

## **Clinical Negligence and Serious Personal Injury Committee Response**

### **Introduction**

1 The Civil Justice Council has since its inception worked to promote efficient and effective dispute resolution by the most appropriate means. The Council has taken a particularly active role in developing, by consensus, the pilot predictable costs regime for low value RTA cases and the recently implemented fixed success fees in both RTA and Employers' Liability conditional fee cases, with the aims of reducing satellite disputes over costs and making CFAs a viable method of funding claims. The CJC is also working on a number of projects to promote better access to justice, has been instrumental in encouraging the development of court annexed ADR schemes and the early rehabilitation of accident victims.

2 The Serious Injury and Clinical Negligence Committee of the Council was established two years ago and has been particularly involved in work on the Chief Medical Officer's report Making Amends, and in new court rules and procedures for structured settlements and for the payment of some large personal injury awards by periodical payments rather than lump sums. Committee members include senior counsel and solicitors, a High Court Master and a District Judge, representatives of the insurance industry, and senior representatives of the NHSLA, and the Medical Defence Unions as well as a civil servant from the DCA. The CJC is responding more generally to the consultation paper. This response concentrates on the proposals in relation to personal injury and clinical negligence cases.

3 A principal concern of the CJC and this Committee is to ensure that proposals made do not impair access to justice. Our views echo those of the Constitutional Affairs Committee as expressed in their paper "Civil Legal Aid: Adequacy of Provision" - it regards access to justice as a basic right.

### **GENERAL COMMENTS**

4 The CJC is very aware of the pressures on the legal aid budget, and the need to focus public funding where it is most needed. So far as the expenditure of civil legal aid on cases of serious personal injury or clinical negligence are concerned, however, this implies that the proposals will reduce cost, and will do so without adverse effects upon access to justice and the quality of legal provision. We have little doubt, too, that those responsible for implementing any change will want to have regard to the way in which some of the effects might be seen by the general public.

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6 The proposals will have effects in terms of:-

(a) costs;

(b) the concentration of the available budget upon fewer cases (with greater rewards for the lawyers in those cases) rather than more general provision for all;

- (c) tending to reduce the competence with which cases are conducted;  
and they
- (d) assume the ready availability of other means of funding.

#### **a) Cost**

7 So far as this particular area of work is concerned, the background is that of a downward trend in the number of cases pursued. The number of clinical negligence cases has been monitored in the High Court of Justice by the Masters concerned . We understand that the figures show a drop in the number of claims issued. We understand that the number of cases passing through the Compensation Recovery Unit shows a reduction year on year in the immediate past. Dr. Tomkins of the Medical Defence Union (one of our members) confirms that the number of claims with which her mutual defence organisation has to deal has dropped. We are told by Mr Walker, Chief Executive of the NHSLA (who is also one of our members) that the experience of the NHSLA is similar.

8 A further point to be borne in mind is that there may well be a falling off in the number of clinical negligence cases. Paragraph 8 of the report of the Constitutional Affairs Committee (CAC) Report, "Civil Legal Aid: Adequacy of Provision" having set out some legal aid spending statistics, states: "These figures indicate that the civil budget has remained fairly constant; however, there are several factors which influence how these statistics should be interpreted. The first is a drop in funding of the civil representation. This is partly explained by the disappearance of personal injury work, which is now done almost entirely on the basis of conditional fee agreements rather than through the legal aid system. The drop in spending on civil representation is rather greater than was predicted when CFAs were introduced, which may suggest that there is a further drop in civil representation over and above that caused by personal injury work."

9 Page 8 of the Partial Regulatory Impact Assessment on proposals for changes to the Civil Legal Aid Funding Code appears to confirm the limited nature of the savings anticipated in respect of clinical negligence work: the proposal "to remove some clinical negligence actions from the scope" is, it is anticipated, likely to affect 900 claimants and effect a saving of £5 million only over the next 4 years (roughly the value of one claim for cerebral palsy, before even taking into account the costs). The proposal to "encourage greater use of ADR, CFAs, and BTE plus other minor scope changes" is anticipated to affect 1200 clients and result in savings of £6 million over the next 4 years. The maximum annual saving from each category is thus £2-3 million as a maximum. One of our members (Adrian Whitfield Q.C.) was told in conversation with the Public Legal Service Division of the DCA (Jasmine Tegnar) that there may be some overlap in the two categories, and, if so, it is right to anticipate that the savings will be less than the maximum £11 million.

10 £11 million is, in context, an extremely small saving when seen in proportion to the restriction of access to justice and the administrative costs of putting the changes which are proposed into effect.

11 This also assumes that the proposals will reduce, and not increase, costs.

12 We believe that far from reducing the cost to public funds, the impact of the proposals will be to increase them (albeit from a different public budget). Those claims

which succeed will, if they are financed by a Conditional Fee Agreement, require the uplift on that Agreement to be paid. Such an uplift is almost certain to be set at the maximum 100%. The costs element of any recovery is thus likely to double. Insurance premiums for “heavy” cases, if insurance is available at all, may be levied in part by reference to a percentage of the ultimate award or settlement. Thus costs to Defendants in individual cases will be at least 200% of current non-CFA costs, and potentially could be up to 100% more again. The cost forecasting which has been done (for instance by the Medical Defence Union) suggests that the proposals outlined in the Consultation Paper will increase, and not decrease cost. We think this is realistic, and not scaremongering.

## **b) Increased Individual Costs for Fewer Cases**

13 Conditional fee Agreements are unlikely to be entered into for high cost litigation, because of the degree of downside risk they involve for the legal professional and insurer concerned, except for those cases in which success is likely. We think that the effect of reducing the availability of community legal funding will be to reduce the “high cost” claims to those which are much more likely to succeed than those which will not, or those in which the central issue is quantum. Quite apart from the impact this is likely to have on access to justice (the case which is a bit, but not much, better than 50-50 is unlikely to be litigated; and the case which turns on lay evidence, as a surprising number of clinical negligence cases do, and which cannot easily be evaluated without the witness giving that evidence and being tested on it, is equally unlikely to be fought even though it may have merit) a result is that those cases which succeed will bring much higher remuneration to the successful lawyers involved. If the savings (as per the Regulatory Impact Assessment) are as modest (in this particular area of practice) as suggested, this implies to us that the available funds will be spread across fewer cases (bad for access) yet with greater rewards for the lawyers involved. It seems to us desirable in principle that the system at its best should afford the greatest access to the courts for the greatest number of reasonable cases, with the lawyers involved remunerated sufficiently but not excessively: the changes tend therefore to move away from this paradigm towards the undesirable – namely spreading the same money (broadly speaking) over few cases, spending more on each.

## **c) Reduction in Standards and its impact on costs**

14 The current gentle reduction in the number of claims pursued, and the extent to which many which are pursued are settled before coming to trial in Court, is because of the increasing expertise of those who act for claimants (defendants' solicitors have on the whole had expertise, though this, too, has been concentrated by a general reduction in the number of firms to whom work for the NHSLA and Medical Defence Societies is directed). This increase in competence has been due, as we see it, in no small measure to the approach of the LSC in franchising practices. This has imposed quality standards, which effectively mean that those who do the work know how to do it efficiently, and have experience in it. Retention of support from the public purse for investigatory work is essential in this. Public funding is restricted to franchised practices. If the preliminary work done in such a practice shows that there is a reasonable case to pursue, it is almost inevitable that the franchised solicitor will be invited on behalf of the claimant to conduct it. Yet this initial decision is one on which considerable cost consequences may turn: it is important, both from a costs perspective and a service perspective to get it right.

15 If, however, public funding is withdrawn, or seriously limited, for the investigatory stages of litigation then claimants will choose any solicitor they like to act for them. They will not be effectively restricted to those who are franchised. This will be regrettable: we see it as important that the system should encourage the public to use the services of specialist practices who are particularly experienced in the work. This has knock-on effects: a lack of experience may result in the abandonment of a good case when it ought to be pursued and, more important for present purposes, the pursuing of a bad case when it ought to be abandoned. Experience results in a proper focus, the expenditure of less time, and greater reliability of the representatives so far as the Court is concerned. It ought to lead to shorter trials. We think that the impact of the proposed changes in tending to dilute the current concentration of expertise will simply add to the costs and uncertainty of the system.

16 It should be noted that evidence suggests current management of clinical negligence cases is skilled and responsible, no doubt in consequence of the LSC franchise scheme and the increasing skill of solicitors on both sides and the impact of the NHSLA:

Paragraph 34 of Chapter 3 of the CMO's report "Making Amends" reads:

"Recent information from the NHSLA suggests that 60-70% of claims do not proceed beyond initial contact with a solicitor or perhaps disclosure of medical records. Of those that do proceed, 95% of the claims settled by the NHSLA to September 2002 were settled out of court. Of those that went to court, the claimant received damages in 78% of cases, though these cases include many which only related to the size of the award (the "quantum") - i.e. the claimant was bound to be awarded something."

The table shows that out of the 26,374 cases on the NHSLA database for the years 1995 to 2002,

- 28% were abandoned by the claimant
- 47% were settled out of court
- 2% were fought in court and won by the claimant
- 1% were fought in court and won by the NHS
- 22% were yet to settle.

#### **d) Other Methods Of Funding**

17 Any assumption that access to justice will be maintained by other sources of funding is misplaced: it is not readily available. Trade Unions do not normally offer their members cover to pursue clinical negligence claims. After the event (ATE) insurance is notoriously difficult to obtain, particularly on bigger cases where the costs may be substantial. Where it is provided, the premium is often calculated by reference to percentage of the sum ultimately recovered, adding further to the costs (see above). Our general experience is that after the event insurance is available for routine, rather than the more difficult cases. This adversely impacts upon access to justice.

18 Moreover, experience shows that a number of after the event insurance policies have been avoided by the insurer for non-disclosure in the event that the claimant has been unsuccessful and has been ordered to pay the costs of the defendant. This adds to the difficulties for the defendant. A body such as the NHSLA has a public duty to pursue the recovery of its costs. They are, however, understandably concerned about the public impact of any report that having (as the claimant might see it) been the source of injury, which they then deny, they are then to be responsible for depriving the claimant even of their house (for example). We would wish to avoid this position,

unattractive as it is likely to seem publicly, however justified it may be on present legal rules.

19 These comments relate in particular to clinical negligence claims. Very few personal injury claims are now funded by LSC, and overall expenditure on clinical negligence claims is under control. Only specialist quality assured solicitors on the LSC panel undertake the work, and the high costs cases are managed to case plans by the Special Cases Unit. Moreover there is no evidence that the number of clinical negligence claims is increasing. The CMO report showed a levelling off of the number of claims in recent years. Also with improved court case management the majority of claims settle before trial, generally following managed negotiations. The NHSLA Annual Report for 2004 states that only 2% of their cases go to final hearings, and that this includes children's settlements which the court has to approve. The consultation paper puts the current success rate of clinical negligence claims at 59%, but this figure will include "old cases" handled by non-specialist solicitors, and cases where protective proceedings were issued but discontinued. The real success rate may be more. In consequence there seems to be no risk of significantly rising net expenditure by the LSC on clinical negligence claims to justify the major intervention that these proposals represent at this time.

### **Access to Justice**

20 It is worth repeating some of the genuine concerns of the CAC:

Para 35. Despite the factors raised by the Legal Service Commission, we are satisfied that there is still ample evidence of unmet demands. When there is no evidence of reduced demand the number of people helped is a key indication of how successful the system is. It is unacceptable that the system is helping fewer people.

Para 49. The evidence on the difficulties of recruiting solicitors and barristers to legal aid work and retaining them underlines one of the most serious threats to the provision of publicly funded legal advice. This significant trend of young lawyers away from legal aid work puts into question the future of the civil legal aid system.

Para 75. There is a serious risk that if legally aided work is associated with very low fees, this may have a serious impact on the quality of people who undertake legally aided cases. The problems that are faced by clients who require legal aid support are often of the most complex variety.

Para 105. At present, the legal aid system is increasingly being restricted to those with no means at all. There is a substantial risk that many people of modest means but who are homeowners effectively will fall out of the ambit of legal aid. In many cases this may amount to a serious denial of justice.

21 At the same time, a number of major changes in clinical disputes are either in the process of being implemented or will take place in the next few years.

- a. The NHS complaints system is changing significantly with the replacement of the Trust-based independent review second stage, with a review by the Healthcare Commission. Only interim regulations have been implemented so far. More changes are to come. One anticipated change that was not, in the event, included in the

Regulations implemented in July 2004, was to permit a complaint to be investigated while a claim was pursued in parallel. Retention of the rule that investigation of a complaint must cease if the complainant intends to make a claim could make the proposal in the consultation paper that most potential claimants be required to first follow the complaints procedure unworkable. Potential claimants would be obliged to be disingenuous about their intentions, or else take the risk that neither option would be open to them if they hoped to be publicly funded.

- b. The CMO's redress schemes (which are intended to provide speedier compensation for many claims by an adjudication process with less legal input and with redress partly in kind) on best available information are likely to be introduced in 2006-7. These schemes will radically change the options available to many claimants, especially those with smaller claims, and the funding that might be required for them.

Making major changes to public funding of clinical negligence changes now when expenditure is under control and when significant reforms to parts of the system have yet to be implemented seems very unwise.

22 Limited research appears to have been carried out to assist in an assessment of the implications of the proposals. Radical reform without an evidence base is very risky. How many clinical negligence claimants will no longer be financially eligible if the proposals in Questions 4 and 5 are implemented? Will specialist solicitors be willing to take on the claims of those no longer eligible for public funding at all or after the investigatory stage? Will the currently very restricted ATE insurance market be able to offer affordable premiums for new CFA cases? How will the proposed changes influence access to justice overall? At the least an attempt should be made to answer these questions before changes on the scale proposed are implemented.

23 Finally, the government is currently conducting a fundamental review of legal aid. The effect of many of the proposals in this consultation paper is likely to be fundamental - especially for clinical negligence claims. They are not "limited reforms" as suggested in the paper. We suggest that the majority of the proposals in the consultation paper should be carried forward to the Fundamental Review. This would also enable some impact assessment to be carried out.

### **Financial eligibility Questions 4 & 5**

24 Aligning the upper limits of eligibility for Legal Help and Representation makes sense-it will be easier for applicants & their advisers and the LSC administrators to comprehend & manage. But there is no analysis in the consultation paper of the numbers & types of claimants who will be affected if the limit is the lower Legal Help one. The proposal will leave in scope only claimants on state benefits. Privately funding a clinical negligence claim (if a cfa was not available) is far beyond the reach of most people on low or average wages.

25 Abolishing the £100,000 home ownership equity disregard would exclude very many homeowners from eligibility, especially those in the South East and major regional cities. It would impact particularly on older claimants whose homes might be their only asset. But owning a home does not mean access to realisable capital, particularly when household income has been drastically reduced following a serious injury to a household member. Many mortgage lenders might well not lend further especially when

future income is very insecure. If extended loans are available they may be at high rates, and could lead a family into a spiral of debt from which it would be very difficult to recover. The group of people affected will be very vulnerable in any event following an adverse and debilitating incident to a family member. Many would be likely to decide they could not take on such a risk with the family's main asset, their home, and would decide not to proceed with the claim.

26 Moreover, a declining number of people have access to legal aid, simply because a greater number each year exceed the financial criteria.

### **Use of the complaint/Ombudsman schemes – Questions 18 and 19**

27 Imposing a requirement to follow a complaint scheme as a prerequisite to access to public funding for a claim is fraught with difficulties because:

- a. The schemes are not necessarily effective - Stage 1 of the NHS scheme is conducted internally & may lack independence (hence the current reforms) and if trusts were aware that their reply to a complaint would decide whether a claim was to be publicly funded they might not be encouraged to admit mistakes. A comprehensive complaints system for the private medical sector is not yet in place.
- b. The NHS complaints scheme can provide an apology, an explanation and system changes for the future, at best. Payment of money is ex gratia, and in most trusts is not available unless a claim is initiated. The recent reforms to the complaints system have not changed this.
- c. Complaints and claims are mutually exclusive under the present NHS complaints system. There is a real risk that a patient opting for, or being required to follow the complaint route, who indicated an intention to claim, would find their complaint was not being investigated, and would then be refused LSC funding for a claim.
- d. Following the complaint route takes time - possibly up to a year for the local stage alone in a complicated case. The Healthcare Commission stage could take a further year if a panel was appointed to consider the complaint. A Health Service Commissioner investigation could take another 2 years. But even if only the first or second stage had to be followed before a decision was taken on public funding, investigation of liability could have been made much more difficult. Vital witnesses might well have moved jobs or left the health service, or simply not be able to recall the details of the incident. Late notification of a claim cause similar difficulties for the healthcare provider.

25 Continuance of the current LSC practice of requiring use of the complaints scheme for low value claims up to £10,000 would be reasonable provided that exceptions are made for serious cases which attract only a low level of damages e.g. where the patient has died without dependants: a sensible exercise of discretion in low value claims should secure reasonable access to justice at low cost.

## **Mediation and other forms of ADR Question 20**

28 The CJC supports the appropriate use of ADR - not just mediation but also early neutral evaluation and expert determination. Some clinical negligence claims are suitable for early pre-litigation ADR. But many require extensive investigation not least because the claimant bears the burden of proof while the defendant possesses most of the information about what happened. Settlement can only be fairly achieved after disclosure of documents, witness statements and expert reports. The majority of clinical negligence cases do settle at that stage by managed negotiation. Some are mediated, usually successfully, when both parties consider an independent facilitator may "add value". Otherwise mediation does not necessarily save costs as experienced mediators charge well into four figures: we point out that "round table" negotiation has become increasingly popular. This is ADR, and is understood by the Queen's Bench Masters to be such, but it is not mediation.

29 The courts encourage ADR - the Court of Appeal in Halsey confirmed that encouragement was the right approach, not ordering mediation, and that there was no presumption for ADR. The standard High Court direction in clinical negligence claims also "encourages". The CJC agrees that the LSC should remind claimants to offer ADR, and to report offers from defendants, and should be prepared to give an explanation if the claimant is minded to decline that offer. Requiring claimants to mediate could arguably be a breach of Article 6 of the ECHR, and would be pointless if the defendants were not willing. Also if a defendant was aware that the legal aid certificate was for mediation only mediation could be a hollow exercise. It is (and will only work well if it remains) a voluntary process.

30 The LSC and NHSLA could jointly promote ADR by publishing guidance based on recent experiences - the Clinical Dispute Forum's publication could also be circulated.

## **Conditional fee agreements Question 21**

31 We understand that about 90% of clinical negligence cases are publicly funded. The success rate of these cases has greatly improved in recent years through the LSC specialist panel system and case planning and management by LSC, solicitors' firms and the courts. The clinical negligence specialist solicitors firms do offer cfas but only the larger firms can carry a number of cfa cases at a time- the risks of losing more than the occasional case are too great for smaller firms. Withdrawing public funding from clinical negligence claims would not mean that the same number of cases would be funded by cfas. Firms would not take the risk and would be selective, taking on the stronger cases. Also the market for ATE products for clinical negligence is very limited, inadequate for the present demand, and as yet immature. Premiums are high - five figure sums are not unusual for even medium sized claims. One of our members reports that the market is even shrinking.

32 Past experience (when CFAs became the principal source of funding in personal injury claims) suggests that if there is a lack of competition from other funding sources (such as legal aid), the effect is to increase premiums in what has become a monopoly market. This additional layer of cost has to be financed from the litigation, and rebounds on the paying party.

33 The pursuit of some clinical negligence claims is in the public interest- healthcare providers must be accountable for negligence and important issues of law are clarified by test cases.

34 Moreover the transfer of more claims to cfa funding would not necessarily reduce public expenditure as the NHSLA and other defendants would have to pay the reasonable success fees and ATE premiums in cases which they lost. With trial success fees now set by statute at 100% for RTA and EL claims, it is highly unlikely that clinical negligence trial fees could be less, and in many cases 100 % for earlier settlement could still be justified unless liability and causation were admitted early. But satellite litigation over fees and premiums might ensue. Apparently in personal injury claims even when a defendant succeeds against a cfa and ATE funded claimant, ATE insurers have often voided the policy for material non-disclosure.

35 If our view it would be premature for the LSC to expect many more claims to be funded by cfas.

### **Partial public funding Question 22**

36 There is some merit in this proposal if the only objective is to reduce LSC expenditure on clinical negligence claims. Firms might be more willing to take on more cases on cfas at later stages but only if affordable ATE was available. (It should be noted that the later in the course of proceedings is the time when ATE is taken out, the more expensive the premium tends to be). Members of the committee have experience of cases they regard as respectable, which it has not been possible to cover with an insurance policy. In such cases, the claimant is often thereby deterred from proceeding when, in a proper system ensuring access to justice for reasonable cases, he should be able to. The same argument in paragraph 15 with regard to increased expenditure by NHSLA, would still apply

37 We think that the funding of group litigation poses particular problems, which we hope to review in the course of our ongoing work.

### **The availability of BTE insurance Question 24**

38 BTE insurance is rarely available for clinical negligence- it is excluded in most policies. Solicitors should check client's policies, however, including for the limited types of personal injury case that are currently publicly funded. There can be no objection to the LSC requesting accurate information on the client's BTE position on the application form.

### **Reducing cost protection Question 25**

39 This would have a damaging effect on claimants who by definition are vulnerable, having suffered an adverse incident in healthcare, and who are on a low income - on benefits if the eligibility proposals in the consultation paper were to be implemented. A costs liability that would have any financial virtue for the defendants would prevent many justifiable claims from proceeding. £200 as suggested in the consultation paper would be of little value to healthcare defendants. If there are unmeritorious cases still being funded by LSC - and defendants consider that there are - it would be fairer for all concerned to tackle this through the merits test.

40 It is perhaps surprising that this suggestion is being made at all as in winning cases which are funded under High Cost Case Contracts, the LSC now insist upon the solicitor, not the client having to pay the Statutory Charge (see Clauses 12 & 16 of the LSC High Cost Case Contract). It raises the question whether the LSC have actually appreciated the impact of this contractual alteration to the longstanding statutory framework in removing the financial incentive for clients to behave reasonably.

41 If the purpose of the £200 proposal, on cases that are lost, is to encourage claimants to "own" their litigation, then the first thing the LSC need to do is revise Clauses 12 & 16 of the LSC High Cost Case Contract (for cases that are won) so that the "Final Payment Choice" does not shift the operation of the statutory charge from the client on to the solicitor.

### **The cost benefit test Questions 26 and 27**

42 There are different views from claimants and defendants. Clinical negligence cases are complex and costs are higher in relation to damages, especially for small to medium size claims, than in many other types of dispute. Cases with a value of £20-£30,000 can fail the current tests. Tightening the test could increase this figure to £30-40,000. Yet we would point out that the more stringent the merits test becomes, the more eligibility for financial support is restricted: and we note that although cases of a value of £20,000 may seem low, seen against the panoply of some others, that value amounts in cash terms to a sum greater than the net average wage currently received in a year. Such sums are therefore significant to those who may claim them. If the CMO's redress scheme for smaller claims is implemented this proposal might have more merit - that would be the right time to consider it.

43 Defendants consider that weak cases are still publicly funded, and that claimant costs are too high and insufficiently controlled in lower value cases. They consider staged funding and better costs controls would help.

### **Exclusion of all personal injury proceedings Question 31**

44 The consultation paper gives no indication of the number of "non-negligent" personal injury cases that are currently publicly funded. While there may be some superficial logic in amending the statute, it is in the public interest that claims against the police, prison officers, and health and care staff for abuse should remain eligible for funding, as should Criminal Injuries Compensation claims (under legal help). Some of these cases are not suitable for cfas.

45 We trust our comments are helpful: our members, collectively and individually would be happy to assist further if asked.