RESPONSE TO

THE MINISTRY OF JUSTICE

REVIEW OF CIVIL LITIGATION COSTS

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About AvMA

1. Action against Medical Accidents (AvMA) was originally established in 1982. It is the UK 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, and succeeded in bringing about major changes to the way that the legal system deals with clinical negligence cases and in moving patient safety higher up the agenda. The legal reforms of Lord Woolf in the clinical negligence field and the creation of agencies such as the National Patient Safety Agency and the Healthcare Commission have followed after years of campaigning by AvMA.

Introduction

2. The contribution that AvMA makes in responding to the consultation is confined to those areas within our knowledge and our remit of campaigning for patient safety and justice. Given AvMA's specific expertise in clinical negligence and healthcare law our response to this consultation relates only to costs in that area of special interest. Of prime concern to us is access to justice for our clients. In that we recognise that in order to find skilled representation our clients will have, in the main, to find solicitors who themselves have to run their practices as a business and survive in the commercial world. It is also one of our key principles that our clients should suffer no deductions from their damages as agreed or awarded by the court. The principal reason for our stance is that the majority of cases where we provide support involve serious disabling injury where the special damage claim for care, equipment and housing is a very large proportion of the damages. In our view therefore the damages should be applied for the benefit of the claimant in total without deduction. Further, where life expectancy is low, general damages are often required to make up the shortfall for capital purchases such as a house where the Roberts –v-

Johnson calculation results in a shortfall. Finally it is our concern that there should be a level playing field between our clients the claimants and defendants. Defendants often have easier access to experts and highly experienced counsel and solicitors who due to the purchasing power of the NHSLA are paid at rates lower than those applicable inter partes.

Clinical negligence as a specialty separate from Personal Injury

3. Clinical negligence is the only area of civil litigation where there are specialist practitioners, solicitors, barristers and judges. Good practice in this specialty is well developed with AvMA being in the forefront of ensuring this expertise by the maintenance of a specialist panel of solicitors as well as provision of resources for lawyers and a comprehensive programme of specialist training for solicitors, barristers and expert witnesses. The Legal Services Commission has also recognised the expertise of panel solicitors (both AvMA and Law Society Panels) in its franchising requirements and has recognised officially that this area of public funding is one of the most efficient. Clinical negligence litigation also differs from personal injury in the degree of complexity. While personal injury claims can be complex, in clinical negligence cases complexity is the rule rather than the exception. In clinical negligence the issues of liability and causation are almost always complex regardless of value with the need for a number of expert witnesses inevitably lead to higher costs.

Executive summary

4. AvMA recognises the need to review the system to try to reduce unnecessary costs in civil litigation whilst staying true to the principles of access to justice. We do not condone the claiming of costs which can not be justified, but it is clear to us that the vast majority of specialist clinical

negligence solicitors (those approved for the AvMA or the Law Society clinical negligence panels) can justify their costs.

5. We support the retention of public funding for clinical negligence claims together with the present merits test. Further it has long been AvMA's policy to call for a raising of the financial eligibility threshold. Such a rise in the threshold would benefit the group (so called MINELAS) currently ineligible for public funding but for whom private funding of litigation is unaffordable. This group is currently denied access to justice unless able to find representation by way of a CFA. AvMA suggests that including the lower income members of the MINELAS group would have the effect of reducing the numbers of clinical negligence claims brought under a CFA at a net saving to the public purse.

6. We recommend that consideration should be given to implementing the NHS Redress Act 2006 which makes provision for the settling of smaller clinical negligence claims against the NHS (those where the costs are more likely to be disproportionate to the damages) without recourse to litigation at all.

7. The principle of 'irreducible minimum' in relation to costs is well known in clinical negligence, regardless of the value of damages. As an organisation we are already seeing the effect of this principle where solicitors are reluctant to take some cases on for economic reasons. We do not believe that when comparing like for like that costs incurred by defendants are significantly lower than claimants' costs in similar cases. It is reported to us by our members that when recovering costs at detailed assessment, defendant's bills are broadly similar to claimants in the same cases.

8. We refer to our concerns about global settlements in more detail below but as well as our general concerns that they may put solicitors in conflict with their clients, have concerns as to how the costs/damages divide is reported in these cases by defendants.. We would like to see more clarity in the way details of costs are provided generally by the NHSLA.

9. While we see benefits for parties to litigation in having the certainty of knowing what the costs of their case are in advance, we do not see that a fixed costs regime such as currently operates in RTA cases would be fair in clinical negligence cases. Budgeting, provided there is wide discretion and flexibility, may be an option if all the eventualities than can occur in clinical negligence were taken into consideration. We note that in drafting High Cost Case Plans in publicly funded cases, solicitors in clinical negligence litigation have experience in budgeting.

10. We would support there being clearer guidelines on hourly rates if there were very strict safeguards following further consultation. Account should be taken of the complexity of cases and special skills of the solicitors and advocates. We support the continuing recovery of success fees on the basis that not to do so would be a bar on the access to justice. We support the recovery of ATE premiums but note that these would be reduced in the event that partial costs shifting were introduced for all clinical negligence and personal injury claims. We do not believe ATE premiums should be deducted from claimants' damages under any circumstances

11. Based on our understanding of the way in which partial cost shifting is expected to work, we anticipate the main effect of partial costs shifting from a claimants point of view would be lower ATE premiums. However, for many claimants in clinical negligence claims there would be no change as they are legally aided. We also note that such a change in the present

position of ‘the costs following the event’ would be a net benefit to the public purse resulting as it would in a net reduction in costs paid out.

12. We see no benefit to claimants in solicitors being able to pay referral fees or buying cases from before the events insurers. We do not support the buying and selling of people’s cases.

13. The Pre Action Protocol for Clinical Negligence Claims is essential to the process of investigating and bringing clinical negligence proceedings. Discovery is of the utmost importance in the investigation of a clinical negligence claim. However, we note that there is a significant variation in practice of adhering to the protocol and its time table.

14. We are cautious about endorsing the introduction of software similar in nature to that used in some personal injury cases into clinical negligence. While we believe it may be a useful tool in lower value claims we do not see how it can operate to achieve a fair and just settlement in more complex claims.

15. We welcome the suggestion of alternative funding schemes (such as CLAF or SLAS) if they will improve the access to justice for those who currently cannot obtain or afford legal representation. We would be willing to be involved in further work on this subject.

16. When addressing the Birmingham seminar on 26 June 2009, Sir Rupert Jackson posed a number of questions. We have used those questions that relate to our objectives and our work with claimants and our solicitor members as headings in our response.

The reasons why claimant costs exceed damages in such a large proportion of personal injury cases.

17. In considering this question we refer to base costs. Percentage uplift and other charges that increase costs we will address separately below. The comments we make on the issues surrounding complexity and its effect on time spent on cases apply equally to disbursements as to solicitors' and counsels' fees.

18. There is a certain irreducible minimum level of work that must be done in each clinical negligence case. In almost every case, liability and causation require at least two experts, sometimes more, due to the complexity of the injury. Further the act that, that an individual who brings a claim in clinical negligence may also have had a pre-existing condition, ensures investigation of causation is rarely straightforward. It follows therefore that in clinical negligence claims the time spent and the hourly rates (see our comments below regarding hourly rates) will be higher.

19. Solicitors in clinical negligence claims act for particularly vulnerable clients. Often the injury itself presents difficulties and the solicitor may take instructions from a Litigation Friend, while always keeping the claimant as closely informed and included as the injury permits. This may often require more face to face meetings and travel to the claimant's home. The time spent in order to deliver appropriate client care can be greatly increased.

20. The pressure of claimant firms not to take on cases where damages may be less than costs is already apparent to us. The LSC funding criteria already operates to deny funding to claims where the value of the damages is less than £10,000 or where the case does not meet the cost benefit criteria. We are increasingly finding that our panel members are

unable to take Fast Track claims on, not for reasons of capacity but because they cannot run these claims on an economic basis. Some claimants may then find representation from firms who will take on the case on a CFA (with solicitors of whose work we know nothing about) but our concern is that a fair proportion of the claimants do not find representation and are denied access to justice

21. AvMA regrets that the NHS Redress Act 2006 has not yet been enacted through the necessary secondary legislation. It was envisaged that such a scheme would enable lower value claims to be run more economically and avoid the situation where costs exceed damages. We acknowledge the Department of Health's aims to embed 'apologies and explanations, a spirit of openness, a culture of learning from mistakes and robust investigation—rather than focusing on financial redress only for those cases' (Lord Darzi written answers and statements, House of Lords 18.03.09). However, until Redress is implemented or some alternative funding scheme is found for these lower value claims it remains the concern of this organisation that claimants will be denied access to justice on economic grounds

22. When the NHSLA criticises claimant's costs by comparison to theirs they do not compare like with like. The NHSLA is able by its sheer size and the volume of work it places with its panel solicitors and counsel, also with experts, to negotiate levels of fees unavailable to individual claimants. However when in the event the NHSLA successfully defends a claim and presents a bill for detailed assessment, it has been reported to us by our members that their fees are very nearly the same as the claimants when compared on a case by case basis. The fees charged by defendant solicitors and counsel to the NHSLA in the event the case is lost are thus considerably less that their inter partes rate. The analogy may perhaps be

made between the fees chargeable to the Legal Services Commission by claimant solicitors in the event the case is lost.

23. Although the evidence we receive from our members indicates in cases that proceed to trial that costs of both sides at inter partes rates are similar, in the early stages it is likely the claimant will incur higher costs simply because the process is not fought on a level playing field. Claimants' solicitors will need to consider a large volume of medical records. Often discovery takes longer than it should with repeated requests for further records and better copies while the defendant is of course in possession of the originals. The defendant is also able to come to a preliminary view on its defence by discussions with its own clinicians while the claimant will have to instruct a number of expert witnesses from the outset. When experts are instructed the defendant has access to a wider pool at lower rates.

24. We are also unsure how the NHSLA record costs when cases are settled on a global basis. As an organisation we are concerned generally where a defendant offers a single sum to cover all claims for general and special damage and costs. Our view is that this can lead to a conflict of interest between the solicitor and client as it blurs the edges between what are the client's damages and what are costs. In the matter of costs, however, it seems to us that when the NHSLA decides how the costs and damages are apportioned for accounting purposes there is an opportunity to weight the proportion allocated to costs. We would welcome details of costs from the NHSLA with a break down to distinguish costs recovered at inter-partes rates from own client costs billed in the event a case is not successfully defended, also how costs are apportioned when cases are settled on a global basis

25. There is much talk about a growing compensation culture and concerns that without a claimant having an interest in costs the number of claims where costs exceed damages will increase. The figures relating to medical accidents and claims issued do not bear this out. Approximately 850,000 medical accidents are reported in secondary care every year, the lapses in patient safety lead to a significant number of deaths. Despite the number of potential claims the number of Legal Aid certificates has fallen in ten years from a high of 18,000 to 3.500 in the latest figures, although there will have been an increased number of claims financed by CFAs, the number of claims notified to the NHSLA remains constant at 6,000. The notifications include where a solicitor makes a request for notes (in some cases) or simply notifies a trust of a possible claim yet does not proceed

26. Although there is no discussion in the Preliminary report of increasing access to public finding it is made clear in the report that in personal injury (as opposed to clinical negligence), the removal of public funding and its replacement almost entirely with CFAs has led to a substantial increase in costs. We would suggest that increased access to public funding for clinical negligence cases, by raising the level of financial eligibility (though not abolishing the means test entirely), would reduce the number of claims funded by conditional fee agreements. We note that it is particularly unfair that the value of the equity an applicant holds in his or her home is taken into consideration, making almost every home owner (however modest the house) ineligible. We make no suggestions in relation to the merits test for public funding save to note we support its retention in some form as a means of preventing the pursuit of unmeritorious claims and a further drain on the public purse.

The feasibility of fixing costs on the Fast Track (a) for personal injury cases and (b) for non-personal injury cases: see Preliminary Report chapter 22.

27. Our overarching concern in any attempt to regulate costs by a fixed costs regime is that the one size fits all model is not appropriate in clinical negligence cases. The facts of the case, the level of vulnerability of the claimant, the number of experts involved and the areas of medical speciality would make it impossible properly to investigate and pursue a claim in clinical negligence.

28. It is said in the May 2009 Review of Civil costs: Preliminary Report that since the advent of CFAs claimants in PI cases have come to expect 100% recovery of their damages and that it is in some sense a bad thing that a claimant has no interest in the level of costs if they know they will never pay them. 100% recovery of damages is not universally the situation in clinical negligence claims. Although it is firmly AvMA's policy that there should be no deduction from a claimant's damages, solicitors' terms and conditions of engagement and the costs rules permit it and the LSC Statutory Charge in some circumstances requires it, when costs and or disbursements are not recovered in full from a defendant.

29. In accepting that costs may be deducted from damages we see it as a benefit to claimants in knowing with certainty what costs will be in advance. The preliminary report refers to budgeting as being a possible alternative to a fixed fee regime. Our concerns would be similar to a fixed cost regime but we could see that provided the budget was set by experienced judges at the CMC on an individual case by case basis, the addition of certainty may be of advantage to a claimant. A matrix of the type reproduced at page 205 of the Preliminary Report would need to allow for the considerable complexity of clinical negligence claims and

allow for flexibility. It is not always the case that clinical negligence cases proceeding in the fast track will have different or simpler costs regimes than those in the multi-track, due to the multiple issues referred to above. We also have a concern that any attempt to fix fees at a certain level would deter the most able and experienced experts and counsel acting for claimants. Our members have already experienced problems with legally aided cases where maximum hourly rates for experts apply. Our members report experts unable to accept instructions where the rates are uneconomical in circumstances such as where medical experts' fees include the costs of providing for locum cover and support staff.

30. We would continue to emphasise that costs must be of a sufficient level to enable solicitors to run their businesses economically and make reasonable profits otherwise the work will cease to be done by many firms. Solicitors who work in the area of clinical negligence are highly committed to the work and their clients. Some firms concentrate almost entirely on clinical negligence litigation but there are also many smaller firms with mixed practices. It is in these smaller firms where, despite their commitment to providing access to justice for patients, they have to take an economic view. Many ceased to do RTA work because of the fixed costs regime. The loss of those firms who decide it is no longer financially viable to take on clinical negligence work would restrict access to justice for many claimants all over the country.

The criteria upon which hourly rates should be set for multi-track cases.

31. Since its inception, AvMA has promoted the idea that solicitors who act in clinical negligence claims should be highly specialised. In pursuance of that aim we administer one of the two panel schemes (the other by the Law Society). Solicitors admitted to our panel have not only considerable

experience and expertise in acting for claimants with clinical negligence claims but also their firms as a whole have an appropriate level of resources. We consider that our role in administering and monitoring our panel together with providing specialist education for our panel members and other solicitors and counsel who specialise in this area has made a major contribution to the improvement in clinical negligence litigation and in access to justice for claimants in medical negligence claims. We also acknowledge the role the Legal Services Commission has played in this in their early work in franchising such that only departments where there are panel members and can demonstrate the requisite level of service for clients are awarded a franchise and are able to act for claimants who have legal aid funding.

32. This level of commitment to clients requires a large investment on the part of specialised firms and comes at a cost. As businesses, solicitors firms must charge a level of fees that make their businesses viable. The fees charged reflect the service provided.

33. It has been long accepted that in clinical negligence claims the hourly rates published by the court service are not applicable. As hourly rates of double or even four times the applicable local rate have been accepted at detailed assessment, the published rates cannot even be accepted as a guide in complex cases.

34. The rates recovered and reported to us are based on a complex matrix of level of experience of fee earner and complexity of the issues of the individual case. These rates are usually (though not necessarily correctly) challenged by the NHSLA on the basis of local court rates, that the level of fee earner is not required for the case and that the case issues are not as complex as claimed.

35. As in the overall level of costs we believe our clients best interests are served by certainty. While the clients are given detailed information on costs at the outset of the case and at regular intervals, the agreement between the client and solicitor may not make clear the ability to recover those costs in the event there is a shortfall. This could place clients at a disadvantage.

36. If there were a mechanism whereby the different issues of the case as described above could be taken into consideration when setting hourly rates, and guidelines provided, we would support this. However, this is provided that solicitors can always still take cases at an economic basis to preserve our clients rights to access to justice. We would welcome further discussion on this subject.

Whether success fees and ATE premiums should continue to be recoverable.

37. Our support for the continued recoverability of success fees and ATE premiums stems from our policy that claimants in clinical negligence claims should not suffer a deduction from their damages (even general damages for the reasons set out above).

38. If success fees were not recoverable from defendants and there was a reversion to Style 1 CFAs, our members tell us that they would not continue to act for as many claimants under such a regime.

39. We believe that the level of success fee should continue to reflect the basket of cases the solicitor takes on i.e. the overall risk to the firm. Although this is not often an argument taken to detailed assessment it should still affect the solicitors' practice. However we recognise the difficulties in making this assessment..

40. The present level of ATE premiums and the way they add to costs are of concern to our organisation. Our view that ATE premiums should still be recoverable is based on our comments on costs shifting below

If success fees and ATE premiums cease to be recoverable, what steps should be taken to promote access to justice, for example one way cost shifting.

41. AvMA supports the idea of one way costs shifting which has long been a familiar mechanism in clinical negligence where cases are funded by legal aid. AvMA does not support an unnecessary burden on the public purse of recoverability of large ATE premiums if another costs mechanism could apply. AvMA notes the comments made in chapter 25 at paragraph 1.2 of the Preliminary Report. Such a change in the costs regime would mean claimants may only have to insure against the costs of their own disbursements, provided counsel and solicitors act on a CFA and ATE premiums considerably reduced. Subject to this we support recovery of ATE premiums as stated above.

42. We regret the growth of referral fees, both those paid to organisations that solicit claims from direct advertising to the public and the payment made for a basket of cases to BTE insurers by solicitors firms. Although not directly recoverable from defendants at detailed assessment such charges must inevitably be passed on as part of solicitors' overheads. Such fees can be of no direct benefit to claimants. We would support the abolition of referral fees.

Whether any reforms are required (a) to the terms of the Personal Injury Pre-action Protocol or (b) to secure enforcement of that Protocol.

43. Our members report considerable variation in compliance with the pre-action protocol for clinical negligence claims. Problems are reported with incomplete disclosure. Disclosure is of the utmost importance to the proper investigation of a clinical negligence claim. The process can take many weeks with defendants providing incomplete disclosure. There is poor photocopying, missing documents and outright refusal when untoward incident documentation is requested. Further delays are experienced in responding to the Letter of Claim. Frequently claimant solicitors are contacted by defendant solicitors to say that they have only just been instructed, three months after the date of the letter of claim. This is despite the trust having acknowledged receipt of the letter of claim within the time scale set by the protocol. Letters of response are then further delayed with it not uncommon for defendants to request extensions of 3 – 6 months and sometimes even then the response arriving in two halves, one on liability to be followed, sometimes several weeks or months later by a response on causation.

44. This not only delays progress and increases costs but has an effect on the solicitor client relationship where the client sees their solicitor apparently unable to proceed with their claim. Issuing proceedings before receipt of a full response from the defendants is usually not an option. It is not a case of a defendant refusing to respond, but delaying, thus when the response eventually comes the specific denials or admissions in relation to the allegations will have a bearing on the particulars of claim. To issue early will only result in more costs involved in amendments to the statements of case.

Do the software systems currently used by insurers for assessing general damages lead to under-settlement of personal injury claims? Could a judicially approved software system for assessing general damages be developed, which would (a) reduce the risk of under-settlement and (b) reduce costs?

45. We can see the benefit for certain claimants, particularly when the claims are of low value of having such software. This is provided their solicitors have access to the programme itself and not just extracts provided by defendants as can apply in personal injury at present. Further, that it is possible to have a programme specifically addressing damages in clinical negligence claims from an independent standpoint, from sources similar to those available to the Judicial Studies Board in compiling their annual guidance on damages. However, we do not see it will be a particularly useful tool in complex clinical negligence cases where a large element of the claim relates to permanent disability and thus a large proportion of damages will be special damage that has to be assessed on a bespoke basis. We do see the value of such a system in small claims track and the lower value fast track claims.

46. CLAF and SLAS

47. This organisation has long had a concern for claimants who have claims that are considered by commercial firms to be uneconomic to run. Even our panel member firms who will go to considerable efforts to take on cases we refer to them are not always able to act. These claims are of great importance to claimants and often arise out of the death of a close relative or child. In other cases the conduct of health professionals is particularly blameworthy yet though likely to be found liable, the damages are modest. These cases are often strongly illustrative of the irreducible minimum principle we refer to in paragraph 1 above.

48. It is self evident that if these cases cannot be run economically as CFAs by solicitors in private practice then the claims will not qualify for LSC funding on their costs /benefit criteria (often also not passing the qualifying means test either). While some cases may be run if a client has Before the Event Insurance, the rest of these claimants are likely to be without representation.

49. If a self funding scheme such as CLAF or SLAS were introduced we would support it, provided it were modified to exclude contributions from damages. We would envisage a scheme which operated to provide access to justice in modest value claims. The test for entry to the scheme being similar to LSC funding but with a relaxed costs benefit regime and no means testing. We suggest that there would be firm agreement on the costs regime from the outset to keep costs more proportionate, with partial costs shifting and a success fee to replace the percentage of damages donation back to the fund to maintain self funding

50. We agree there would need to be a pilot and note that there would be difficulties with piloting in private practice only. We suggest that it may still be possible for such a pilot to be administered by a not for profit organisation but also with selected private firms invited to participate so to enable the proper evaluation of the financial viability of such a scheme. As an organisation we would be willing to participate in further discussions.

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