Action against Medical Accidents (AvMA) Response to the Access to Justice Inquiry, call for evidence:

Closing date: **Tuesday 30th September 2025 at 23:59**

Submitted: **30th September 2025**

Contacts: **Paul Whiteing, CEO AvMA (paul@avma.org.uk) and Lisa O'Dwyer, Director Medico- Legal Services, AvMA (lisa@avma.org.uk)**

About AvMA:

- Action against Medical Accidents (AvMA) is the national, independent, patients' charity for patient safety and justice.

- AvMA's public facing services provide free independent specialist advice and support to patients and families who have been affected by avoidable harm in any kind of healthcare setting. 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.

- Most of the people AvMA help do not go on to make a clinical negligence claim, however clinical negligence litigation is a vitally important option for many who need compensation. A fair and proper award of compensation can help a patient who is injured as a consequence of negligent medical care cope with the implications of the injury and/or loss that has been sustained. In our experience, litigation is often resorted to when injured patients and/or their families have exhausted other attempts to resolve their concerns and hold the organisation responsible for the injury to account.

- AvMA was the first organisation to accredit specialist claimant solicitors, our accreditation panel is the longest running clinical negligence accreditation scheme. Additionally, AvMA provides training for lawyers practising in clinical negligence. We get useful intelligence from the claimant lawyers we work with and from our data base of specialist medico-legal experts; we use this intelligence to help inform our responses to consultations.

- AvMA's public facing services provide free, independent, impartial and confidential advice, information, and signposting to the public. Our advice and information can be accessed through our written services including our inquest

service and/or delivered via our telephone helpline service which is open to the public five days a week, from 10.00 am to 3.30 pm. The helpline is staffed by professional volunteers, mainly clinical negligence lawyers and some medics, who have been trained by experienced AvMA staff.

- Some of the enquiries we receive on the helpline need bespoke help and assistance. Members of the public requiring this level of service complete a New Client Form. The New Client Form is submitted with any documentation they consider relevant and/or supportive of any potential case they may have.

- AvMA operates a pro bono inquest service for members of the public whose loved one has died as a result of healthcare service provided or omitted. AvMA works closely with the bar, especially chambers specialising in clinical negligence work to arrange representation at the inquest hearing.

- AvMA understands the litigation process but does not engage in litigation. AvMA does not issue proceedings or run litigation or enter any sort of funding arrangement.

- All of the responses, and views offered in this call for evidence are offered from a healthcare and clinical negligence perspective only.

Short summary of AvMA's response:

The submission highlights the barriers to justice faced by patients and families in clinical negligence cases, particularly for vulnerable groups such as children, the elderly, those with learning disabilities, and individuals with mental health conditions. Many claims with merit are deemed commercially unviable due to proportionality rules, leaving claimants without representation and undermining accountability for healthcare failings. The document also criticises the Parliamentary Health Service Ombudsman for deflecting complainants to legal remedies, often leaving them without recourse. AvMA stresses the crucial role of supplementary advice services and independent advocacy in empowering patients, notes the risks of self-representation, and questions the sustainability of funding models such as CFAs, SLAS, and CLAF in this field. It argues that priority investment should go into reforming the NHS complaints process and embedding fair ADR mechanisms. While digital innovation and AI may play a supporting role, they cannot replace independent, empathetic advice. Legal aid provision is described as almost non-existent for clinical negligence, with restrictive eligibility and impractical funding levels. Overall, AvMA calls for systemic reform to ensure vulnerable groups are not denied access to justice and that failings in healthcare are properly addressed.

The call for evidence https://committees.parliament.uk/work/9286/**:** The Committee invites evidence submissions addressing any or all of the following questions:

1. **How does the current state of the legal services and representation market in England and Wales, and associated operating pressures, affect access to justice for clients?**

1.1 Potential clinical negligence cases are assessed by claimant lawyers on the basis of their commercial viability, this means the cases must have reasonable prospects of succeeding and be commercially viable, the costs must be proportionate which means the cost of bringing the proceedings must not outweigh the amount to be recovered. Any costs which are deemed to be disproportionate may not be recovered and will cost the claimant firm money, they cases are not commercially viable, and lawyers tend to avoid the risk associated with these cases. Cases which have merit but are not commercially viable are therefore unlikely to secure legal representation.

1.2 One example of a case that may have merit but may not be commercially viable is a case involving the death of a minor (under 18 years) where damages are generally limited to statutory bereavement award (£15,120) plus reasonable funeral expenses. The cost of bringing these cases often outweighs the amount to be recovered. The situation has been impacted by the decision in Paul v Wolverhampton https://www.supremecourt.uk/cases/uksc-2022-0038 - a supreme court case where the judgment delivered in Jan 2024 severely curtailed a parents ability to bring a secondary victim claim – the value of such claims has been reduced making them far more likely to offend the rules on proportionality. This has reduced the commerciality of bringing these types of claim, despite the fact they are important claims.

1.3 Other examples of the types of cases which may have merit but are uncommercial because they offend the principle of proportionality include elderly care cases where an older person may have a number of co morbidities making causation difficult and expensive to prove because a number of medico legal experts may be required.

1.4 Mental health cases are also difficult to bring because of the complexities involved in taking reliable witness statements, together with the fact that individuals with serious mental health issues are often not able to work and therefore have no loss of earnings claim. There is an additional cost in terms of supporting clients and/or their families who have mental health difficulties, they tend to need more support due to the fact they are vulnerable which means lawyers need to spend more time with them. Solicitors are often challenged on costs recovery in such cases and this together with the generally low value of the damages to be recovered in such claims mean that this cohort of people often struggle to find representation.

1.5 Similarly, other vulnerable groups, such as those with learning difficulties can struggle to find legal representation. The awards of damages are low in value, the client is vulnerable and needs more time to give instructions, solicitors do not always recover all the costs of these cases and therefore avoid them.

1.6 It should be noted that there is a higher incidence of death and poor outcomes from learning disability groups compared to the general population. The Learning Disability Mortality Review Report (LeDeR) https://www.kcl.ac.uk/ioppn/assets/pdfs/leder/leder-annual-report-2023.pdf

states that "*A relatively high proportion of deaths of adults with a learning disability are considered avoidable... 38.8% of deaths being considered avoidable in 2023…"* This is nearly twice as high as figures for the general population where avoidable deaths accounted for 21.6% of all deaths.

1.7 It is not known how many of those deaths were the subject of clinical negligence litigation however it is known that 37.2% of those who died in 2023 experienced a delay in their care or treatment. It stands to reason that there would have been grounds for at least some of these deaths to become potential claims. 27.1% of these adults lived in the most deprived areas (Index Multiple Deprivation (IMD) levels 1 and 2) compared to 20.8% general population which suggests that those who died were on a very low income and any claims would be of low value. People with learning difficulties find it challenging to secure representation because of the value of their claims.

1.8 There are particular challenges for people with learning disabilities, mental health issues and the elderly in securing legal representation because of proportionality. The cost of bringing proceedings is likely in most cases to exceed the value of the claim. This creates an access to justice problem for some of the most vulnerable in society. This in turn also creates a wider problem for society as a whole in that a lack of representation can mean that healthcare is not being held to account for failings. If the opportunity to learn lessons is not harnessed those failings will be allowed to perpetuate and the public will not benefit from improvements in care. It also means that an individual's right of redress becomes a right in name only and this in turn will create discontent and frustration.

1.9 The lack of representation in low value clinical negligence claims is also impacting on the ability of grieving families to be represented at inquest. This leaves them feeling like they are not being heard. The situation is compounded by the knowledge that very often a trust will be represented at the inquest hearing by specialist counsel. This uneven playing field creates resentment, adds to the feelings of disempowerment, as well as conspiracy and cover up. It fosters distrust between the state and the public it is meant to serve.

1.10 Operating pressures can also be seen with the Parliamentary Health Service Ombudsman (PHSO) in carrying out its statutory function to review the way in which the NHS complaints process has operated. AvMA has seen an increase in the number of enquiries from members of the public who are concerned that their request for an investigation into their healthcare complaint has been turned down by the PHSO on the basis they have an alternative legal remedy (ALR) in clinical negligence litigation.

1.11 In the financial year 2020-21 the PHSO handled 23,124 complaints including carrying out 3,864 primary investigations. In the financial year

ending 2022-23 the PHSO handled 35,103 complaints (a 20% increase on pre pandemic levels 2018-19). There has clearly been increased demand and pressure on the PHSO in recent years.

1.12 This correlates with AvMA's experience, in recent years we have received an increase in the number of requests for advice from the public on what can be done when the PHSO turns them away for a review of their NHS complaint. The PHSO are most commonly turning the public away on the grounds that they have an alternative legal remedy. We have seen correspondence from the PHSO which says *"…our starting point is that the Ombudsman is not able to investigate unless she is satisfied that, in the particular circumstances, it is not reasonable to expect that person to resort to [legal proceedings]".*

1.13 Even where the strength of the legal claim is not clear the PHSO has written stating that they want to see that the complainant has been turned down for legal advice. We have seen letters from the Ombudsman advising that the complainant must obtain three letters from three different solicitors turning the case down before they will consider investigating. In other correspondence they have stated "*the law says we Cannot investigate a complaint where a person has the option to take legal action. We do not consider whether the legal action will succeed but whether it is a reasonable option to look in to"*

1.14 The PHSO own complaint form arguably leads the complainant into asking for compensation it asks*: "If you want the organisation to pay you compensation, what amount are you hoping to achieve?".* It needs to be appreciated that at this stage the complainant is seeking to use the complaints process, they are not looking to litigate. It should also be noted that the complainant is unlikely to have received any legal advice at this point and will not be in a position to quantify the amount they are hoping to achieve.

1.15 AvMA has written to the PHSO and referred to the case of Regina (Miller and another) v Health Service Commissioner for England [2018] EWCA Civ 144, para 88.1 – 88.2. where it made clear that*:* "*The presence of an alternative legal remedy does not preclude the ombudsman from investigating…the decision is a matter of weighing several factors. If the complainant is primarily seeking financial redress, that points to the legal remedy being appropriate. If the person is primarily seeking an apology or wider systemic change, that points to the legal remedy being inappropriate. Neither factor is, however conclusive."*

1.16 When the PHSO sends the public off like this, it can take time for them to secure three letters turning down their case for litigation – that is assuming that a letter is forthcoming, many firms do not write turning cases down as it is not commercial for them to do this. Even if the public can achieve what the PHSO requires them to do, they are at serious risk of being outside of the PHSO own 1 year time limit, if the time limits are missed the PHSO will not investigate in any event as they consider the concern to be time barred.

1.17 The poor state of the NHS Complaints process was commented on by Professor Henrietta Hughes OBE, Patient Safety Commissioner for England in her recent "Patient Safety Commissioner Impact" report published in September 2025: https://www.patientsafetycommissioner.org.uk/wp-content/uploads/2025/09/PSC-Impact-Paper-1-1.pdf where she comments "*I welcome the planned overhaul by DHSC of the complaints process which requires substantial improvement, as witnessed by the number of complainants who approached the ombudsman".*

1.18 In AvMA's experience, most patients want to know what went wrong with their or their loved one's care, they want to know that lessons have been learnt, and changes will be made to prevent others suffering as they have done. The public want acknowledgement that a mistake has been made and accountability, they want to be treated honestly and fairly, they want matters resolved swiftly, they do not want litigation. When redress processes such as the PHSO are under pressure and refer the public to alternative legal remedies, they are essentially corralling them into litigation.

1.19 Where litigation is not an option because the case is not commercially viable it creates a situation where there is no real redress from law or alternative processes. This further alienates the public. The lack of access to representation makes patients and/or their families feel voiceless, disempowered, angry and lose trust in healthcare providers especially the NHS. It drives the public to the media.

1.20 It would appear that it is the most vulnerable in society, who feel the greatest impact from the paucity of legal services providing access to justice.

2. What is the role of supplementary advice services in supporting access to justice?

2.1 Supplementary advice services are often the only source of advice, information, support and appropriate signposting available to the public. Agencies, like ourselves offer some direction which may enable some access to justice where it would be otherwise unavailable.

2.2 As explained above, most people do not want litigation, they want accountability. They want to know lessons have been learnt and that change has been affected, so that no other patient/family has to suffer the way they have.

2.3 Effective independent and impartial advocacy can help the public communicate their dissatisfaction, give them confidence and support in expressing their concerns, and what they want.

2.4 Supplementary advice services provide information which in turn gives the public an awareness of their options. This in turn, empowers people who have been injured to make an informed decision about what steps are right for them and what steps they can take next.

3. What is the impact of those acting without legal advice and / or representation having on access to justice?

3.1 The impact of no legal advice or representation is to deny access to justice, this fosters distrust between the public and the state. It follows that frustration and disempowerment create anger and discontent and a profound sense of the state being unfair.

3.2 There is a parallel between the way disaffected patients feel and behave, and the injustice recognised in the post office scandal, infected blood inquiry, windrush and others.

3.3 A sense of injustice promotes anger and frustration which can drive people to act as litigants in person (LiP) even if that action is not necessary or appropriate. LiP then clog the courts and increase the costs of litigation as the courts will generally make allowances for LiPs that would not be made if they were represented. Managing LiPs in court proceedings is generally not cost effective and only adds to the already considerable delays being experienced by court users.

4. **Without impacting the public purse, what potential funding options would increase access to justice? e.g. an access to justice fund levy, conditional fee arrangements, third party funding**.

4.1 It is difficult to see how any meaningful attempts to create funding options to increase access to justice can be done without impacting the public purse. If there is a real and serious will to address this issue, then it cannot be done without the public purse being affected.

4.2 A no win, no fee agreement or to give its correct term, a Conditional Fee Agreement (CFA) is a commercial agreement between the solicitor and client, it is a contract that enables the solicitor to recover costs in the event the claim is successful. In clinical negligence the solicitor is employed to prove that the care provided fell below an acceptable standard and where this can be shown to recover damages for the injury caused by that substandard care. Damages are awarded on the basis of the successful claimants needs, any deductions from those damages to contribute to access to justice more generally is to deduct funds which the claimant has been awarded for their care and other needs. Deducting from the award of damages creates a shortfall in the claimant's award which renders them susceptible to needing to fall on the state for benefits, be those social security, disability payments, care or other benefits, all of which have an impact on the public purse.

4.3 Third party funding is an arrangement between a specialist funding company and a client (the claimant in litigation). The funder agrees to finance some or all of the claimant's legal fees in exchange for a share of the case proceeds. The impact on third party funding arrangements will be as described for CFAs (see above paragraph).

4.4 Over the years there have been various discussions about possible financial models which lend themselves to increasing access to justice such as a Supplementary Legal Aid Scheme (SLAS). SLAS is a self-funding mechanism which is built into or added onto an existing publicly funded legal aid scheme and administered by the relevant legal aid authority. There is no

real legal aid for clinical negligence work and so a SLAS is not a realistic option for this type of work.

4.5 Another model which has previously been mooted is the Contingent Legal Aid Fund (CLAF). This is a proposed self-funding mechanism financed by deducting a portion of each claimants damages, the deduction is then recycled to support other claims. However, this mechanism will not work in clinical negligence work because there is largely no legal aid funding available.

4.6 Both the SLAS and CLAF models were explored by Jackson LJ in 2016. For more info see: https://www.judiciary.uk/wp-content/uploads/2016/02/lj-jackson-speech-clf-160202.pdf. They have not been introduced in clinical negligence claims because legal aid funding largely no longer exists for this category of case.

5. If limited funds were available, what would be the priority areas for spending?

5.1 If limited funds were available, the priority areas for spending would be on improving the NHS complaints process. Part of this would entail providing access to independent, impartial, advice, information and appropriate levels of advocacy at the complaints stage.

5.2 The complaints process should be able to work with Alternative Dispute Resolution (ADR) mechanisms like mediation to facilitate resolution of complaints and encouraging issues to be resolved early on, including offering a financial award in recognition of the failings identified. It is AvMA's view that if there was an effective complaints process that this would lead to a reduction in litigation and increased satisfaction in the NHS through earlier resolution.

5.3 It is important that any ADR scheme utilised in conjunction with the complaints process is fair and offers patients a level playing field including equal access to relevant documentation which may be medical records, investigation reports, statements, datix information and such like. The public will need independent and impartial support to understand their medical notes, and any reports, some people will need an advocate to also speak for them and help them through the process.

6. How are the legal services regulators responding to their obligation to improve access to justice under the Legal Services Act 2007?

6.1 AvMA does not have the data to access this question

7. How is pro bono work and free legal advice being used to support access to justice and what reliance is placed on it?

7.1 AvMA is an independent charity which gives free help, advice and information via our helpline, written advice and information service and inquest service. We serve over 3,000 people a year and we know there are many more people who need our help but who do not know of us or who we are unable to support because the demand exceeds what we can deliver by way of advice and information.

7.2 AvMA's own strategic plan is to widen our reach to support diverse groups as well as the general population, but we are hampered by lack of funding.

7.3 AvMA's feedback from the public tells us that considerable reliance is placed on our services. We empower people with information that enables them to make informed choices. We signpost where appropriate and necessary.

7.4 AvMA gives the public advice, information and direction, we help people identify what they need to focus on and support them in moving forward with expressing their complaint and exploring their concerns.

7.5 Where litigation is appropriate or wanted by the patient, AvMA puts people in touch with lawyers who are accredited by us. Our AvMA clinical negligence accreditation is a mark of quality denoting lawyers who have demonstrated expertise and experience in clinical negligence work as well as client care skills. AvMA refers the public to accredited lawyers to ensure that where legal representation is required that the public will be properly advised, their expectations managed, and care given to them as they move through the exploring the possibility of litigation.

7.6 AvMA's public facing services are all free of charge. Our advice helps people understand their options for redress, the difficulties they can expect to encounter through litigation and meeting the legal test for negligence. It gives information, and direction to help people find resolution.

7.7 At a time when it is becoming more difficult for patients/or families to find representation in litigation a great deal of reliance is placed on our pro bono services

8. How can advice, legal support or non-court dispute resolution, such as mediation and restorative justice, help the early resolution of disputes?

8.1 Mediation and ADR is a powerful tool but for it to be fair and effective there needs to be a level playing field. This means the patient must have access to good quality, independent advice, equal access to relevant documentation and access to advocacy support if required.

8.2 AvMA believes there is a role for the ADR and complaints processes to work together, and we have been modelling some options as to how this might work in practice – we are happy to discuss our suggestions and believe that a pilot will be required initially.

8.3 AvMA also considers that in the lower value cases, applying a more diluted, common-sense approach, to the strict legal test for negligence would aid resolution and restorative justice. We are currently exploring what such a test might look like.

8.4 We refer to a paper published on 2nd April 2025, Harmful Experience of Healthcare Study, contributors include the academic Helen Hogan: https://qualitysafety.bmj.com/content/early/2025/04/02/bmjqs-2024-017213

8.5 This paper identifies that "***most people who were harmed wanted help to redress the harm"*** it notes there is a lack of support for people. The paper recognises the impact of compound harm. Compound harm is the additional

harm that occurs when someone who has been harmed through treatment and then raises concerns about that treatment is repeatedly told there is nothing wrong; the trust fails to engage openly, honestly and with candour. The paper notes a correlation between a lack of independent advocacy support and resolution opportunities and litigation which is extremely costly.

9. **What role is there for digital innovation and data collection in supporting access to justice?**

9.1 Not only is there a role for data collection but there is also a need to ensure that data is collected in a uniform and consistent way so that real comparisons can be made.

9.2 Data collection will help trusts share and disseminate information on how they have addressed improvements to their services. Trusts sharing information on what works and what does not will require a culture change, not least to move to greater openness and a willingness to recognise when attempts to change processes/procedures have not been effective enough, or at all.

9.3 It may be that Artificial Intelligence (AI) does have a role to play in supporting access to justice, for example, it can help to draft letters of complaint. AI is unlikely to be a complete panacea to supporting access to justice, it will not be able to support the patient emotionally, offer real empathy and reassurance which are important factors in this type of litigation. AI may be part of the solution, but it will not be able to overcome the inequalities in healthcare and redress, that will take independent and impartial advocacy.

9.4 Digital innovation may enable some access to justice but only for those who do not experience digital poverty, are familiar and confident with IT and are able to understand the digital prompts to enable access to justice.

9.5 Clinical negligence is a complex area of law, the average reading age in England and Wales is thought to be between 9 – 11 years of age even with digital innovation it should be expected that the average user will struggle to access justice via this route. Independent advice and support will still need to be made available to enable proper use of digital innovation.

9.6 In our experience, many members of the public can comprehend breach of duty, however the concept of causation can be more challenging. This is especially true, if there is has been a recognised breach of the duty of care but causation does not follow. These are legal concepts which digital innovation alone will not be able to overcome.

9.7 Digital innovation may be a more effective tool for providing some access to justice if the legal test for negligence in low value clinical negligence claims can be diluted. Diluting the legal test in this way may require parties to be open to a change of approach such as shifting the burden of proof from the claimant to the defendant. This might mean that in certain cases, the presumption of negligence exists unless and until the trust/defendant can show the injury was not as a consequence of the treatment provided.

10. How could the current system of legal aid be improved to provide a cost-efficient and cost-controlled service, with suitably remunerated legal practice across civil, criminal and family law?

10.1 Up until April 2013, legal aid for clinical negligence cases was fairly widely available, subject to clients being able to show that their claim did appear to have reasonable prospects of success and that they satisfied the legal aid means test.

10.2 This changed in April 2013, and now only certain types of clinical negligence cases may be eligible for legal aid. Where it can be shown that a person has suffered a neurological injury resulting in a physical and/or mental disability caused by negligent treatment and that injury occurred whilst the individual was in the womb or during their birth or within eight weeks after their birth then legal aid for clinical negligence is still available.

10.3 Even where legal aid funding is available there are problems running cases funded this way owing to the restrictions imposed by the Legal Aid Agency (LAA) on the amount that can be spent on medico legal expert's fees. The medico legal expert is the backbone to any clinical negligence case and therefore pivotal to whether a case can succeed or not.

10.4 Medico legal experts operate in an open market, where medico legal experts demand and may receive lucrative terms for their work, consequently many medico-legal experts simply refuse to work at legal aid rates which are considered to be too low. This makes it impossible for practitioners who still have a clinical negligence legal aid franchise to run their case funded by legal aid. Usually, practitioners explain the situation to the client and invite them to move over to a CFA and ATE insurance which then makes instructing experts possible.

10.5 Legal Aid, Exceptional funding is available for inquests but to be eligible families must show that they fall within the merits test. The merits test for exceptional funding demands that a family can demonstrate that either the inquest is an Article 2 inquest or there is a point of public interest which will benefits a wider group of people other than just the family. Since the Supreme Court handed down its judgment in the case of Maguire https://www.supremecourt.uk/cases/uksc-2021-0038 it has become far more difficult to persuade a coroner to open an Article 2 inquest in deaths involving healthcare providers. Where it is available an article 2 inquest provides an opportunity to explore not only how a person came about their death, but how and in what circumstances they died.

10.6 One of the key features arising from the judgment in the Maguire case was to emphasise that the individual lapses of individuals in putting in a proper system of care (which might be considered negligent and therefore subject to a clinical negligence claims) is not to be confused with a deficiency in the system itself.

10.7 The effect of this is that in clinical negligence law, although some legal aid funding appears to be available for this work, its availability is only in very controlled and exceptional circumstances.

10.8 As there is no real system of legal aid in this area of work, there is no system upon which improvements can be made to create a cost-efficient system of funding.

11. What has been the impact of the Legal Aid Agency cyber-attack, revealed in April 2025, on recipients and providers of legal aid work, and how have the Legal Aid Agency and Ministry of Justice responded?

11.1 As explained above, legal aid is rarely used in clinical negligence work. Consequently, the legal aid agency cyber-attack of April 2025, had little impact on practitioners specialising in this area of work.
