Introducing Fixed Recoverable Costs in Lower Value Clinical Negligence Claims – A Consultation
Question 1

Do you agree that Fixed Recoverable Costs for lower value clinical negligence claims should be introduced on a mandatory basis?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No</td>
</tr>
</tbody>
</table>

If not, what are your objections?

Clinical negligence is a complex and specialised area of law. There is often a huge amount of investigative work carried out by the claimant’s solicitor to be able to first establish and then to prove the negligence. Simply because damages in a case may be valued at less than £25,000.00 does not mean that the case itself is any less complex/that less work is required than in a case where damages are valued in excess of £25,000.00. The proposed fixed fee scheme places in jeopardy both the amount of work, and the level of service of the work that the claimant can expect from their solicitor. Where cases are taken on they are likely to be assigned to much more junior members of the team. It will also have a potential impact on the claimant’s damages. Where a solicitor is willing to take a case on then, owing to the level of fees recoverable, it is likely that more monies will be taken from the claimant’s damages to cover the shortfall. This would result in less money for them for any rehabilitation or long term care needs.

The fixed fee scheme runs the very real risk of preventing claimants' access to legal representation and to justice. There is a concern for the families who lose vulnerable members of society, such as the disabled, the elderly and children. Often these individuals do not leave dependants. Accordingly claims brought by their estate tend to be minimal in value, yet they are the very claims that mean so much to their families and society as a whole.

There is a worry, in particular, that if a claim estimated to be worth less than £25,000.00 is complex or if liability is denied, the claimant will not be able to find a solicitor willing to take on their case. This will lead to an increase in the number of litigants in person clogging up court time unnecessarily. The claimant in person will be unable to present their case to the same level as the defendant. They will lack the legal skills and the evidence they would have access to had they had a solicitor acting for them. They will not be able to instruct medical experts to provide them with the necessary evidence from which to base their allegations and this will give the defendant an unfair advantage.

In many cases it is the defendant’s stance that escalates the claimant’s legal costs. They will often deny liability in cases where it is shown it was inappropriate to do so. A Freedom of Information Request made by SCIL indicated that 76% of cases which had been issued at Court subsequently settled and therefore cases are unnecessarily defended and costs increased.

Arguably there are already effective measures in place for safeguarding against the risk of any inflated costs being claimed. Solicitors representing successful claimants cannot simply recover any figure of their choosing by way of costs. They can only recover costs that were reasonably and proportionally incurred on the case. In the event of any dispute with the defendant as to costs, then the court have the power to assess the claimant’s legal costs and readily exercise their power. If the case is issued at Court, the Judge will consider the costs at the very first Hearing and set a budget for the remainder of the case.

Savings have already been made by the introduction of the Legal Aid and Sentencing and Punishment of Offenders Act (LASPO) and continue to do so with the abolition of the recoverability of the success fee from the opponent and the reduction in the ATE premiums. There has been insufficient time to fully evaluate the impact of LASPO and therefore this consultation is premature. Similarly, the National Audit Office and Lord Justice Jackson are part way through their review of litigation costs and therefore it would be beneficial to await the response from these reviews.

Of course, the vital element here when looking at tackling the costs issue, is that the defendant will only be responsible for paying the claimant’s legal costs following a successful claim. The
Focus really should be centred on avoiding the claims arising in the first place and where the claims do arise, on them being handled as efficiently as possible by the defendant. The defendant should fully investigate the circumstances to determine whether an early admission of liability should be made.

The statutory Duty of Candour was introduced in 2014. This is a legal duty on hospital, community and mental health trusts to inform and apologise to patients if there have been mistakes in their care that have led to significant harm. They must act in an open and transparent way with patients with regards to the care and treatment that has been provided and offer apologies where appropriate. If the opponent complied with their statutory duty, this would reduce unnecessary costs and potentially minimise the amount of claims brought.

The fixed fee scheme runs the very real risk of further delays and defending of cases. A defendant may be even more inclined to deny liability if they know that the claimant cannot secure legal representation under a fixed costs regime and cannot afford to incur the disbursements necessary to investigate a claim. This could ultimately lead to the same mistakes being made by hospitals and GP’s without any lessons being learned.

Focus should shift to the defendant as set out above, rather than looking towards a voluntary scheme which would not provide the perfect solution either. Perhaps lessons should be learnt from the voluntary Redress Scheme in Wales which does not seem to be working due to cases being removed from the Scheme due to delays and significant undervaluation of claims by the defendant.

<table>
<thead>
<tr>
<th>Question 2</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you agree that Fixed Recoverable Costs should apply in all clinical negligence claims:</td>
<td></td>
<td>No</td>
</tr>
<tr>
<td>Option A: above £1,000 and below £25,000 (preferred)</td>
<td></td>
<td>No</td>
</tr>
<tr>
<td>Option B: Another proposal</td>
<td>Yes</td>
<td></td>
</tr>
</tbody>
</table>

Please explain your choice:

Clinical negligence is a complex area of law which is not measurable by the amount of compensation awarded and therefore it is unhelpful to set a range in respect of damages as this by no means has any bearing on the complexities or issues involved, unlike in some other areas of civil litigation such as road traffic accidents or accidents at work.

There is an inequality of arms between the knowledge, skill and expertise of the clinician involved in the claim and the lay claimant. The clinician, and their medically qualified advisors, are able to seek to rely on their contemporaneous records/protocols and national guidelines. The claimant however, with no medical knowledge, no contemporaneous records of the events and no guidance to make reference to has an uphill battle to seek legal representation, source funding, obtain the medical records and thereafter instruct an expert of like discipline to opine on the issues. It is not until this stage, at the very earliest, that the claimant or their legal representatives can form an opinion on the prospects of success.

Clinical negligence cases cover a very wide ranging spectrum of medical issues which we do not consider is replicated in any other area of law. The duty of care is tailored towards the specialism, rather than a general duty. It is complicated by the fact that the claimant has an underlying medical condition otherwise they usually do not need to seek medical attention. Further, the need to differentiate between the outcome as a result of the alleged negligence and that which would have occurred in any event is wholly dependent upon specialist expert evidence and is not within the knowledge of the layman.

The cases which will frequently fall within the £1000 to £25,000 range typically will include delay in diagnosis of cancer, stillbirths, early neonatal deaths and death of the elderly who
have no or little financial dependency. All of these cases involve enormous importance to the public. Should such cases be uneconomic to investigate, those responsible for the negligence will go untouched and there will be a significant threat that deaths due to medical negligence will not be appropriately investigated.

In addition, such cases will also target and encompass vulnerable sections of society including children (with no financial loss) and those who are unemployed or not able to work due to ill health. Again, if the cases are uneconomic to investigate, access to justice will be reserved for those who have suffered financial losses due to the fact that they are employed and have lost earnings. It will become a class system; those who are less wealthy in society will be denied the opportunity to investigate their case and seek compensation whereas those with money will be able to proceed.

FRC’s cannot be fixed by reference to damages except if there are specific exclusions for cases. For example, those which involve the Fatal Accidents Act, Law Society (Miscellaneous Provisions) Act, children and cancer to name just a few.

A FRC regime could work for straightforward dental claims were there is already a tariff like system to value the case and the complexities of the case are far less and typically involve just one expert. It may also be appropriate to extend this to straightforward orthopaedic claims, such as missed fractures etc. where the value of the claim is less than £25,000 and liability is admitted.

However, a blanket imposition of a FRC regime by crude reference only to damages carries a real danger that access to justice will not be available and lessons will not be learned from the NHS who will continue to make mistakes without accountability.

It is necessary for a working party of interested stakeholders to be created to investigate additional savings that can be made in addition to those which are already being evidenced by LASPO.

---

**Question 3**  
Which option for implementation do you agree with:

| Option 1: all cases in which the letter of claim is sent on or after the proposed implementation date. | No |
| Option 2: all adverse incidents after the date of implementation. | Yes |
| Another proposal | No |

Please explain your choice:

The industry has only just begun to see the practical effect of LASPO. To introduce another sweeping change before the effects of the Jackson reforms have been fully analysed is unnecessary. However, to respond to the consultation, I would say that the implementation date could only be option 2, after the date of implementation this is a clear-cut deadline following which the new, fixed costs rules are to be followed by all parties.

Cases of £1,000-£25,000 are often as materially complex as the higher value claims. That said, much of claimant solicitors’ time is currently spent chasing delayed or missing records; little or no response to the Letter of Notification; poor or vague responses to Letters of Claim and repeated failures of defendants to make early admissions and resolve claims. Costs will be quickly eaten up in FRC cases by actions outside of the claimants’ control and therefore the implementation date needs to be option 2 to allow the defendants to effectively ‘put their house in order’ and make wholesale changes in the way they conduct litigation. More emphasis must be placed on earlier resolution of disputes at the complaint stage, notification stage and Letter of Response stage.
Option 2 will prevent a raft of hastily prepared Letters of Claim being submitted (perhaps without the benefit of medical evidence) prior to the deadline to ensure they’re subject to the non-FRC rules.

Option 2 will ensure that cases are prepared properly, with the benefit of expert evidence and Counsel, (if necessary) thus reducing the amount of time and money that needs to be spent by the defendant investigating the claim. It promotes access to justice.

According to the consultation at 3.13, there is to be a further transitional period after the Letter of Claim has been served, to settlement or issue. Option 1 gives rise to a defendant potentially delaying their response to a Letter of Claim (as they already so often do), to allow for the new FRC to apply, forcing claimants to issue proceedings and incur unnecessary Court costs in cases that could have achieved settlement without recourse to the Court, had prompt admissions been made. This in turn wastes Court time. The claimant would have no recourse for the defendants’ conduct. Option 2 resolves this issue.

The fact that an injury is as a result of negligence is not always immediately obvious. The consultation will need to take into account that the date of the adverse incident may fall before the date of knowledge of the negligence. Consequently, the appropriate limitation date should not be restricted to the date of the adverse incident but date of knowledge thereof.

Disclaimer: “All incidents” referred to in replying to this query does not take account of the responses to the other consultation questions regarding children / vulnerable / fatal cases, which should be excluded from the FRC regime altogether.

<table>
<thead>
<tr>
<th>Question 4</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Looking at the approach (not the level of fixed recoverable costs) do you prefer:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Option 1: Staged Flat Fee Arrangement</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Option 2: Staged Flat Fee Arrangement plus % of damages awarded: do you agree with the percentage of damages?</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Option 3: Early Admission of Liability Arrangement: do you agree with the percentage of damages for early resolution?</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Option 4: Cost Analysis Approach: do you agree with the percentage of damages and/or the percentage for early resolution?</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Option 5: Another Proposal</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Please explain why:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Options 1 to 3 bear no regard for the time which is needed to investigate clinical negligence claims. The adversarial system we have is for the claimant to prove the case on the balance of probabilities. It is the responsibility of the injured party, who is already disadvantaged due to their lay knowledge, to prove the claim against the tortfeasor. All of the work is front loaded and the investigations into each case vary so dramatically that these cases cannot be considered akin to road traffic accidents. Clinical negligence cases are in stark contrast to a road traffic accident where the parties are easy to identify, the negligence of the tortfeasor is obvious to the lay person and therefore the issues that usually require determining are restricted to causation and quantum only.

In respect of a clinical negligence case; the tortfeasor is not usually readily identifiable, breach of duty and causation are not at all clear and necessitate evidence gathering and thereafter independent experts to advise on one or both issues. Quantum is far from easy to value. The JC guidelines are aimed at personal injury claims with an assumption that the
accident has caused the injury complained of. In many delay in diagnosis cases they are impossible to value from a tariff or guideline.

As outlined previously in this consultation, the value of the claim bears no relevance whatsoever to the complexities involved. It is common to have a case settle for £20,000 which involves multiple expert disciplines to support breach of duty, causation and condition and prognosis but in contrast a straightforward dental claim with a costed menu of restorative remedial treatment will not require the same level of investigation. Both cases will be subjected to the same level of costs under Option 2 irrespective of the investigatory work and expert involvement in cases which involve multi disciplines of experts.

Option 3 is very unsatisfactory in that there should be no reduction in the FRC awarded for an early admission of liability. As outlined above, it is the claimant’s case to prove and therefore the investigatory work is necessary prior to even submitting a Letter of Claim or Letter of Notification to the tortfeasor. The same amount of work is required to prepare and submit a compliant Letter of Claim and therefore the prospect of a percentage reduction in recoverable fees just because the tortfeasor has made a limited admission will not have any bearing on the work which has already been undertaken until that point. The tortfeasor should not receive a reduction in what is to be paid as the work has already been done. A more appropriate way would be to add on penalties if the tortfeasor fails to respond within the 4 month Protocol period (with a strict application of this) or fails to admit liability and causation in full within the Letter of Response. If the tortfeasor omits to act within the spirit of litigation and the Protocol then either a penalty should be added onto a FRC, or more appropriately, that the claim withdraws from the FRC regime and proceeds in the usual way. This will promote good behaviour by the opponent and encourage early settlements. A reduction in fee would seek to apply a punitive sanction on the investigations necessary by the lay person, a person who is already at a disadvantage due to their restricted or little knowledge, skill and expertise.

If FRC was to be mandated then the only feasible approach would be on a costs analysis basis as suggested in Option 4. However, the illustrative rates as set out in Table 7 would need considerable revision to enable the claims to be investigated in an economic manner and permit those who have been injured as a result of clinical negligence access to justice.

The ‘swings and roundabouts’ argument is not justified in clinical negligence cases as the conversion rate is around 5%, unlike personal injury claims which have a much higher conversion rate.

In the event that the government is adamant that FRC is to be imposed on clinical negligence cases then a proper time analysis calculation should be the economic assessment as to whether there will continue to be access to justice for those who have suffered due to the negligence of the NHS and other medical bodies. This should be considered by a working party of interested stakeholders.

<table>
<thead>
<tr>
<th>Question 5</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you believe that there should be a maximum cost of £1,200 applied to recoverable expert fees for both claimant and defendant lawyers?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Please explain why:</td>
<td>We do not agree that recoverable expert fees should be capped at £1,200. The consultation does not suggest that the need for expert involvement will be diminished by the introduction of fixed fees.</td>
<td></td>
</tr>
</tbody>
</table>
If admissions are not made following a Letter of Notification, then the draft pre-action Protocol provides that a claimant should obtain independent expert evidence in advance of submitting a Letter of Claim. If a claim remains contested, then expert input will be essential at other stages in the litigation. Such involvement will include, but is not necessarily restricted to, the following:

- Obtaining comments on the defendant’s Letter of Response.
- Obtaining comments on disclosed witness evidence.
- Obtaining comments on disclosed expert evidence.
- Joint meetings
- Trial

At current expert rates, it is inconceivable that the expert fees associated with the above work would be £1,200 or below for claims involving up to two experts.

In relation to expert fees, we have reviewed internal data for claims which have settled for £25,000 or less during the last three years. When expert evidence was required, the average fees incurred up to settlement were £4,198.54 – approximately £3,000 over the proposed cap. The average cost per report was £1,448.03 - this alone is over the proposed cap. Indeed, in a two expert case it is very possible that three reports will be required (one to comment on breach, one to comment on causation and one to comment on condition and prognosis). Above two experts, it falls out of Fixed Costs. However, two experts might still be required, in certain situations, to prepare more than two reports. For example, an orthopaedic surgeon might prepare a liability and causation report and then a separate condition and prognosis report.

We respectfully suggest that, with the existing proposal to cap legal fees at £1,200, any shortfall in the recovery of expert fees will have to be borne by the injured claimant. With the real prospect of CRU, success fees and ATE premiums already being taken from compensation, a further deduction could lead to damages being extinguished in full.

If the extent of expert involvement is to remain unchanged then the next question is whether experts will agree to work for significantly reduced fees. It is a reality that defendants will be able to make use of economies of scale to negotiate reduced expert rates. Unlike a claimant they will also be able to rely upon in-house expertise. For example, the NHSLA will continue to make use of panel experts who agree to work for lower rates in exchange for a guarantee of a number of regular instructions. However, due to the disparity in size of the organisations, it will not be possible for claimant firms to enter into similar agreements with individual experts. This is wholly inappropriate and sets a completely uneven playing field between defendants and claimants.

As the Department of Health will be aware, in the (extremely) limited situations where legal aid is still available, experts are already subject to fixed hourly rates. In our experience, such rates have led to many experts rejecting legal aid work to the extent that it is virtually impossible to find suitable experts in certain specialism such as General Practice. Indeed, the independent charity AvMA have sent a survey to their database of 800 experts and found that the majority will not work for the Claimant’s ona fixed fee basis.

To comply with a cap of £1,200, experts would need to reduce their rates (based on our figures)by 71%. This is wholly unrealistic and will lead to a disparity between the parties in that claimants will be forced to instruct cheaper, inexperienced experts whereas defendants will be able to rely upon more seasoned and experienced experts, whose evidence has already been tested over time in the Courts. This would also create a further legal dilemma in that case law suggests that it would not be reasonable for such junior doctors to comment on the actions of more senior practitioners (such as consultants).

Expert fees are already scrutinised at the time of cost budgeting. After claims are served, and directions are made, the Court has to approve the potential involvement of experts (and thus
the cost of such disbursements). We believe that this is a more than sufficient safeguard to maintain realistic and reasonable expert disbursements.

However, in the event that fixed fees are introduced for expert fees then we suggest that it would be more appropriate and realistic if the fees were based loosely on the model adopted by the legal aid agency. We suggest capped expert hourly rates, reviewed annually to ensure that claimants are not being prevented from instructing experts. Defendants already have in-house expertise whereas claimants don’t. A working party of interested stakeholders including medical experts is necessary to examine expert fees in clinical negligence cases.

<table>
<thead>
<tr>
<th>Question 6</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Expert fees could be reduced and the parties assisted in establishing an agreed position on liability by the instruction of single joint experts on breach of duty, causation, condition and prognosis or all three. Should there be a presumption for single joint experts and, if so, how would this operate?</td>
<td></td>
<td>No</td>
</tr>
</tbody>
</table>

We do not believe that there should be a presumption for single joint experts, after all clinical negligence claims are solely based on independent expert evidence.

The basis of clinical negligence claims is to establish whether a reasonable and logical body of medical practitioners would have acted in the same way as the proposed defendant. It is therefore essential that a court is able to hear the range of opinion that may legitimately exist.

With single joint experts, parties are prevented from having any discussions or correspondence with the expert, without the other side being copied in or being present. This can inhibit open and honest discussion of the strengths and weaknesses of evidence. There is also a significant danger that the court may be exposed to a single joint expert’s bias or prejudice towards a certain school of thought or methodology.

Furthermore, if a party fundamentally disagrees with a report, there is a likelihood that an alternative expert will be instructed to test the original opinion. This could lead to costly satellite litigation to rely upon further evidence, thus increasing costs.

In addition to the disadvantages detailed above, we also contend that a saving of costs should not be presumed with joint instructions. In particular, it seems inevitable that increased costs will be seen in other areas – such as more time being taken to instruct experts with written questions likely to be lengthier and asked by both sides and an increased use of Part 35 Civil Procedure Rules.

In summary, we do not believe that single joint experts are appropriate to determine issues of breach of duty and causation. However, if such issues have been admitted in full (following a response to a Letter of Notification) we propose that there could be requirement for the parties to consider whether the instruction of single joint experts is appropriate for outstanding issues relating exclusively to condition and prognosis.

<table>
<thead>
<tr>
<th>Question 7</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you agree with early exchange of evidence?</td>
<td></td>
<td>No</td>
</tr>
<tr>
<td>If no, do you have any other ideas to encourage parties to come to an early conclusion about breach of duty and causation?</td>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>Please explain:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Early exchange of expert evidence on breach of duty and causation is likely to result in early resolution of the claim by way of either an admission of liability, or discontinuance of the claim so in that respect we agree with the proposal.

We do not agree, however, that disclosure of the expert evidence should be sequential. In order to ensure an equal playing field and transparency between the parties, it is imperative that the expert evidence in breach of duty and causation is disclosed simultaneously.

It is our suggestion, therefore, that the parties comply with the Letter of Claim and Letter of Response as set out in table 9 of the consultation, but without disclosing expert evidence on breach of duty and causation at that stage.

If liability is denied within the Letter of Response, we suggest that the parties then proceed to simultaneous exchange of expert evidence on breach of duty and/or causation, depending on whether a full or partial denial has been issued within the Letter of Response.

We also propose that the joint meeting of breach of duty and causation experts takes place following exchange and prior to issue of proceedings (assuming that there remains disagreement between the experts) as this is likely to further narrow the issues between the parties and would afford the parties the opportunity to further resolve the case prior to the issue of proceedings. The fee for experts will, however, require increasing for this stage and it is not envisaged that it will be possible for this step to take place within the current proposed fee for experts.

Once such exchange and the joint meetings have taken place, it is agreed that the parties should consider ADR as the last resort prior to commencing Court proceedings.

In terms of expert evidence on condition, prognosis and quantum, we agree that disclosure of the same can take place sequentially and we agree that the same be disclosed with the Letter of Claim/Letter of Response. The effect of this is that if the defendant makes a full admission of liability, the parties can proceed straight to settlement negotiations and it will not be necessary to serve any expert evidence on breach of duty or causation.

If the defendant denies the claim, within their Letter of Response, we suggest that it would be hugely beneficial for them to disclose their supportive witness evidence at this time. It is possible that the explanation contained within the statements could change the views of the claimant’s experts and possibly prevent the need for further litigation. However, a preferred approach would be to establish a working party made up of interested stakeholders to consider ways in which the claims process can be streamlined.

---

**Question 8**

**Do you agree with the proposals in relation to:**

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Trial Costs</strong></td>
<td></td>
<td>No</td>
</tr>
</tbody>
</table>

**Please explain why:**

We agree that Trial costs should be paid on top of any FRC, but do not agree that the level of fees should be commensurate with the fees allowed for a Fast Track Trial. Expert evidence is not usually heard in Fast track Trials, whereas expert evidence will almost always be required for a clinical negligence claim, along with evidence from the claimant and treating doctor(s). The length of the Trial is therefore usually at least 3 days, whereas the length of the Trial in Fast Track cases is limited to one day.

It could therefore be suggested that the starting point for Trial costs should be based on hourly rates and current guideline rates. With Counsel’s fees and expert’s fees to be paid in addition.

---

**Multiple Claimants**

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
</tr>
</thead>
</table>
Please explain why:

We agree with the proposal that FRC should apply to each claimant that instructs a Solicitor regarding a claim.

However, we feel that a similar proposal should apply to claims that involve only one claimant but multiple defendants. It is common in clinical negligence claims for there to be a number of defendants (i.e. a GP and a Hospital). In multiple defendant cases, although there can be some overlap in the investigation of the claim, more work is required for example in writing to two or more parties and preparing separate Letters of Claim etc.

<table>
<thead>
<tr>
<th>Exit Points</th>
<th>No</th>
</tr>
</thead>
</table>

Please explain why:

We do not agree that claims should only fall out of the FRC in ‘exceptional circumstances’. This is obviously open to interpretation and will no doubt lead to satellite litigation regarding what qualifies as an ‘exceptional circumstance’.

The recent data from SCIL has shown that approximately 76% of cases settle once Court proceedings have been issued. This indicates that many of these cases should have been settled prior to Court proceedings being commenced, as it is very rare that a claimant’s case will change significantly between the Letter of Claim and Particulars of Claim. To encourage the early settlement of cases and save Court time and both parties’ costs, we would therefore suggest that claims should fall out of the FRC if the Reasoned Response denies liability or if there is a failure to provide a Reasoned Response within 4 months of the Letter of Claim.

This will hopefully prevent Court proceedings being issued prematurely, but will focus both parties’ minds as to that importance of the Pre-Action Protocol and whether a case should be settled at an early stage.

Technical exemptions (including claims that involve more than two experts and Child Fatality cases) | Yes |

Please explain why:

We agree with the exemptions that have been listed within the consultation. In addition, we would expect that any stillbirth claims would be incorporated within the definition of Child Fatality cases.

We would also suggest that any Fatal claims brought either under the Law Reform Miscellaneous Provisions Act 1934 and Fatal Accident Act 1976 should be exempt from the scheme, as they are all very sensitive cases and generally involve issues of Public interest and raise access to justice concerns.

Interim Applications | Yes |

Please explain why:

We would suggest that interim applications for varying the Court timetable could be largely reduced by including a provision within the CPR that the parties may, by prior agreement in writing, extend the time for compliance with the directions by up to 28 days without the need to apply to the Court (currently covered by CPR 3.8(4)) and then that ‘Beyond the 28 day period, any agreed extension of time must be submitted to the Court by email, including a brief explanation of the reasons, with confirmation that it will not prejudice any hearing date and with a Draft Consent Order in Word format. The Court will then consider whether a formal Application hearing is necessary’. This is included within most parties’ directions in any event and will cover most circumstances when an extension of time/variation of the Court timetable is needed. The Court fee would also need to be recoverable in full from the defendant.

www.stephensons.co.uk
If a variation/extension cannot be agreed between the parties, then the Application to the Court could be covered by an additional fee being added to the FRC. The costs of the Application and subsequent Hearing should be based on guideline rates and the Court fee recoverable.

This would encourage the parties to co-operate within the litigation and hopefully ensure cases are dealt with expeditiously.

### London Weighting

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>We don’t agree with London Weighting. Most firms now take instructions from clients around the UK and therefore need to utilise experts and facilities within London in the best interests of the client. Many firms also have offices/premises in London, even if this is not where there clinical negligence team is based.</td>
<td></td>
</tr>
</tbody>
</table>

However, a preferred approach would be to establish a working party made up of interested stakeholders to consider ways in which the claims process can be streamlined.

### Question 9

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are there any further incentives or mechanisms that could be included in the Civil Procedure Rules or Pre-Action Protocol to encourage less adversarial behaviours on the part of all parties involved in lower value clinical negligence claims, for example use of an Alternative Dispute Resolution process (ADR)? This would include both defence and claimant lawyers, defence organisations including NHSLA, the professionals and/or the organisation involved.</td>
<td></td>
</tr>
</tbody>
</table>

**Please explain why:**

**Duty of Candour**

The Duty of Candour is a legal duty to inform and apologise to patients if there have been mistakes in their care that have led to significant harm. In future, this could include an obligation on healthcare providers to provide patients with written explanations of what happened and signpost them to Law Society accredited clinical negligence Solicitors. If clients are able to provide their Solicitors with a written explanation of what happened, including an admission of liability if appropriate, Solicitors could focus their investigations on causation and value thus speeding up the process and reducing costs.

**Defendant Behaviour**

One of the reasons for high and increasing costs in clinical negligence claims can be as a result of delays on the part of the defendant when responding to Letters of Claim. Defendants often take in excess of the 4 months permitted in the Pre-Action Protocol which leads to delays and increased costs. Occasionally, as a result of this delay, it becomes necessary to issue Court proceedings as, from a claimant perspective, it is not just and reasonable to continue to await a Letter of Response for a number of months over and above that which is permitted in the Pre-Action Protocol.

In order to combat this it is proposed that if a Letter of Response is not received within the 4 month Protocol period, the claim then falls out of any Fixed Recoverable Cost regime. It is

---

hoped that this mechanism will encourage defendants to investigate thoroughly within the Protocol period.

A further mechanism which could be introduced to discourage certain defendant behaviour is for the claim to fall out of any Fixed Recoverable Cost regime if the claimant is forced to issue proceedings in a claim where liability is admitted. Usually, in these instances, the defendant agrees an extension to the Limitation period. On many occasions however the claimant is forced to issue proceedings. On these occasions, provided that the parties are able to move towards settlement, the claim would never be brought before the Court. By forcing claimants to issue claims, the defendant is increasing the time spent on the case and therefore the cost.

It is suggested that, if a defendant unreasonably refuses to extend limitation in an admitted claim, the claim should then fall outside of any Fixed Recoverable Costs regime.

**ADR**

Currently ADR is not used frequently in low value clinical negligence cases because it is too costly. If it was obligatory for parties to consider ADR in a Fixed Recoverable Cost regime, the cost of arranging, preparing for and attending ADR as well as the negotiators’ fee, would need to be included as an additional amount under the regime. If this was not included as an additional amount, there would be no incentive for parties to consider ADR as it would not be cost-effective.

A Fixed Recoverable Costs regime which encourages ADR would have to provide a list of agreed mediators which the parties could choose from who had the necessary experience in clinical negligence. The mediators on the list would also have to agree to a set fee.

The appropriate time to consider ADR would have to be following any Letter of Response which admits liability unless liability has been admitted at an earlier stage. In order to encourage participation, any claim where liability is admitted and the defendants refuse to participate in ADR could then fall out of any Fixed Recoverable Costs regime. It is envisioned that claims will fall out of any Fixed Recoverable Costs regime if liability is disputed, however, an option could be provided to the parties to at least consider ADR in these circumstances as, even with claims falling outside of the regime, ADR could be a useful tool to settle claims expeditiously and with lower costs. However, the costs of ADR would need to be in addition to the FRC proposed.

**Question 10**

Please provide any further data or evidence that you think would assist consideration of the proposal, particularly for other than NHS provision. In particular, we are interested to gather data from private, not-for profit and mutual organisations delivering healthcare. Please identify your organisation in your response. We would be interested in hearing views on: the scale of expected savings if Fixed Recoverable Costs outlined is introduced; the expected growth in the number of claims received and settled over the next 10 years to help in modelling the impact of the proposals; any details on the number and size of legal firms involved in clinical negligence (primarily as claimant lawyers), any information on the likely administrative savings and set up costs due to introduction of Fixed Recoverable Costs. Please indicate whether your organisation would be willing to work with DH in providing more details on the impact for future IA analysis. This would be provided in confidence and anonymised in any future analysis. Please provide evidence.

The proposal would undoubtedly reduce the amount of costs paid out on clinical negligence claims and there is talk of a saving of £80m but to date the Government has not been able to provide any evidence to back that figure up. In addition it needs to be recognised that the
savings made will be a reflection of the fact that the proposal will result in fewer people being in a position to bring a claim. The costs for claimant Solicitors are not sufficient to justify the time, investigation and expense of pursuing a claim, so claimants with cases of a value of £25,000 or less will ultimately be unable to bring a claim. Experts are highly unlikely to work to the proposed rates for reports if the NHSLA’s data is accurate, 60% of claims would no longer be pursued as there would be insufficient funds to enable investigation. Whilst this will provide an obvious windfall to the NHS it would prevent access to justice for the majority of patients who have been injured as a result of negligence. The number of claims made for cases of £25,000.00 or less will significantly reduce under the proposal but again this would be a reflection of there being very little access to justice for those victims. Very few law firms would be able to sustain the staff required to investigate those cases and make a profit to sustain a viable business. This would result in a significant amount of litigants in person, putting extra pressure on an already overstretched court service. Organisations such as law centres and CABs (who already have limited hours of assistance) are constantly closing so they would not be able to assist the Courts with the additional litigants in person. Many injured patients will turn to their local MP’s and expect them to advise and guide them through the litigation process. The increased burden on Court staff to assist these people would be impossible to deal with (as well as taking Court officers away from their actual roles) and the Court staff ultimately don’t have the knowledge to be able to advise them properly. Litigants in person would ultimately be left without knowledge of the CPR or Court system to pursue their claims and the vulnerable members of society (including the elderly, uneducated and mentally ill) will be even more disadvantaged. Even those with a vast amount of free time, resources easily accessible and a good education would struggle to follow the claims process, so to think that victims with claims of £25,000.00 or less can be litigants in person is a naïve assumption. A further additional point to consider is whether insurers would take advantage of them in under settling the claims knowing that the majority of people would not know what to claim for or the amount at which their injuries should correctly be valued. The shift in power to insurers would be unjust and intimidating for claimants.

The savings from LASPO have not yet been truly seen, nor has the outcome of Lord Justice Jackson’s review and the National Audit Office investigation. To put in place the proposal before this information is available would be premature as well as unjust to claimants who would be left without representation and unlikely to be compensated for very real and not insignificant injuries. The sum of £25,000.00 is not a modest amount. To give it perspective, it is more than the average full time working person’s salary for a whole year.

Question 11

The government has prepared an initial assessment of the impact of fixed recoverable costs on equalities, health inequalities and families. This assessment will be updated as a result of the consultation. Please give your view on the impact of these proposals on: age; gender; disability; race; religion or belief; sexual orientation; pregnancy and maternity; carers; health inequalities and families.

The proposal for Fixed Recoverable Cost (FRC) is that there will be fixed legal costs for claims of between £1,000 and £25,000. It is anticipated that the recoverable costs for lawyers and their medical experts carrying out this level of work will be reduced. It is therefore anticipated that claimants who have claims valued up to £25,000 may well be negatively impacted in a number of ways.

Lower costs for lawyers will lead to lesser qualified, less experienced lawyers carrying out the work on claims of this level and cheaper, possibly less experienced medical experts reporting in the claims. This could lead to poorer outcomes for such claimants and even where claimants are successful they may obtain less favourable outcomes to their cases due...
to settlement negotiation and valuation of claims being carried out by less experienced lawyers.

The stark reality is that many practitioners will decide not to take on claims below £25,000 as it will be uneconomic to do so. This will ultimately lead to less choice for claimants who may struggle to find a lawyer in their geographical area who is prepared to investigate claims on their behalf. This will inevitably lead to a reduction in access to justice for claimants whose claims fall within the FRC scheme.

It is therefore necessary to look at how the introduction of FRC will impact on the groups identified above. Certain categories of claim will certainly suffer.

**Age**
The consultation paper refers to data demonstrating that 18% of Clinical negligence claims against the NHS in England were from those aged 68 and over and 23% of the claims between £1,000 and £25,000 were by the same age group, which suggests that they are disproportionately represented in the lower value claims. To introduce FRC would therefore have a disproportionate impact on this group, in the way suggested above. This group would experience a reduction in access to justice, more than other groups. This group of claimant is more likely to rely on local solicitors, possibly solicitors that they have relied upon throughout their lives. If as is anticipated smaller, ‘local’, firms refuse to take on such work then this group of potential claimant will find it hard to gain access to justice.

The elderly, as well as the unemployed, will generally have a lower income. This will impact on their potential claim for lost earnings which is more likely to bring their claims within the FRC scheme, bringing the proposed negative impact of the FRC to these lower income groups.

**Gender**
The consultation paper relies on data that in 2015/16 56% of clinical negligence claims against the NHS were by women and 44% by men. Data shows that for mid 2013 51% of the population were women and 49% were men. The paper makes the assumption that the higher level of women is due to cases where there are gynaecological and obstetric injuries.

One sub £25,000 value claim where the impact would be felt by female claimants is where negligence leads to stillbirth claims. Such claims would affect females and families (or likely potential families, for first time mothers). This would impact on mums, generally young mums, who are often reliant on the outcome of a claim to put a traumatic incident behind them.

In these claims there is often an element of psychiatric injury and expert evidence is required in the claim to initially establish breach of duty and causation. Even if this can be done by one expert there is still the need to investigate the extent of psychiatric injury. With the proposed limitation of expert fees it would not be possible to obtain sufficient reports and decisions may be made not to obtain condition and prognosis evidence. This could lead to claimants not being properly compensated or the extent of their condition properly recognised. The majority of such claimants are young females, a vulnerable group who would not be able to pursue important claims.

**Disability**
The paper does not have access to data to support the potential impact of FRC on this group. It does recognise that there may be a difference between those who become disabled due to the negligence and those who are disabled and bring a claim. If the negligence leads to a disability then such a claim is likely to be of sufficient value to take it out of the scheme. However, where the disabled claimant has a claim subject to FRC then they may experience problems similar to those suggested in the ‘age’ category above. Mobility may be an issue so finding local solicitors to take on a case or local experts who are willing to report at the fee levels necessary in such cases, may be difficult. Such a group may well find themselves
traveling long distances to medical experts. In addition, there is no flexibility within the proposals to account for more time to be spent with disabled claimants to ensure that they understand the issues within the claim.

**Race and Religion or belief**
Again, the paper does not have access to data to support the potential impact of FRC on this group. What it does rely on is a report that shows that women in ethnic minority groups are over represented in cases of maternal death. Such claims will generally fall under the £25,000 compensation level and will therefore face the issues set out above.

**Sexual orientation**
The paper does not have access to data to support the potential impact of FRC on this group. If it is correct, as assumed by the paper, that some gay or transgender people find it difficult to disclose their sexuality to healthcare professionals then it may be the case that they will find it difficult to confide in a lawyer about a claim that may well relate to their sexual orientation. Such a claimant may have a close link or trust in their local solicitor but, as discussed above, that solicitor may decide not to take on cases that fall under FRC, thereby reducing the access to justice by this claimant.

**Pregnancy**
The report relies on data that shows that 16% of clinical negligence claims in 2015/16 were obstetric and gynaecological and that these represented 45% of the claims received in 2015/16. As mentioned in the gender section above, there would be a dramatic impact on cases where there was a stillbirth. Again, as mentioned above, these cases have devastating impact on claimants who often see the conclusion of clinical negligence investigations as a necessary process to get over the trauma they have suffered.

**Carers**
This section is linked to the ‘families’ section as the majority of carers are family members who are left to care for a family member who has been injured by clinical negligence.

**Health inequalities and families**
One example would be bereavement claims where there is a death of a child, or the death of a spouse where there is limited financial dependency. These will fall within the proposed scheme. Nothing can be more devastating to a family than to lose a loved one and more so to learn that it was due to clinical negligence. To erode or remove the ability of the family to investigate such claims would be a devastating blow to the family. The process of investigating bereavement claims often provides the family with answers and closure, allowing them to move on with their lives.

If FRC is introduced for such claims then claimant lawyers will be economically unable or unwilling to take on claims as they may not be able to recover the costs of proper investigations.

One solution may be to exclude certain claims where the above vulnerable parties are affected, especially with cases such as those where family members are injured or die. We would propose that any claims brought under the FAA ILR (Misc Prov) Act are automatically excluded from the scheme.

However, a preferred approach would be to establish a working party made up of interested stakeholders to consider ways in which any additional savings that can be made in addition to those that will be delivered by LASPO and changing defendant behaviour.