Ministry of JUSTICE

Solving disputes in the county courts: creating a simpler, quicker and more proportionate system

Questionnaire

We welcome responses to the following questions set out in the consultation paper. We would be grateful if you would consider, in the first instance, responding via the on-line questionnaire at: http://survey.euro.confirmit.com/wix/p625833348.aspx

However, if you prefer, you can return this questionnaire by email to civiltj@justice.gsi.gov.uk or in hard copy to Judith Evers, Ministry of Justice, Post point 4.12, 102 Petty France, London, SW1H 9AJ.

Please send your response by 12:00 noon on 30 June 2011.

About you

Full name	Action against Medical Accidents

Job title (or capacity in which you are responding to this consultation exercise)

- ☐ Academic
- ☒ Advice sector/Debt Adviser
- ☐ Bank/Financial Institution
- ☐ Business/Commercial
- ☐ Claims Management Company
- ☒ Consumer Representative Organisation
- ☐ Government Department/Non-Departmental Public Body
- ☐ Insurer
- ☐ Judiciary
- ☐ Legal Profession
- ☐ Local Authority
- ☐ Mediator/Mediation service provider
- ☐ Member of public
- ☐ Other – please specify

Company name/organisation (if applicable)	Action against Medical Accidents
Address	44 High Street Croydon Surrey
Postcode	CR0 1YB
Date	29.6.11

☒ If you would like us to acknowledge receipt of your response please tick this box (emailed responses will be acknowledged automatically).

Address to which this acknowledgement should be sent, if different from above	legaldirector@avma.org.uk

Section 2 – Preventing cost escalation

Question 1: Do you agree that the current RTA PI Scheme's financial limit of £10,000 should be extended?

☐ Yes ☒ No

Please give reasons.

Having considered in broad terms the RTA PI scheme and how it may work if applied to clinical negligence claims it is our postion that the limits should not be raised above £10,000 for the reasons set out below.

If as the proposals state, the limits were to apply to all other personal injury claims including clinical negligence we would oppose raising the financial limit beyond £10,000.

The complexity of a case does not necessarily bear a relation to value. Many claimants will be denied access to justice if the value of the present scheme is raised, as the procedure and the costs regime would not permit adequate investigation of more complex issues and sufficient provision of independent advice.

If as the proposals state, the limits were to apply to all other personal injury claims including clinical negligence we would oppose raising the financial limit beyond £10,000. Further, beyond £10,000 the value of the claim is no indication of complexity. Many fatal claims, currently just outside the scope of the present scheme, even if confined to berevement damages only, are highly complex. Further £25,000 may represent an year or more's net income for those on the minimum wage or a gratuitous care claim - either will require investigating, documents in support and independent advice.

Question 2: If your answer to Question 1 is yes, should the limit be extended to:

(i) £25,000 ☐ Yes ☐ No

(ii) £50,000 or ☐ Yes ☐ No

(iii) some other figure (please state with reasons)? ☐ Yes ☐ No

Please give reasons.

A high proportion of damages awarded in clinical negligence claims falls between £10,000 and £25,000, an equally high proportion, under £50,000. The value of these claims does not directly equate with the ability to run the claim using proformas, fixed processes and at fixed costs. Raising the limit to £25,000 will bring under the scheme all Fatal Accident Act ("FAA"), cases where there was a party entitled to Bereavement damages, but who had no financial or services dependency on the Deceased. FAA cases differ greatly one from another and can not be litigated in one way.

In the majority of RTA claims, the evidential requirement is for a police report, the proofing of witnesses, a review of the claimant's loss of earnings position and care requirements, and the need for usually one but sometimes 2 medical experts to comment on condition and prognosis, and causative issues relating to the extent of the injury that relates to the negligence. Medical Records pertaining to the accident period can be obtained by the expert directly and it is common practice amongst lawyers not to review the medical records themselves but to rely on the expert review.

In the "average" clinical negligence claim, there will be a requirement to collect in all medical records relating to life time treatment; by its nature a clinical negligence claim arises out of treatment of someone who is already ill. Previous medical history is highly relevant and must be reviewed. Once obtained the records must be reviewed and sorted with a chronology; then the lawyer is in a position to analyse the potential breach and causation issues and instruct an expert. The value of the claim is not a reliable indicator of the number of experts required to advise. It is safe to assume that over 50% of cases that would settle for under £25,000 will require at least 2 experts to report one on breach and one on causation, for example, where the breach arrises in A&E and the injury is treated in another department such as cardiolody, nephrology or orthopaedics. Only evidence offered by experts practising in the relevant discipline is accepted by the courts. Otherwise any general doctor could offer a general opinion. Clinicians do not work in isolation from other disciplines; medicine is highly specialist as a profession and if you are suing a medical institution or clinician for professional failures then you have to step into their discipline and approach obtaining the evidence in the same way as they practice, clinical negligence cases are professional negligence claims quite distinct from personal injury.

The problems outlined above will arise in all claims regardless of value.

Rather than raise the threshold above £10,000 we would argue that further refinement to the Pre action protocol and enforcement of streamlined disclosure procedures (the NHS is a particular problem and currently disclosure of records is not managed by the NHSLA, but by each individual trust) would reduce costs and ensure access to justice and equality of arms. It must be remembered that whilst the claimant in a medical negligence case has to find the documentation and get its own expert evidence the defendant has the records and the requisite expertise in house and readily available. They are starting from a position of knowledge which the claimant, in 99.9% of cases, will not have. Those cases should not be litigated on a fixed fee basis and within a RTA portal scheme as the lack of flexibility will cause immense hardship to claimant, and defendants, who may not be able to properly defend cases. It will increase the number of applications for exceptions to the experts instructed and increase costs.

Such restrictions would be unjust and put the injured patient at a disadvantage given such inequality of arms where the Defendants have access to resources, evidence and the expertise significantly greater to that the Claimant has access to. Fixed costs would limit what steps could be taken to obtain evidence, and pursue the claimant's case.

Very importantly there is another aspect to clinical negligence cases that we would argue cannot be quantified, but that will be lost through adoption of a portal system, and that is the risk management and patient safety aspect of these claims. By streamlining them you will lose the ability to investigate the cases properly in the Trusts, and in private healthcare settings. Such a scheme (except with considerable refinement) does not provide for apologies, provision of Serious Untoward Incident reports to the family, or allow for a declaration that these incidents of negligence will be used to learn lessons for the future.

We are gravely concerned that the scheme would remove at least 3000 cases a year (NHSLA figures) from the number of patient errors that are scrutinised publically, with the Trusts being held to account for their

actions. Instead Trusts may be able to report them internally but do nothing to learn from the experience. Clinical negligence litigation does not serve solely to compensate the injured for the unnecessary injuries they have suffered, but also serves to improve patient safety for everyone's benefit.

At a recent AvMA conference a specialist neonatologist, an NHS consultant and expert witness of many years standing, quoted clinical negligence claims as a direct cause of improvements in monitoring during labour. He stated that improvements in midwifery training, in the interpretation of CTGs (the electronic monitoring of a woman's contractions and her baby's heart rate in labour) was as a direct result of litigation on behalf of children with cerebral palsy where the brain injury was caused by midwives failing to detect oxygen deprivation during labour.

Question 3: Do you consider that the fixed costs regime under the current RTA PI Scheme should remain the same if the limit was raised to £25,000, £50,000 or some other figure?

☐ Yes ☒ No

Please give reasons.

Our response is in respect of clinical negligence claims only and made on the basis that we believe the scheme should not apply to claims over £10,000.

Further that, if the current RTA PI Scheme were to be extended to clinical negligence the fixed costs regime that presently applies should be examined in the light of the work required to resolve a clinical negligence claim.

In personal injury claims only one medical expert's report is often all that is required. There is rarely a dispute over what injury was caused by the admitted negligent act and the issues to be decided generally confined to extent and longevity of the injury or disability. In clinical negligence, assuming that a claim would remain in the scheme if liability is admitted, there would be a need for at least two further medical reports, one on causation and one on condition and prognosis. See our response to Q2 above.

Question 4: If your answer to Question 3 is no, should there be a different tariff of costs dependent on the value of the claim? Please explain how this should operate.

☒ Yes ☐ No

The tariff of costs should reflect complexity as well as value. Complexity in clinical negligence claims is not always reflected by the value of the damages.

We believed those already disadvantaged by disability or poverty will be disproportionately affected, the mentally ill, the long term disabled and the elderly, and children. Already meritous claims are not brough on their behalf because the likely level of damages that can be recovered are disproportionate to the cost of pursuing the case. If a

We therefore believe that if fixed costs are to be implemented and if this scheme is to apply to clinical negligence claims, detailed discussions must be held as to how such a fixed costs regime may be implented in relation to complexity. We believe that key stakeholders,including AvMA, the only independent organisation that represents the interests of claimants in clinical negligence claims and solicitors who represent both claimants and defendants, should discuss and identify a framework on which such a regime can be built.

It should also be acknowledged that proportionality already operates in the assessment of costs. The proposals to fix and reduce costs in clinical negligence claims is always based on a premis that costs are out of controll. This is not universally so. Clinical negligence claims are highly complex. If liability AND causation is not admitted at an early stage both must be investigated fully, regardless of the value of the claim, before a letter of claim can be sent. Not withstanding the need to investigate, and often the defendant continuing to defend a case with no sensible offer to settle until just before trial, the principle of proportionality does prevail when either settling costs by negotiation or at detailed assessment.

Question 5: What modifications, if any, do you consider would be necessary for the scheme to accommodate RTA PI claims valued up to £25,000, £50,000 or some other figure?

Please give reasons.

We do not believe clinical negligence claims of this value should be subject to a scheme similar to the current RTA PI Scheme. But should clinical negligence claims be subject to a scheme similar to the current RTA PI Scheme we strongly oppose it applying to claims valued over £10,000. If necessary clinical negligence claims should be subject to a separate lower limit to that of the rest of personal injury.

Question 6: Do you agree that a variation of the RTA PI Scheme should be introduced for employers' & public liability personal injury claims?

☐ Yes ☐ No

Please give reasons.

Not applicable.

Question 7: If your answer to Question 6 is yes, should the limit for that scheme be set at:

(i) £10,000	☐ Yes	☒ No
(ii) £25,000	☐ Yes	☒ No
(iv) £50,000	☐ Yes	☒ No
(v) some other figure (please state with reasons)?	☐ Yes	☒ No

Please give reasons.

See answers above

Question 8: What modifications, if any, do you consider would be necessary for the scheme to accommodate employers' and public liability claims?

Please give reasons.

Not applicable.

Question 9: Do you agree that a variation of the RTA PI scheme should be introduced for lower value clinical negligence claims?

☐ Yes ☒ No

Please give reasons.

We do not believe that a variation of the current RTA PI Scheme should be introduced for lower value clinical negligence claims as the scheme presently stands. However, if there were to be a decision to introduce a limit of £10,000, then we believe that there should be detailed discussions held between patients' and lawyers' representatives (both claimant and defendant) in order to work out a suitable protocol in which such a scheme can operate distinct from Road Traffic Accident Act claims. There must also be provision for the claimant to drop out of the scheme with no financial or limitation penalties if it emerges the claim is worth over £10,000.

Such a scheme should ensure that claimants have access to specialist independent advice prior to joining. Safeguards should be in place for litigants in person.

If a claimant is legally represented then the solicitor should be an AvMA or Law society specialist panel member

If medical experts are required they should be taken from a specialist list (AvMA can assist with this)

Information on claims should be recorded and coordinated with other NHS data on clinical incidents in order that lessons are learned

We understand that the NHSLA has approached APIL with a voluntary scheme devised by the NHSLA for the litigation of what it deems as low value clinical negligence claims (under £25,000 in value) but we wish to emphasize that we as the only organisation that represents claimant patients' interests in clinical negligence claims have not yet been consulted. To our knowledge the only organisation that has been consulted is APIL which represents solicitors who act for claimants in personal injury litigation.

We therefore emphasize how vital it is that, in the words of paragraph 2 herewith, consultation takes place with all clinical negligence stakeholders across England & Wales and not simply one organisation. Not only has AvMA not been consulted but we were initially refused a copy of the document that is being discussed.

Question 10: If your answer to Question 9 is yes, should the limit for the new scheme be set at:

(i) £10,000	☒ Yes	☐ No
(ii) £25,000	☐ Yes	☒ No
(iii) £50,000 or	☐ Yes	☒ No
(iv) some other figure (please state with reasons)?	☐ Yes	☒ No

Please give reasons.

Without considerably more detail and discussion with all relevant stakeholders we do not agree that such a scheme should be introduced at all. But if a change to the current limit is imposed the scheme for clinical negligence claims should be limited to those worth no more than £10,000. However we retierate that we do not consider a change needed see answer to 2 above..

Question 11: What modifications, if any, do you consider would be necessary for the scheme to accommodate clinical negligence claims?

Please give reasons.

Any scheme designed to settle clinical negligence claims must take into consideration the very large volume of documentation required from the outset. Further, while an admission of liability is currently a prerequisite of the RTA PI Scheme this will not be sufficient to guarantee progress towards a settlement of a clinical negligence claim. In order to establish causation (unless that is also unequivocally admitted) it will be necessary to obtain independent medical evidence. In addition a condition and prognosis report from a separate specialty will be required.

Because of the huge difference between personal injury RTA claims and clinical negligence claims we regard it as essential that all stakeholders are not only consulted but also involved in the decision making process on how such a scheme could be adapted for use in clinical negligence claims.

Question 12: Do you agree that a system of fixed recoverable costs should be implemented, similar to that proposed by Lord Justice Jackson in his Review of Civil Litigation Costs: Final Report for all Fast Track personal injury claims that are not covered by any extension of the RTA PI process?

☐ Yes ☐ No

Please give reasons.

Clinical negligence claims are not amenable to process driven dispute resolution with set stages where the time and costs involved are easily estimated.

We believe that a framework might be possible subject to detailed consultation and discussions with all stakeholders but very often the complexity of the claimant's medical condition and the huge amount of differences between the types of claims that are made will make anything but the most flexible of systems unworkable. We also remind the government that detailed analysis of the schemes was undertaken by the pre-action clinical disputes forum and that served very well to introduce procedures to improve litigation. It addressed the behaviour of defendants and claimants, and their legal advisors, which we argue is the appropriate way to manage clinical negligence claims.

In Wales a procedure has recently been introduced for lower value claims (Speedy Resolution) any system of fixed recoverable costs should be compatible with those agreed in Wales, with agreed stages and hourly rates

Question 13: Do you consider that a system of fixed recoverable costs could be applied to other Fast Track claims? If not, please explain why.

☐ Yes ☐ No

Please give reasons.

Not applicable.

Question 14: If your answer to Question 13 is yes, to which other claims should the system apply and why?

Please give reasons.

Not applicable.

Question 15: Do you agree that for all other Fast Track claims there should be a limit to the pre-trial costs that may be recovered?

☐ Yes ☐ No

Please give reasons.

Not applicable

Question 16: Do you agree that mandatory pre-action directions should be developed? If not, please explain why.

☒ Yes ☐ No

Please give reasons.

We recommend that the Pre Action Protocol for Clinical Negligence Claims should be the guide in setting such directions. We would welcome a more rigorous set of directions with costs penalties to encourage defendants to consider the issues early and promote early admissions in place of the present practice of general denials and late admissions In personal injury the pre action protocol is shorter and appears simpler than in clinical negligence. It also assumes that letters of claim are sent and all cases are capable of resolution before expert evidence is obtained (if it is required at all) which is not at all possible in clinical negligence. The newly revised protocol for clinical negligence claims recognises the need for obtaining expert evidence by both claimant and defendant as a crucial part of an initial investigation.

Question 17: If your answer to Question 16 is yes, should mandatory pre-action directions apply to all claims with a value up to:

(i) £100,000 or ☐ Yes ☒ No

(ii) some other figure (please state with reasons)? ☒ Yes ☐ No

Please give reasons.

While we would welcome a greater emphasis on compliance with the Pre-Action Protocol for Clinical Negligence claims with costs penalties for failure to comply we do not support mandatory directions. We would make an exception if a scheme for clinical negligence claims were implemented similar to the present PI RTA scheme for claims of £10,000 and below. In that case we would support a streamlined mandatory pre-action directions for those claims that left the scheme and where proceedings were anticipated, these directions should be based on a simplified form of the PAP.

Question 18: Do you agree that mandatory pre-action directions should include a compulsory settlement stage? If not, please explain why.

☐ Yes ☒ No

Please give reasons.

There is already a provision for parties in clinical negligence claims to consider ADR. Making this mandatory when there are no prospects of the parties coming to an agreement will only increase costs.

Question 19: If your answer to Question 18 is yes, should a prescribed ADR process be specified? If so, what should that be?

☐ Yes ☐ No

Please specify and give reasons.

Not applicable.

Question 20: Do you consider that there should be a system of fixed recoverable costs for different stages of the dispute resolution regime? If not, please explain why.

☐ Yes ☒ No

Please give reasons.

In clinical negligence claims any such system should be compatible with Speedy Resolution in Wales (see answer to Q12 above).

Question 21: Do you consider that fixed recoverable costs should be:

(i) for different types of dispute or ☒ Yes ☐ No

(ii) based on the monetary value of the claim? ☐ Yes ☒ No

If not, how should this operate?

Please specify and give reasons.

See above answers to Qs 4 and 12 .

Question 22: Do you agree that the behaviours detailed in the Pre-Action Protocol for Rent Arrears and the Mortgage Pre-Action Protocol could be made mandatory? If not, please explain why.

☐ Yes ☐ No

Please give reasons.

Not applicable.

Question 23: If your answer to Question 22 is yes, should there be different procedures depending on the type of case? Please explain how this should operate.

☐ Yes ☐ No

Please give reasons.

Not applicable.

Question 24: What do you consider should be done to encourage more businesses, the legal profession and other organisations in particular to increase their use of electronic channels to issue claims?

Please give reasons.

A question for the users of electronic channels.

Question 25: Do you agree that the small claims financial threshold of £5,000 should be increased? If not, please explain why.

☐ Yes ☒ No

Please give reasons.

It is a misconception either that in lower value claims the issues are correspondingly simple or even that such sums are low value. Raising the limits will prevent some of the most vulnerable members of society obtaining access to justice. While the small claims limit was set to encourage litigants to act in person and not instruct lawyers there is already inequality of arms where large organisations instruct lawyers regardless of the value of the claim whereas the individual cannot afford to do so.

Question 26: If your answer to Question 25 is yes, do you agree that the threshold should be increased to:

(i) £15,000 or ☐ Yes ☐ No

(ii) some other figure (please state with reasons)? ☐ Yes ☐ No

Please give reasons.

Not applicable.

Question 27: Do you agree that the small claims financial threshold for housing disrepair should remain at the current limit of £1,000?

☐ Yes ☐ No

Please give reasons.

Not applicable.

Question 28: If your answer to Question 27 is no, what should the new threshold be?

Please give your reasons.

Not applicable.

Question 29: Do you agree that the fast track financial threshold of £25,000 should be increased? If not, please explain why.

☐ Yes ☐ No

Please give reasons.

Not applicable (the limit in clinical negligence is £50,000)

Question 30: If your answer to Question 29 is yes, what should the new threshold be?

Please give your reasons.

N/A

Section 3 – Alternative dispute resolution

Question 31: Do you consider that the CMC's accreditation scheme for mediation providers is sufficient?

☐ Yes ☒ No

Please give reasons.

It is vitally important that mediators in clinical negligence claims are experienced in the subject. Clinical negligence claims involve a large amount of scientific and technical medical information. While it is vitally important that all mediators are properly qualified in the practise of mediation, with regards to clinical negligence they should also be experienced in resovling clinical disputes.

Question 32: If your answer to Question 31 is no, what more should be done to regulate civil and commercial mediators?

Please give reasons.

There should be a specific mediation service for clinical negligence claims. Such people should be properly accredited mediators (from CEDR or a similar professional organisation) who possess additional training in mediating medical claims

Question 33: Do you agree with the proposal to introduce automatic referral to mediation in small claims cases?

☒ Yes ☐ No

Please give reasons.

It is unlikely that there will be many clinical negligence claims brought under the small claims procedure. But if there are any, as they should involve a very slight injury and very little items of special damage they should be capable of settlement by mediation which could be compulsory on the grounds of proportionality

Question 34: If the small claims financial threshold is raised (see Question 25), do you consider that automatic referral to mediation should apply to all cases up to:

(i) £15,000 ☐ Yes ☐ No

(ii) the old threshold of £5,000 or ☐ Yes ☐ No

(iii) some other figure? ☐ Yes ☐ No

Please give reasons.

N/A

Question 35: How should small claims mediation be provided?

Please explain with reasons.

By the courts mediation service with suitably accrediated mediators held at the court, as soon as possible after issue of proceedings (unless the defendant has indicated they are not going to defend the claim).

Question 36: Do you consider that any cases should be exempt from the automatic referral to mediation process?

☒ Yes ☐ No

Please give reasons.

Fast and multi track clinical negligence cases should be exempt but not small claims cases (unless liability admitted)

Question 37: If your answer to Question 36 is yes, what should those exemptions be and why?

All claims above the small claims track for reasons of complexity (and because provision for ADR is already in the standard directions)

Question 38: Do you agree that parties should be given the opportunity to choose whether their small claims hearing is conducted by telephone or determined on paper?

☒ Yes ☐ No

Please give reasons.

It is important that claimants, particularly in small claims where they are more likely to be unrepresented, are given the choice between telephone or determination on paper. For some providing the paperwork is an insurmountable obstacle, for others they may find presenting their claim on the telephone too difficult.

Question 39: Do you agree with the proposal to introduce compulsory mediation information sessions for cases up to a value of £100,000? If not, please explain why.

☐ Yes ☒ No

Please give reasons.

In clinical negligence claims compulsory mediation at an early stage, particularly in higher value claims that are likely to be fully defended is not appropriate and unlikely to achieve a satisfactory result for either party. We would see the only outcome as increasing costs to the parties in funding the mediation. A more appropriate type of considering ADR in clinical negligence claims, particularly those of higher value, is immediately prior to trial, before the trial costs, such as brief fees etc have been incurred. In most clinical negligence claims the defendant very often lags behind the claimant in preparing their case. While the claimant will already have obtained its expert evidence prior and received advice from counsel in conference prior to issue of proceedings, the defendant may commence these steps on receiving the Particulars of Claim.

Question 40: If your answer to Question 39 is yes, please state what might be covered in these sessions, and how they might be delivered (for example by electronic means)?

Please give reasons.

N/A

Question 41: Do you consider that there should be exemptions from the compulsory mediation information sessions?

☒ Yes ☐ No

Please give reasons.

Exemption should be provided where there is already an accepted practice of using ADR at an agreed stage

Question 42: If your answer to Question 41 is yes, what should those exemptions be and why?

All clinical negligence claims, should be exempt from compulsory mediation information. The only exception should be where there has been an admission of liability and quantum is restricted to past losses and general damages only.

Question 43: Do you agree that provisions required by the EU Mediation Directive should be similarly provided for domestic cases? If not, please explain why.

☒ Yes ☐ No

Please give reasons.

Question 44: If your answer to Question 43 is yes, what provisions should be provided and why?

It is essential that the outcome of a mediation has the same force as a court order. If proceedings have already been issued, this can be achieved by way of a consent order. If not, then new regulations/legislation will have to be brought in in order to obtain an agreement analogous to a consent order which can be directly enforced. We are also concerned at the cost of mediation services and believe that any mediation should be paid for out of existing court fees i.e. in clinical negligence where we believe that ADR should take place in the run up to trial but prior to incurring trial costs thus, the fee for mediation could be taken out of the setting down fee.

Section 4 – Debt recovery and enforcement

Question 45: Do you agree that the provision in the TCE Act to allow creditors to apply for charging orders routinely, even where debtors are paying by instalments and are up to date with them, should be implemented? If not, please explain why.

☐ Yes ☐ No

Please give reasons.

Not application to clinical negligence.

Question 46: Do you agree that there should be a threshold below which a creditor could not enforce a charging order through an order for sale for debts that originally arose under a regulated Consumer Credit Act 1974 agreement? If not, please explain why.

☐ Yes ☐ No

Please give reasons.

Not applicable to clinical negligence.

Question 47: If your answer to Question 46 is yes, should the threshold be:

(i) £1,000 ☐ Yes ☐ No

(ii) £5,000 ☐ Yes ☐ No

(iii) £10,000 ☐ Yes ☐ No

(iv) £15,000 ☐ Yes ☐ No

(v) £25,000 or ☐ Yes ☐ No

(vi) some other figure (please state with reasons)? ☐ Yes ☐ No

Please give reasons.

Not applicable to clinical negligence.

Question 48: Do you agree that the threshold should be limited to Consumer Credit Act debts? If not, please explain why.

☐ Yes ☐ No

Please give reasons.

Not applicable to clinical negligence.

Question 49: Do you agree that fixed tables for the attachment of earnings should be introduced? If not, please explain why.

☐ Yes ☐ No

Please give reasons.

Not applicable to clinical negligence.

Question 50: Do you agree that there should be a formal mechanism to enable the court to discover a debtor's current employer without having to rely on information furnished by the debtor? If not, please explain why.

☐ Yes ☐ No

Please give reasons.

Not applicable to clinical negligence.

Question 51: Do you agree that the procedure for TPDOs should be streamlined in the way proposed? If not, please explain why.

☐ Yes ☐ No

Please give reasons.

Not applicable to clinical negligence.

Question 52: Do you agree that TPDOs should be applicable to a wider range of bank accounts, including joint and deposit accounts? If not, please explain why.

☐ Yes ☐ No

Please give reasons.

Not applicable to clinical negligence.

Question 53: Do you agree with the introduction of periodic lump sum deductions for those debtors who have regular amounts paid into their accounts? If not, please explain why.

☐ Yes ☐ No

Please give reasons.

Not applicable to clinical negligence.

Question 54: Do you agree that the court should be able to obtain information about the debtor that creditors may not otherwise be able to access? If not, please explain why.

☐ Yes ☐ No

Please give reasons.

Not applicable to clinical negligence.

Question 55: Do you agree that government departments should be able to share information to assist the recovery of unpaid civil debts? If not, please explain why.

☐ Yes ☐ No

Please give reasons.

Not applicable to clinical negligence.

Question 56: Do you have any reservations about Information applications, Departmental Information Requests or Information Orders? If so, what are they?

☐ Yes ☐ No

Please give reasons.

Not applicable to clinical negligence.

Question 57: Do you consider that the authority of the court judgment order should be extended to enable creditors to apply directly to a third party enforcement provider without further need to apply back to the court for enforcement processes once in possession of a judgment order? If not, please explain why.

☐ Yes ☐ No

Please give reasons.

Not applicable to clinical negligence.

Question 58: How would you envisage the process working (in terms of service of documents, additional burdens on banks, employers, monitoring of enforcement activities, etc)?

Not applicable to clinical negligence.

Question 59: Do you agree that all Part 4 enforcement should be administered in the county court? If not, please explain why.

☐ Yes ☐ No

Please give reasons.

Not applicable to clinical negligence.

Section 5 – Structural reforms

Question 60: Do you agree that the financial limit of £30,000 for county court equity jurisdiction is too low? If not, please explain why.

☐ Yes ☐ No

Please give reasons.

Not applicable to clinical negligence.

Question 61: If your answer to Question 60 is yes, do you consider that the financial limit should be increased to:

(i) £350,000 or ☐ Yes ☐ No

(ii) some other figure (please state with reasons)? ☐ Yes ☐ No

Please give reasons.

Not applicable to clinical negligence.

Question 62: Do you agree that the financial limit of £25,000 below which cases cannot be started in the High Court is too low? If not, please explain why.

☐ Yes ☐ No

Please give reasons.

Not applicable to clinical negligence as the financial limit is to remain at £50,000.

Question 63: If your answer to Question 62 is yes, do you consider that the financial limit (other than personal injury claims) should be increased to:

(i) £100,000 or ☐ Yes ☐ No

(ii) some other figure (please state with reasons)? ☐ Yes ☐ No

Please give reasons.

Question 64: Do you agree that the power to grant freezing orders should be extended to suitably qualified Circuit Judges sitting in the county courts? If not, please explain why.

☐ Yes ☐ No

Please give reasons.

Not applicable to clinical negligence.

Question 65: Do you agree that claims for variation of trusts and certain claims under the Companies Act and other specialist legislation, such as schemes of arrangement, reductions of capital, insurance transfer schemes and cross-border mergers should come under the exclusive jurisdiction of the High Court? If not, please explain why.

☐ Yes ☐ No

Please give reasons.

Not applicable to clinical negligence.

Question 66: If your answer to Question 65 is yes, please provide examples of other claims under the Companies Act that you consider should fall within the exclusive jurisdiction of the High Court.

Please give reasons.

Not applicable to clinical negligence.

Question 67: Do you agree that where a High Court Judge has jurisdiction to sit as a judge of the county court, the need for the specific request of the Lord Chief Justice, after consulting the Lord Chancellor, should be removed? If not, please explain why.

☐ Yes ☐ No

Please give reasons.

Not applicable to clinical negligence.

Question 68: Do you agree that a general provision enabling a High Court Judge to sit as a judge of the county court as the requirement of business demands, should be introduced? If not, please explain why.

☐ Yes ☐ No

Please give reasons.

Not applicable to clinical negligence.

Question 69: Do you agree that a single county court should be established? If not, please explain why.

☒ Yes ☐ No

Please give reasons.

Section 6 – Impact assessments

Question 70: Do you agree that we have correctly identified the range of impacts under the proposals set out in this consultation paper?

☒ Yes ☐ No

Please give reasons.

Question 71: Do you agree that we have correctly identified the extent of impacts under these proposals?

☐ Yes ☒ No

Please give reasons.

With regard to the impact assessment, MOJ O69 extension of the system for dealing with low value RTA PI claims:-
We believe that the impact assessment on providers of legal services, particularly that set out at paragraph 2.7 where it is suggested that legal services providers will only incurr adjustments costs but not ongoing costs, is inaccurate. In order to properly process their client's claim it is likely that legal services providers will incurr more time costs than in allowable at a fixed cost regime. This could have a number of effects, all of which are detrimental to the interests of claimants and access to justice. On recovering lower costs legal services providers may take one of a number of courses of action:

1. Work may be allocated to unqualified clerks working in large groups supervised by a single solicitor. This will inevitably lead to a lack of careful analysis of the issues. Following a small pilot scheme called 'Resolve' AvMA reviewed some of the cases, our review raised a concern that some firms were forced to use cheaper inexperienced staff as the fee structure did not allow experienced staff to be employed.

People who work in the area of small claims need to have sufficient experience of clinical negligence work to recognise the possible causes of action and heads of damage to ensure mistakes are not made within a framework where time and resources are limited

2. Investigations and obtaining evidence may be truncated leading to a lack of examination of all the issues. Heads of damage may not be identified and/or schedules of damages not properly prepared

3. Some solicitors may decide to cease to act for claimants in clinical negligence claims, in particular when this is coupled with other fundamental changes in clinical negligence litigation funding. This could result in a significant lack of choice of legal representatives for claimants.

Regarding the impact on claimants the assumption is that a simpler process will result in lower costs and speedier resolution of the claim. However, as we have already stated the issues in clinical negligence claims are often far from simple. This scheme may, in fact, delay the resolution of claims by introducing an additional layer of process in which the claimant must go through but failing to resolve at this stage still has to resort to litigation.

That claimants may act in person is seen as a benefit. We dispute this. In the main this is due to the complexity of clinical negligence claims, but also to the lack of access to expert witnesses for claimants. Even if expert witnesses are to be jointly instructed (which we oppose) the claimant will still be at a disadvantage when dealing with a defendant organisation. We also consider that defending a claim brought by a litigant in person very often increases the time and costs that a defendant legal representative must spend on his client's case.

Question 72: Do you agree have any evidence of equality impacts that have not been identified within the equality impact assessments? If so, how could they be mitigated?

☐ Yes ☒ No

Please give reasons.

Thank you for taking the time to let us have your views.