Response to Department of Health Consultation –
Introducing Fixed Recoverable Costs in Lower Value Clinical Negligence claims

May 2017

Introduction

The Council is concerned that the proposals may impede access to justice.

Costs in lower value clinical negligence cases are often disproportionate to the sum involved; but not to the complexity. However, the sum involved (level of damages) is only one of the criteria involved in assessing proportionality by the Court. Under CPR[1] 44.3.5 costs incurred are proportionate if they bear a reasonable relationship to –

(a) the sums in issue in the proceedings;

(b) the value of any non-monetary relief in issue in the proceedings;

(c) the complexity of the litigation;

(d) any additional work generated by the conduct of the paying party; and

(e) any wider factors involved in the proceedings, such as reputation or public importance.

Caution must be exercised when the focus is solely placed (as it is in the paper and the independent review) on the direct relationship between award/settlement value and costs. It should be recognised that the use of the phrase disproportionality (e.g. paragraph 3.9) ignores the wider definition under the CPR. It would be wholly wrong to design a FRC system that denied a Claimant damages below £25,000 because the issues were complex. The focus on a narrow view of proportionality ignores the complexity and evidential requirements of this type of action and the proposals as set out particularly as regards experts may indeed prove to be a barrier to the access to justice.

A Claimant will almost inevitably need advice from an expert in a potential clinical negligence at the outset to be able to evaluate the breach of duty/causation issues i.e. whether there is a case and also worth pursuing (sometimes more complex as an issue than breach of duty; given that the nature of this claim pre-supposes a need for treatment). For obvious reasons the Defendant will always have the advantage that those accused of breach of duty have the relevant expertise.

[1] CPR – Civil Procedure Rules

This currently makes the use of a single joint expert at pre-action undesirable. If the Claimant has to use a single joint expert before any letter of claim (who cannot be asked to provide advice in conference etc) from a centrally held list there will be a feeling of material disadvantage/lack of (even handed) access to justice. Put simply, expert opinion is often needed before a letter of claim is issued. A big difference between clinical negligence cases and many other forms of litigation (such as personal injury) is that, save in the most unusual cases, the solicitor cannot advise as to breach without an expert report.

If fees for experts in cases under £25,000 are inadequate then experts may refuse to take instructions in these cases (preferring to restrict their work to larger value cases).

The problem becomes more acute in areas of specialisation where there are fewer experts willing to undertake medico-legal work. A sum of £1200 to cover a report, a conference and a joint report with an expert instructed on behalf of the Defendant will not be thought by many experts to be adequate remuneration (particularly in some specialist areas); and the position is highly unlikely to allow more than one expert to be instructed; which is necessary in some cases.

The Judiciary sees expert costs through costs recovery. In many cases an initial report will cost £1500 or more (in case of a specialism such as neurology often significantly more); so capping fees at £1200 would be unrealistic on the current market (it is to be noted that there has been no analysis of expert fees), and would prevent many cases being brought, particularly in certain clinical disciplines.

So the paper, whilst recognising the need to ensure that Claimant lawyers are not deterred from taking on low value cases, fails to adequately recognise the need to ensure that experts, critical in this type of litigation, are not deterred. That is not to say the court should not seek to exercise controls on expert costs given the context of lower value claims.

The Council believes that the proposals do not adequately address the issues of complexity of litigation and the need for expert evidence, and as a result; experts.

However, as a general principle none of these concerns should give the impression that the Council does not support the application of fixed recoverable costs in principle. It does so, as a means of reducing litigation costs and increasing greater proportionality if costs, where the FRC regime is structured and financed properly.

The Council notes that this consultation has taken place in parallel with the wider review of fixed recoverable costs undertaken by Lord Justice Jackson. We hope that the results of both exercises will be pooled and analysed in full by the Government before bringing forward finalised reform proposals.

The Council raises the issue of the whether there may be space for a bolder vision for smaller value clinical negligence cases with a streamlined procedure.

Answers to specific Questions

Question 1: Do you agree that Fixed Recoverable Costs for lower value clinical negligence claims should be introduced on a mandatory basis?

The Council supports the application of fixed recoverable costs in principle, where the FRC regime is structured and financed properly.

Question 2: Fixed Recoverable Costs Ranges – do you agree they should apply above £1000 and up to £25,000?

Claims under £25,000 are not subject to costs budgeting if kept on the fast track. However, due to complexity and length of hearing, Clinical Negligence claims often get allocated to the multi-track. They should still be subject to budgeting (albeit only the first page of the Precedent H costs budget form).

In reality, the problem is that the court cannot costs manage those costs incurred before, and as claimants in clinical negligence will normally have to seek expert evidence to establish the validity of a claim prior to issue, costs are front loaded and expended before the court can manage them. Another factor is the court's obligation to assess proportionality, and the unusual if not unique disparity in the damages/costs ratio for clinical negligence litigation compared with other work.

However there is a risk of being out of kilter/incompatible with other Multi-track cases if fixed costs are introduced for cases of more than £25,000 and issues with access to justice that increase with the value and complexity of the claim. Therefore we would regard the upper ceiling of £25,000 as appropriate, and we welcome the dropping of the pre-consultation suggestion that fixed costs be applied in cases up to £250,000 in value.

Question 3: Options for implementation

The root problem in setting transitional provisions for the introduction of a new costs regime is that - unlike many other areas of litigation - much investigation, obtaining records and the instruction of an expert may have taken place before the letter of claim has been prepared. Indeed, the current pre-action protocol states:

> *3.11.1 Following receipt and analysis of the records and, if appropriate, receipt of an initial supportive expert opinion, the claimant may wish to send a Letter of Notification to the defendant as soon as practicable*.

So if implementation covered a letter sent after the date it would retrospectively catch cases where substantial work had been done on one expectation of recovery on current basis.

Question 4: Setting rates

Cases in Clinical Negligence litigation vary very considerably in terms of complexity, and this does not lend itself to a fixed costs regime based on a time analysis approach as proposed in options 1, 2 and 3. The CJC favours a current costs based analysis - option 4. This is consistent with other fixed cost rules and more evidence-based in terms of costs of existing cases. Option 4 is thus the least subjective and the most likely to enable continued access to justice.

Question 5: Expert witness costs, and a maximum cap of £1200

We are opposed to the imposition of a flat cap for all expert witnesses. The instruction and payment of experts will be a problematic issue in applying a fixed costs regime. There is a substantial risk that many current experts would refuse to do lower value work. This problem will be especially acute in specialised areas of medicine where there are limited numbers of

suitable experts. Setting a blanket cap would make it less flexible and responsive to market and inflationary pressures in the future.

The consultation paper itself envisages cases in which more than one expert is properly required (paragraph 6.11). Is the flat capped fee of £1,200 to cover all work including a conference answering Part 18 questions and trial attendance?

Question 6: Single Joint Experts (SJEs)

We regard this proposal as highly undesirable. Without an expert report a claimant cannot evaluate if he/she has a claim, and this raises issues about how a SJE could be properly instructed pre–issue. It would also require a re-think of the current pre-action protocol (see comments below in the response to question), which in any event allows for SJEs to be appointed where the parties are able to agree. There are potentially large costs associated with establishing and maintaining a register of experts for this purpose.

Question 7: Early exchange of evidence

We agree that there should be an early exchange of witness evidence. However, in most cases the parties will necessarily require expert evidence before a view can be taken and the case settled. How can the instruction of an SJE pre-issue be woven into the protocol (obviously there is no desire to increase costs by making that expert unavailable if the case is issued)? That is not addressed and is a lacuna within the approach.

Question 8: Draft protocols and rules

- *Trial costs* – we agree with the proposal if the trial is one day's duration, given that the proposal is based on a Fast Track trial which is by definition a one day one. However, if it is two plus days we consider a higher fee should apply.
- *Multiple Claimants* – we agree with the proposal.
- *Exit points* - we agree with the proposal, and the principle that there should be exit points.
- *Technical Exemptions* - we agree with the proposal.
- *More than two experts* - we agree with the proposal.
- *Child fatalities* - we agree with the proposal.
- *Interim applications* – in a Clinical Negligence Multi-track claim there are inevitably experts involved and this necessarily requires two hearings. One to determine in which disciplines they are required (at the time of setting the trial timetable) and a second to determine whether such experts will be called and whether the case is ready for trial (plus the length of trial etc). So there is normally a minimum/usual requirement of two hearings. Beyond that there may be further applications but the costs should be free standing (i.e. the winner should recover their costs), and the court will award costs on a proportionate basis.
- *London weighting* - we agree with the proposal.

- *Practice Directions* - we agree with the proposal. The Civil Procedure Rule Committee has the option of undertaking its own consultation on post-issue processes.

Question 9: Behavioural Change

NHS Resolution (formerly NHSLA) has made significant efforts to increase the number of cases resolved by ADR, including establishing a panel of independent mediators. This will undoubtedly increase the number of ADR mediated outcomes with cost savings.

Question 10: Evidence

The CJC does not hold such data.

Question 11: Equality impact assessment

The CJC notes with concern the paucity of data on the potential impact of the reforms on some protected characteristic groups (including people with disabilities and from ethnic minority communities), and it hopes that other consultation respondents will be able to provide data. The Department is to be commended for having established an Equalities Advisory Group for this exercise, although the CJC feels its work would have been better informed by extending membership to equalities groups, alongside providers and patient groups.