Response to Civil Justice Council Interim report on ADR and Civil Justice

1. The following comments are made only in the context of the role of ADR in clinical negligence claims and disputes and in response to questions 10.8, and 10.12.- 10.13

2. It is trite to note that the concept of introducing compulsory provisions to require parties to mediate – even by way of a procedural hurdle rather than a bar – has never sat easily with the ethos of ADR and risks being struck down as an erosion of the jurisdiction of the Courts and the ECHR rights under Article 6.

3. Sanctions – in the form of "penalties" may be developed in relation to costs where parties refuse without good reason to engage in ADR but – as history shows – are not easy to develop into a code which is clearly understood or consistently applied. Apart from promoting engagement in ADR as a factor to be taken into account on costs it is difficult to see what more can be done.

4. In both cases there is an allied disadvantage that such measures will not – in either case – win over any hearts and minds to mediation or change the culture.

5. I therefore do not favour either "Type 1" or "Type 2" compulsion but regard Type 2 as more workable

6. If compulsion is to be introduced both clinical negligence and boundary disputes would be eminently suitable classes of case in which to conduct a pilot.

7. But it might be more effective to consider ***incentives*** rather than sanctions and to consider building on the existing framework of the CPR rather than introducing new prohibitory or penalising provisions.

8. CPR Part 36 and in particular 36.17 already contains a set of mechanisms for enhancing the impact of Part 36 offers and thereby encouraging litigants to make such offers. These mechanisms are a blend of financial incentives for those who make early and realistic offers and financial consequences for those who do not respond constructively to such offers.

9. The use of mediation in clinical negligence claims could be promoted by (a) constructing a bespoke mechanism of a similar kind for offers made in mediations or (b) making the operation of CPR 36.17 in clinical negligence claims dependent upon the parties engaging first in mediation.

10. The first approach might be achieved by giving special status (with enhanced consequences over and above those provided for in 36.17) to "part 36 offers" made either at or after the mediation. The mediator could perhaps be asked to "certify" that the relevant offer was made at the mediation or the rules could simply define such offers by reference to the date of an effective mediation – or there could be different consequences for each type of offer designed to encourage parties to bring forward their "best" proposals at the medation.

11. The second approach might be achieved merely by amending 36.17 so as to make it clear that in clinical negligence claims there would be (a) no entitlement to make Part 36 offer with full cost enhancements unless such an offer is made after mediation has been

offered and unreasonably refused. This inhibition could be “strict” or it could be worded in the manner of a presumption – adopting CPR 36.17(4) – i.e. as a provision which denies such enhancements “unless the Court considers it unjust to do so”

12. The latter approach would be less radical and easier to introduce but by the same token may not carry the same bite. Litigants would be quite likely to behave exactly as they do now – but merely to take advantage of the provision as a potential tactical bonus. Nor would it be easy to enforce without unpredictably and undesirably extending disputes over costs.

13. The former approach – even if qualified by a similar discretionary provision – as the advantage that it would provide a positive incentive on parties to engage in mediation and – having done so – to make Part 36 offers which – if the incentive is to be realised – must nevertheless be realistic and “better” than the ultimate result at trial.

James Watson QC

11th December 2017