's internal investigation processes are. For example, serious incident reports have been noted to be generally of a poor standard. If that is correct, where a SIR has been produced and is later shown to be inadequate then a penalty ought to be imposed for pushing the claimant into litigation.

6.3. A similar approach could and should be taken in relation to the complaints process.

6.4. It is possible to envisage a change to the litigation process that requires parties, following exchange of Letter of Claim and Response to mutually exchange preliminary medical expert evidence prior to the issue of proceedings. However, careful consideration has to be given to the status of those expert reports in the event that mutual exchange pre issue does not result in the matter being resolved.

## *7.* Challenges for online dispute resolution.

7.1. We are concerned about whether ODR can deliver justice in cases as complex as clinical negligence. A clinical negligence claim is only as robust as the medical evidence obtained. A robust and honest expert opinion requires the medical expert to be independent; able to review all relevant documentation and have time to consider the issues in the case. All of that relies on the expert being paid a market rate for their work.

7.2. There are additional complexities with clinical negligence, not least the cases where condition and prognosis reports are required. The often sensitive and personal nature of injuries arising as a result of clinical negligence claims means that these cases have to be dealt with sensitively. Claimants need to be seen by an expert for a condition and prognosis report – it is difficult to see how an ODR scheme for clinical negligence can deliver on these types of issues.

7.3. Furthermore the complex nature of these cases also demands that if these cases were to be dealt with by ODR, judges must be able to demonstrate experience on clinical negligence work.

7.4. Our concern is that whilst ODR is clearly appropriate for some forms of litigation, clinical negligence is not one of them. There is a very big risk that were ODR to be engaged as a means of resolving low value disputes it would not be able to achieve fair outcomes. This would be damaging to the reputation of litigation standards in the UK.

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