RESPONSE TO CIVIL JUSTICE COUNCIL'S CONSULTATION ON COSTS:

13th October 2022

1. About AvMA

1.1 Action against Medical Accidents (AvMA) is the national patients' charity for patient safety and justice. We provide free independent specialist advice and support to patients and families who have been affected by avoidable harm in any kind of healthcare. This provides us with a unique and extensive insight into the experience of patients and families following such patient safety incidents. We use this experience and our knowledge of the healthcare system to work with others to develop policies, systems and practice to improve patient safety and the way that patients and families are treated following avoidable harm.

1.2 Although most of the people AvMA help do not go on to make a clinical negligence claim, such claims are a vitally important option for many who need compensation to help cope with the implications of the injury or loss that has been sustained, and/or have exhausted other attempts to resolve their concerns and hold the organisation responsible for the injury to account. We have therefore always taken a strong interest in clinical negligence and have extensive in-house knowledge of how the system works.

1.3 We accredit specialist claimant solicitors and provide training for lawyers practising in clinical negligence. We get useful intelligence from the claimant lawyers we work with and from medical experts which we use to help inform our response.

1.4 As part of the AvMA accreditation process we ask individual lawyers to identify what percentage of their caseloads are valued at under £30,000 and then what percentage are valued at £30 - £100,000. We ask about how firms risk assess cases, what stage they meet with their client, how they manage client expectation, instructing medical experts and counsel. We also explore how many cases settle before and after proceedings commence and whether the solicitor has been able to assist the client with bringing a complaint and/or referring an individual to the professional regulators eg GMC, NMC etc.

1.5 However, our focus is always on the needs of injured patients and their families and on representing their interests.

2. Our Experience:

2.1 AvMA services provide advice, information, and signposting to the public. Our advice and information can be delivered via our telephone helpline service which is open to the public five days a week, from 10.00 am to 3.30 pm. The helpline is staffed by professional volunteers, mainly clinical negligence lawyers and some medics, who have been trained by experienced AvMA staff.

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

2.3 AvMA operates a pro bono inquest service for members of the public whose loved one has died as a result of, or where healthcare service provided or omitted are thought to have contributed to the death. AvMA works closely with the bar, especially chambers leading in the field of clinical negligence to arrange representation at the inquest hearing for cases that meet our criteria.

2.4 AvMA understands the litigation process but importantly, does not act for its beneficiaries. AvMA does not issue proceedings or run litigation or enter any sort of funding arrangement.

2.5 If a beneficiary needs or wants to bring legal proceedings then AvMA will signpost them to an AvMA accredited solicitor for further advice and if appropriate, representation. However, beneficiaries who act as litigants in person are given generic advice on the process as well as the risks associated with acting in person. AvMA does not tell beneficiaries how to proceed, only what options are open to them and what the various steps in the litigation process mean.

3. Our Response:

3.1 AvMA is responding to this consultation on the basis that the working group has stipulated that this costs review is intended to be holistic in nature. AvMA notes that the CJCs primary focus is on costs budgeting; guideline hourly rates, costs under pre action protocols/portals and the digitisation of the justice system and the consequences of the extension of fixed costs.

3.2 It is outside of AvMA's remit to speak with any authority on the issues of focus, namely: Costs budgeting; Guideline hourly rates; Cost under pre action protocol/portals and the digital justice system; Consequences of the extension FRC.

3.3 AvMA has responded to this consultation on the basis that our overview of the litigation process and in particular the challenges it poses for individuals as members of the public does enable us to contribute to this review.

3.4 In 2022 alone, over 400 people downloaded our costs leaflets (costs principles: https://www.avma.org.uk/wp-content/uploads/Costs-principles.pdf and understanding legal costs: https://www.avma.org.uk/wp-content/uploads/Understanding-legal-costs.pdf). We deal with close on 100 calls to the helpline from members of the public who need advice and assistance with costs related issues.

4. Consequences of the extension of Fixed Recoverable Costs:

4.1 AvMA's experience is with clinical negligence cases. In responding to this consultation, we are mindful that the CJC Costs Working Group – Consultation Paper of June 2022, does state: "***Nor is it part of the Working Group's remit to cut across the work being done relating to costs in clinical negligence cases. Rather the Working Group is tasked with considering the wider implications of the changes to FRC for the rest of the civil justice system…" (para 48).***

4.2 The government's consultation on fixed recoverable costs in low value clinical negligence claims closed at the end of April 2022, the government has yet to publish their reply to the responses received. There is no indication of when this might be expected.

4.3 AvMA accepts that it is far from clear that fixed recoverable costs in low value clinical negligence claims will be introduced. However, if they are introduced in low value clinical negligence claims it is also unclear whether the government and/or the CJC will create an opportunity for discussion on fixed costs in clinical negligence and its interaction with access to justice. Issues around digitisation of the justice system, vulnerable court users and a functioning civil justice system, not just as a bedrock of the economy, but especially as a forum for promoting rights and an opportunity for dispute resolution are important issues for members of the public bringing clinical negligence claims.

4.4 In June 2022, AvMA received a letter from the then Parliamentary Under Secretary of state for Primary Care and Patient Safety, Maria Caufield who made clear that she was looking at fixed costs in low value clinical negligence claims to enable claims to be "***…processed more quickly, enabling faster resolution for claimants and defendants at a lower, more proportionate cost than under the current system. The consultation proposes a set of fixed legal costs for lower-value claims…and a new streamlined process to promote faster resolution for all parties."*** Ms Caufield went on to say: ***"Only the amount of legal costs recoverable following a successful claim is affected, and not the compensation that a claimant could receive."*** In our view that is wrong and shows a fundamental misunderstanding of how Conditional Fee Agreements operate.

4.5 The concept of fixed recoverable costs sits alongside a Conditional Fee Agreement (CFA) which dictates the solicitor/client hourly rate. Any shortfall in

costs agreed under a CFA is payable out of the client's damages. There is no protection for the client's damages when it comes to a shortfall in the solicitor/client own costs – unlike a success fee which is ringfenced to no more than 25% of a client's recovered past losses and general damages. This means that it is entirely possible that a considerable portion of the client's damages will be reduced to cover their legal costs, it is equally possible that a shortfall in costs could wipe out a client's damages altogether.

4.6 Costs are complex and there is an inequality of bargaining power between a client and a solicitor. The decision of the Court Appeal in the Belsner case may help to improve the issue of inequality, although that remains to be seen. Even if Belsner is found in favour of the claimant, it will remain the case that while it is entirely possible that some members of the public seeking clinical negligence services will "shop around" for the best hourly rate, these people are the exception, not the rule. It also has to be recognised that providing people with more information does not mean they are in a position to give informed consent. There needs to be an understanding of how costs operate.

4.7 To prevent a fixed costs regime from impinging on an injured persons compensation, the fixed rates offered need to be high enough to be commercially viable for firms. The remuneration offered on a fixed costs regime should reflect the market rate. If that were to happen lawyers would be less likely to have to deduct money from client damages or could more easily limit the amount deducted from client damages. The rates need to be indexed linked so they remain attractive and economically viable. Penalties for failing to make reasonable offers of settlement and or to seek to settle at all should be sufficiently severe to make them worth paying attention to and for lawyers to want to avoid them.

4.8 Fixed rates should be high enough to stand alone, without a CFA being introduced to prop them up. It may be that the Guideline Hourly Rates could be used as a gauge for whether the hourly rate charged in a CFA is fair and reasonable. That will require those rates to be reviewed regularly. However, the details of this are outside of AvMA's remit.

4.9 While fixed rates remain low and sit with a CFA, then access to justice will be compromised. The cost of clinical negligence litigation will not be reduced because fixed costs are introduced, all that will happen is that cost of litigation will effectively be shunted from the original tort feasor – in a clinical negligence claim, that is likely to be the NHS (via NHS Resolution) or similar defence/indemnifying organisation to the injured party. The injured party is then effectively paying twice, once with their injury and then again financially, out of the damages awarded to them.

4.10 A failure to protect the injured party's damages will give rise to a situation whereby the claimant receives no benefit from bringing litigation. While that will

save costs, it will not create accountability, it will not promote patient safety and it will not be a fair and equitable system.

4.11 If specialist lawyers are unable to undertake low value claims on rates which are economically viable to them, they will simply not take those cases on. If, the proposals on fixed costs in low value clinical negligence claims remain unchanged and CFAs continue to sit alongside an inadequately remunerated fixed cost regime, specialist lawyers will simply refuse to take those cases on.

4.12 Reputationally, many specialist clinical negligence lawyers will not risk a situation where their client's damages are significantly reduced to ensure the litigation undertaken was adequately funded. Injured patients will not be able to find a lawyer to represent them, this becomes an access to justice issue.

4.13 AvMA has long called for a proper review to identify the factors that give rise to high costs – this exercise would enable stakeholders to identify the root of the problem. It could be done collaboratively with defendant organisations, but it has not been done. Identifying the root of the problem will enable parties to tackle it properly and effectively.

4.14 There is no evidence that the current fixed costs proposals for clinical negligence will be truly effective. It will prevent claims being brought because lawyers will not represent clients for the reasons identified above. Where lawyers do represent clients it will be on the more obvious cases, where liability is less likely to be in dispute, the so called "barn door" cases. Other, more complex cases will fall away, reducing the number of claims being made – savings will be achieved through cases not being brought, not because fixed costs are a success.

4.15 This will likely have unintended consequences for the NHS and other defence organisations. Specialist claimant solicitors currently 'screen out' the majority of unmeritorious clinical negligence claims. Non specialist solicitors will be less effective in screening cases out which may result in defence organisations having to spend more time and money on dealing with cases that are not likely to succeed.

4.16 Fixed costs in clinical negligence claims will not head off a deny and defend culture. On the contrary, it will encourage it as defendants will be aware that tactically, claimants can be priced out of a claim if it is defended.

4.17 The inability of some would-be claimants to challenge denials through legal action will damage public confidence in the NHS and the court system.

4.18 AvMA is mindful that the fixed costs regime does not offer any suggestions or means of encouraging learning from litigation. The best way to save money as well as the human cost of clinical negligence is to invest more in patient safety – preventing the mistakes happening in the first place.

4.19 AvMA has offered some suggestions on how this can be achieved but there needs to be greater emphasis on this. This important cost saving aspect has been ignored under the proposed fixed costs in low value clinical negligence claims regime. Money is a blunt tool for most clinical negligence claimants, what they really want is to make sure the same mistakes are not made again. AvMA would suggest that ultimately, this is what healthcare providers want too.

4.20 Healthcare providers do not qualify and devote their lives to serving others to cause harm. The effects of making a mistake, especially one which causes additional harm to another person in need of care is devastating for professionals. We do not support a system that vilifies medical professionals – that is not what accountability is about. It is not what most claimants want either.

4.21 Medical professionals want the ability to learn from their mistakes and for those mistakes to be shared so they are not repeated by others. Fixed recoverable costs does not offer a way forward on this, this is a missed opportunity.

4.22 Jackson LJ recommended operating a docketing system. This would enable specialist judges to retain cases assigned to them so there was at least consistency in approach. Docketing also lends itself to a more efficient use of court time and consistency of approach. This would result in fairer judgements, better use of court time and ultimately costs savings.

5. Digitisation of court process

5.1 **Use of remote and partial remote hearings:** During the Covid 19 pandemic, AvMA's Pro Bono Inquest Service gained experience of supporting clients where Pre Inquest Review Hearings and the inquest hearings were held either remotely or partially remotely. AvMA has first-hand experience of the pros and cons of experts and witnesses giving evidence remotely, as well as problems with digital poverty or lack of confidence with IT generally.

5.2 On the plus side, it is correct to say that many grieving families like being able to access the court process from the comfort of their homes. It takes the anxiety out of travelling and from having to attend a legal process which is formal in nature and foreign to the bereaved. That is an important factor, given that grief can manifest itself in many ways, including depression, self blame, and loss of confidence. Those factors can also give rise to grieving families being unable to work which in turn has economic consequences for them and society.

5.3 It is also a convenient way to access treating healthcare workers who already have considerable demands on their time. From that point of view it is both cost effective and time efficient, in turn this may lend itself to expediting the hearing process. Time is not lost looking for a day when all the witnesses are available to travel and attend court to give evidence.

5.4 Some grieving families can find it difficult to be in the same court building as a healthcare provider who they perceive was responsible for or contributed to the death of their loved one. Remote hearings can put distance between the bereaved and the treating clinicians and many members of the public feel more secure in that knowledge.

5.5 There are clearly positives with remote hearings, the gravitas associated with a formal hearing can be lost or at least dissipated through the use of remote hearings. It can be difficult to know if a witness is being unduly influenced or being interfered with.

5.6 While it has not happened in any of AvMA's cases we are aware of situations where the person giving evidence under oath has been reminded by a family member to mention a particular point they considered pertinent. There have been other reports of witnesses being offered a cup of tea in the middle of giving evidence. These situations are difficult to police, monitor and manage - partial remote hearings may offer a compromise in these circumstances.

5.7 However, even hybrid hearings can be challenging especially where the allegedly negligent witness or witnesses do not attend in person. It can also be difficult to examine and cross-examine professional witnesses remotely. AvMA is aware of at least one case where the CVP link which enabled those attending court to see the remote witnesses give their evidence, failed.

5.8 It was also a case where it was clear that the technology required to support the process was not available. Issues included the sound quality - feedback was an issue as was the sound of the witnesses' voice bouncing back at them. This made it difficult to examine and cross examine the professional witnesses and the witnesses of fact and did not lend itself to a fair trial.

5.9 It should be recognised and openly acknowledged that remote and partial remote hearings are not a panacea. A lot is lost by examining a witness remotely, many important human interactions and observations are lost in remote hearings.

5.10 If remote technology is to be used there need to be clear and easy to use guidelines to ensure that there is parity between the parties and the trial is fair. Parity between the parties should include that all those participating remotely have access to and be confident in the use of the technology.

5.11 Both parties should have the confidence to use the IT, have equally good access to reliable and sufficiently fast Wi-Fi, broadband and equipment to enable them to participate in the process. Consideration should be given to whether a remote or partially remote trial is appropriate at all where one of the parties has English as a second language and/or where capacity is an actual or potential issue. These issues are likely to be particularly relevant to elderly people and those with learning disabilities.

5.12 There need to be safeguards to protect witnesses, especially lay witnesses. Due regard should be given to the complexity of the case, this is more than just the issues in the case, the number of people required to give evidence and potentially the value of the claim should be a consideration. However, it must be noted that in clinical negligence claims, a low value claim does not mean the case is not complex.

5.13 Just because a case can be conducted remotely, does not mean that it should be conducted remotely. More work on safeguarding the remote hearing and trial process needs to be carried out to ensure that these hearings remain fair and fearless.

5.14 **Use of IT more generally**: AvMA is supportive of the concept of using IT to improve the court system. The delays in the civil justice system are well documented and if IT can be used to speed up and improve the litigation process then it must be introduced. However, proper provision needs to be made for those people who are not able to use online systems, whether because of socio-economic issues, poor Wi-Fi and/or broadband speeds and accessibility issues. According to Ofcom, 1.5 million households still do not have Wifi: Digital divide narrowed by pandemic, but around 1.5m homes remain offline - Ofcom and the ones that have caught up are still potentially functioning at a learner level. A failure to do so, will result in an inequitable legal system and that cannot be allowed to happen.

5.15 The burden of proof in clinical negligence claims is a high bar and difficult to discharge. AvMAs support for improving technology in the courts should not be confused with support for creating a clinical negligence portal which claimants' access without legal advice, support and/or proper evidence.

5.16 **Portal systems**: There has been a suggestion that a portal system should be set up for all civil cases in England and Wales. AvMA has not seen any proposals for how a portal would work in clinical negligence claims – would it be restricted to low value claims? Or all clinical negligence claims? There is a real difficulty in responding to this point in a vacuum, where there are no specific proposals for consideration. In light of that, AvMA has commented in general terms.

5.17 There are various views on whether the portal for low value personal injury claims, (RTA, employers liability claims and public liability claims) is indeed successful.

5.18 It is understood that the low value personal injury portal is designed to be used where there is only one defendant. Cases which proceed against more than one defendant fall outside of the portal system.

5.19 It is not unusual for there to be more than one defendant in clinical negligence cases. Despite initial investigation it can be difficult in practice to identify liability and there may be an argument on contribution. Practitioners should not be

penalised for doing their job properly and protecting their injured client's interests. These cases should fall to being assessed in the usual way, on the standard basis and should not be subject to fixed costs.

5.20 AvMA is aware of the case of Madej v Maciszyn [2013] the Court of Appeal considered where ***"…a claimant is a child, or someone who cannot speak English, or who requires an intermediary, is nothing to do with the dispute itself". Age, linguistic ability, and mental wellbeing are all characteristics of the claimant regardless of the dispute. They are not generated by or linked in any way to the dispute itself and cannot therefore be said to be a particular feature of that dispute"***

5.21 AvMA suggests that had this been a clinical negligence claim, the Court of Appeal may have found otherwise. AvMA is mindful of the 2020 LeDeR report: https://www.england.nhs.uk/wp-content/uploads/2021/06/LeDeR-bristol-annual-report-2020.pdf which identified that ***"preventable medical causes of death in adults were 24% in 2018, 23% in 2019 and 24% in 2020. For children the proportion was 10% across the three years. Treatable medical causes of death in adults were 41% in 2018, 40% in 2019 and 39% in 2020. For children, the overall proportion was 29%. Compared to the general population, people with learning disabilities were more than 3 times as likely to die from an avoidable medical cause of death (671 per 100,000 compared to 221 per 100,000 in the general population)."***

5.22 The CQC also recognised a lack of attention being given to people with learning difficulties and or mental health problems who die: https://www.cqc.org.uk/news/stories/deaths-people-learning-disabilities-or-mental-health-problems-not-always-given-adequate

5.23 The CQC noted: "***We also found that the deaths of people with a learning disability or a mental illness do not consistently receive the attention they need."*** The report also quoted Professor Sir Mike Richards, Chief Inspector of Hospitals, said: "***Investigations into problems in care prior to a patient's death must improve for the benefit of families and, importantly, people receiving care in the future... This is a system-wide problem, which needs to become a national priority."***

5.24 The above independent findings would strongly suggest that a claimant's capacity and mental wellbeing will almost certainly be factors in clinical negligence cases. The features of a claimant in a clinical negligence claim may be integral to the nature of the dispute itself.

5.25 It is understood that medical evidence for whiplash and low value RTA cases can be obtained inexpensively. However, a distinct difference between low value PI claims and clinical negligence claims is that in low value PI claims, liability can generally be determined with reference to statute. The facts will enable an assessment to be made.

5.26 In clinical negligence claims, liability can only be determined through consideration of independent expert evidence stating what the standard of care is, what the standard of care provided was and whether it fell below an acceptable standard. It goes without saying, that experts hold differing views on their interpretation of the standards within the profession and ultimately the decision may rest with whose expert evidence the judge prefers. That is far more subjective than referencing liability to provisions in statute. The expert's evidence does need to be tested in conference prior to claimants being put to the expense of issuing proceedings.

5.27 The medical expert evidence in a clinical negligence claim, will invariably require careful consideration of the medical records and other documents, including available witness statements. Where relevant the claimant's witness evidence should be considered too. The complex nature of the medical issues in a clinical negligence claim means that reports on liability and/or causation cannot be done cheaply. To this extent the current PI portal which offers inexpensive medical reports offers no comparison.

5.28 However, a portal could be used to speed up access to information which is being disclosed under the Pre Action Protocol for Resolution Clinical Disputes, so the court can track the nature of the disclosure and form an early view on how open and honest parties have been with each other. We would support the court having access to this information but important safeguards such as specialist clinical negligence judges and docketing of cases should also be introduced. AvMA believes specialist judges would be required so a proper assessment of the disclosed evidence and the value of it can be made.

5.29 AvMA can see benefits in a portal being used to exchange medical evidence providing there are safeguards for ensuring that exchange of evidence is simultaneous, not sequential. Sequential exchange will not encourage defence organisations to carry out their own robust, independent, impartial investigations and assessments of the circumstances of the alleged breach. Instead, it will encourage defence organisations to simply focus on the evidence contained in the claimants reports and respond to those elements of the claim only. That will be a loss for patient safety.

5.30 In conclusion there are benefits in principle to using a designated clinical negligence portal but more detail is required to ensure it operates fairly and to its maximum effect.

6. Vulnerability:

6.1 Clinical negligence clients invariably have an underlying health issue, this is the reason they sought medical advice in the first place. It is for the client/claimant to discharge the burden of proof and demonstrate that the medical care provided

(or omitted) fell below an acceptable standard and consequently they have suffered further injury. That is a high bar and a complex test for most members of the public.

6.2 Without exception, clinical negligence clients/claimants have experienced detrimental health issues. Those who have experienced additional injury because of negligent treatment are further injured and may have experienced financial loss too. For claimants bringing an action on behalf of someone who has died, whether a dependency claim and/or statutory bereavement claim they will also be coming to terms with their loss and grieving.

6.3 These claimants are vulnerable. It is imperative that they can protect their rights and recourse to litigation should that be necessary. This means providing them with access to specialist lawyers who are experienced at managing the dynamics and emotions that invariably accompany clinical negligence claims. It also requires the legal system to recognise at the outset of the claim that their vulnerability is clear and obvious. It is difficult to see any rational justification for saying that a court can only decide vulnerability at the end of their case.

6.4 The facts should be allowed to speak for themselves, the vulnerability of clinical negligence claimants should be readily identified and accepted at the outset – there should be a presumption of vulnerability in these cases. The defendant organisation should be able to provide evidence of why the claimant should not be considered vulnerable so the presumption can be rebutted if demonstrated.

7. Costs under pre action protocols

7.1 Even when harm is caused most of the legal costs can be avoided if the case has been investigated properly and early admissions and offers made. Currently, the NHS defends too many cases for too long, causing high legal costs to be run up. Around 80% of cases where legal proceedings have been issued settle in favour of the claimant.

7.2 Many clinical negligence claimants see litigation as a last resort and trial as something that should be avoided, if possible. We are supportive of clients/claimants having access to dispute resolution.

7.3 AvMA also supports a judge being able to give due consideration to whether a claimant had no choice but to bring proceedings because other non-litigious processes had failed them. To this end, the consideration of at least compliance with Pre Action Protocol for Clinical Disputes in a timely, efficient and reasonable way should be examined. Parties who for no good reason do not comply with the protocol should be penalised.

7.4 AvMA supports the court taking this further so that conduct prior to the Pre Action-Protocol stage can be considered with a view to identifying if there were failed or missed opportunities to resolve the claim. For example, this would mean looking

at how the healthcare providers complaints process operated and examining why the failings were not picked up beforehand.

7.5 There are other opportunities to resolve clinical negligence claims, it does not just rest with the complaints process. There are obligations under the statutory Duty of Candour and Serious Incident Reporting process also. The court should be in a position to ask: Could and should the issues in the case have been further narrowed and/or resolved without the need to implement the Pre Action Protocol for Resolution Clinical Disputes?

7.6 In circumstances where an offer to settle has been made in the pre protocol stage or following the implementation of the Pre Action Protocol process, the courts should also be able to consider whether the offer was fair and reasonable given the level of injury.

7.7 It can be the case that offers to settle are made to claimants in person but when they seek independent legal advice, only then do they understand whether the offer made was a fair and reasonable one. It is important that offers to settle are fair and reasonable and can be justified.

7.8 A system of reviewing the evidence to determine whether the party's behaviour was reasonable and complied with the spirit of the Pre Action Protocol would operate most efficiently if designated clinical negligence judges were appointed.

7.9 Jackson LJ recognised the importance of specialist judges and noted that this was a much more cost efficient and fairer way of conducting litigation. Experienced clinical negligence judges are well placed to be able to consider the information available and assess how open and honest parties have been with each other.

7.10 AvMA considers there to be some force behind the concept that judges should have power to impose penalties if a retrospective of the case shows parties missed opportunities to settle before issue, that is in the Pre Action Protocol stage. In a clinical negligence claim opportunities exist to admit liability even before the Pre Action stage, judges should be able to review these opportunities and decide whether an admission of liability could have been made and if so, why the opportunity was missed.

7.11 Where defendant organisations can be shown to be at fault for not resolving the claim in the pre litigation stage penalties might include the claimant's costs be paid by way of assessment on the standard basis. Those case should fall outside of any fixed costs regime which may be introduced

7.12 Equally, where the claimant has done all that was reasonably possible to use other forms of redress and opportunities to admit liability were missed, there should be additional compensation for the claimant. Claimants should not have to bring litigation to seek redress and admissions which can properly be made

without recourse to litigation. Additional compensation could be made by allowing an uplift on their damages of say, 20%.

7.13 Penalties of this nature would encourage parties to focus their attention on exhausting all processes (not just litigation and pre action protocol) and for admissions of liability to be made as soon as possible with a view to resolving matters at the earliest opportunity.

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