Scottish Government

Consultation on Recommendations for No-Fault Compensation in Scotland for Injuries Resulting from Clinical Treatment

A response by the Association of Personal Injury Lawyers

November2012

The Association of Personal Injury Lawyers (APIL) was formed by pursuers' lawyers with a view to representing the interests of personal injury victims. It is a not-for-profit organisation with over 20 years history working to help injured people gain access to justice they need and deserve. APIL currently has over 4,400 members, 170 of which are in Scotland. Membership comprises solicitors, barristers, legal executives and academics whose interest in personal injury work is predominantly on behalf of injured pursuers.

The aims of the Association of Personal Injury Lawyers (APIL) are:

- to promote full and just compensation for all types of personal injury;
- to promote and develop expertise in the practice of personal injury law;
- to promote wider redress for personal injury in the legal system;
- to campaign for improvements in personal injury law;
- to promote safety and alert the public to hazards wherever they arise; and
- to provide a communication network for members

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Introduction

APIL has been campaigning for better access to justice for victims of personal injury for over twenty years, and welcomes the opportunity to comment on the proposed no-fault compensation scheme for victims of clinical negligence. Whilst we recognise that the existing system needs reform, we do not believe that a no-fault scheme would be the correct choice at this time.

We believe that a no fault scheme would be lacking in several of the necessary components of a compensation scheme. Clinical negligence claims do not only involve difficult issues of fault. They also frequently involve difficult issues of causation and/or quantification. The proposed scheme does not adequately deal with those issues. Any person injured through negligence must continue to be entitled to litigate if he wishes to receive full compensation. Victims of clinical negligence should not be treated any differently than those injured by other types of negligence.

In addition, the system must allow for patients to raise their concerns with the Health Board. The current complaints system should be reformed to ensure that it addresses the concerns of injured patients to a satisfactory conclusion; this should include a thorough investigation which is transparent to ensure that on conclusion the patient or their family has the reassurance that the full circumstances of the incident have been investigated and where appropriate there is a satisfactory apology.

Any reforms to the current system should therefore focus on improving the process by which complaints and claims are pursued without reducing the value of, or access to, compensation. We propose in our paper below a number of cost neutral procedural improvements which could be made to the current system to ensure:

- Full compensation for the injured person;
- Swifter resolution of the claim,
- Reduction in cost for the defender.

APIL believes that these should be developed, in place of a no-fault scheme.

Executive Summary

APIL acknowledges that the current system for dealing with clinical injuries is in need of vast improvement. Yet this area of law is complex, and we believe that a no-fault system is not the correct option to achieve this improvement for various reasons:

- The Deputy First Minister has suggested that a no-fault scheme, could be implemented for potentially the same costs as the NHS currently pays in compensation and legal fees[1]. This is not realistic. It is not possible to say that a no-fault scheme would be cost neutral. The unanimous recommendation of the No Fault Compensation Working Party chaired by Professor Sheila McLean was that any such scheme would have to extend to not only Hospitals, but also all primary care providers including GP practices and private health care providers. The costings carried out by the Government are based on figures provided by the CLO and do not cover the costs of a scheme covering GP and private treatment. No adequate costings have been carried out in relation to the implications of such a scheme covering primary care providers (and GP's in particular). If a scheme were to be introduced without an increase in overall costs, there would be an increase in potential claims (there would no longer be any need to prove negligence, thus opening up the "flood-gates"), and if attempted, it would leave compensation awards decimated. There have been previous recommendations for improvement to the current system, for example by Lord Ross in 2003[2]; and there are likely to be other reforms recommended once Sheriff Principal Taylor concludes his review of expenses and funding in civil litigation cases. We believe that it would be premature to embark on a hugely expensive scheme when instead there are cost-neutral improvements that would deliver benefits for both the injured person and the defender.
- If a no-fault scheme were implemented, the volume of potential claims would increase substantially. In 2011/2012, the number of complaints received for hospital and community health services was 8,117 with 36.3 per cent these

[1] http://www.scotland.gov.uk/News/Releases/2011/02/18132915
[2] http://www.scotland.gov.uk/Publications/2003/03/16844/20522

complaints relating to treatment.[3] These people would all potentially be able to bring a claim under the no-fault scheme, as there would not be any need to prove negligence. Compensation costs would therefore increase significantly if a no-fault scheme were introduced, and in order to keep costs down, the damages awarded in each case would have to be reduced, and would thus be inadequate to fulfil the purpose of compensation in personal injury cases i.e. to put the injured person back to the position they would have been in had the incident not occurred.

- In addition, we believe that the proposed no-fault scheme would not be successful in Scotland at present, because those countries where a no-fault scheme is currently in place have a much more generous and effective welfare system. This is because the volume of claims in a no-fault system is higher than in a system based on negligence and the sums paid out in compensation in a no-fault system are lower meaning that the compensation will not fully cover the victims care and treatment needs. This does not matter in countries where the welfare system is such that that injured people receive the care and treatment that they require. A no-fault scheme in Scotland, on the other hand, together with the current welfare provision, would mean that people would receive insufficient compensation to ensure that they received the treatment and care required for their needs.
- A further issue is that the scheme proposed is a no-fault scheme, not a no-causation scheme. Causation is the most complex issue in most of these cases; therefore many of the problems associated with the current claims process will not be removed. In fact, the problems could get worse because a no-fault scheme could mean that lay people will be left to tackle these difficult issues without the benefit of legal expertise
- This is all the more so in relation to quantification. A no-fault scheme is not a no-quantification scheme. A no-fault scheme could mean that lay people are left to tackle complex issues of quantification without the benefit of legal

[3] http://www.isdscotland.org/Health-Topics/Quality-Improvement/Publications/2012-09-25/2012-09-25-Complaints-Report.pdf

expertise. This would lead to a serious risk of victims of clinical negligence receiving compensation which is insufficient to meet their losses and future needs. In contrast, the victim of a road traffic accident, for example, would not face that risk of under-compensation.

- APIL would also argue that it is unproven that a no-fault scheme, if implemented, would alter wider issues and create safer hospitals, or promote a system of increased openness and accountability. There is no empirical evidence from other no-fault schemes that this would be the case.

We have suggested within this paper several procedural improvements that could be introduced into the current system, which would go some way to tackling existing issues cost neutrally and effectively. We would suggest that these are developed and implemented, in place of a no-fault scheme.

Consultation Questions

Q1. What, if any, steps do you feel are necessary or appropriate to ensure that when an error has occurred, patients receive a meaningful apology?

APIL recently commented on the proposed Apologies (Scotland) Bill, and believes that receiving an apology is an important part of obtaining justice. At present, we see this as a problem area that needs improvement. Whether or not a Health Board provides an apology at all, and the standard of any apology, is varied. We strongly believe that there are several vital components to a satisfactory apology. An apology should contain acknowledgement of the facts, accountability, and reassurance that a factual investigation is taking place. What often happens is that Health Boards send out pseudo-apologies, which include phrases such as “We are sorry that you feel this way”. This leaves the victim feeling frustrated and ignored- they are not getting the answers and reassurance that they need. This can make recovery more difficult, as it can lead to stress and anger. The Health Boards are also incredibly selective as to the details they put into the apologies- they very rarely include a true and accurate account of what actually happened. It is not unusual for information to be deliberately withheld in the first instance, only being revealed after many attempts to obtain it. A real mistake will have been made but the apology given does not reflect this.

Q2. Do you agree that the principles and criteria set out above are essential in a compensation scheme? Are there any to which you would attach particular priority or importance?

APIL suggests that whilst the ideal system would comply with all of the criteria listed at paragraph 3.7.1 of the consultation paper, many are simply not achievable. The criteria therefore do not really aid in making any practical decisions- of course everyone would like a court system that satisfied all of these criteria, but this is not realistic. We would suggest that the first, third and fifth criteria are those that are most important and practicable. Specifically, we feel that it is essential that any system provides for an appropriate level of compensation to the patient, their family or carers; that the scheme is easy to access and use, without unnecessary barriers; and that timely decisions are made with regard to compensation.

APIL believes that the favoured Swedish no-fault model, to which the proposals suggest basing the Scottish no-fault scheme on, is flawed- as it does not match up to these essential criteria. We would argue that the Swedish system, if implemented in Scotland, would not give adequate compensation because a no-fault system would result in lower compensation awards as more claims would be made. The interim report of the Working Party (Chapter 3, para3.4) makes it clear that in the Nordic no fault schemes, *"levels of compensation remain relatively low by comparison to what claimants would receive for successful clinical negligence claims under delict/tort based systems*". The Swedish system works because their process of on-going care and rehabilitation facilities are different, and this means that lower levels of compensation can be awarded, as the victim will still get access to an appropriate level of care, medication and necessary equipment. This would not translate sufficiently into our system to ensure adequate compensation.

As well as a higher volume of claims reducing the amount of compensation awarded to victims in a no-fault system, the threat of lower compensation is also clear as the Deputy First Minister has suggested that any system imposed could be introduced for the same costs as the NHS currently pays out in legal fees and compensation. This would be unachievable for a no-fault system because of the volume of claims, and if it was attempted, it would also leave compensation sums decimated. For a

system in Scotland to work, it could not be cost neutral because the benefits system would need to be improved, to ensure that people received the care that they required. The no-fault scheme would substantially shift the cost to the welfare system. It would not be acceptable to have a no-fault scheme that will award lower compensation for clinical negligence claims than for road traffic accidents, where one has suffered the same injury.

Q3. Do you agree that these criteria are desirable in a compensation system?

The outcomes mentioned at paragraph 3.7.2 of the consultation paper are, as above, obviously desirable to any compensation system, but whether they are realistic and achievable is a different matter. In our view it is likely that not all of them are.

Q4. Do you have views or ideas on how a compensation scheme could more effectively contribute to the wider issues identified above?

APIL believes that it is naïve to think that wider issues will be changed by a no-fault compensation scheme. Even if an "at fault" clinician were not to face the prospect of having to give evidence in Court in a damages case, that clinician could still face (a) GMC proceedings, (b) giving evidence in a Fatal Accident Inquiry or (c) being pilloried in the press. A no fault compensation scheme will do little to create a culture of transparency and openness. If a clinician faces the prospect of being cross examined in an FAI or a GMC hearing, then the prospect of having to pay compensation will not really make a huge difference- that person will still have a damaged reputation. A no-fault scheme will not lead to a system of complete openness, because of these fears.

In addition, there is no empirical evidence from other no-fault systems (New Zealand for example) that this will lead to safer hospitals- the hospitals in New Zealand are no safer or more dangerous than hospitals in Australia or the United Kingdom[4].

There is even an argument that a no-fault system leads to less accountability and less responsibility, because if there is no-fault or blame, a person will get

[4] http://www.thompsons.law.co.uk/clinical-negligence/no-fault-compensation-scheme.htm

compensated but the mistake may not be traced back to an individual, and no one will be held responsible. This is unsatisfactory for victims, who would like to see that someone is held accountable, and that investigations are taking place to find out exactly what happened and to ensure that it does not happen again to someone else.

Q5. Based on the background information on the system in operation in Sweden given in Annex A, would you support the approach suggested in Recommendation 1?

The weakest point of the Swedish model is that it is a no-*fault* scheme, but not a no-*causation* scheme. Causation is often the most problematic area in these types of claims. Frequently, the case is much more complicated than just a question of whether the practitioner has been negligent. The patient often already has something wrong with them to start with, there is often a complex chain of events to establish and the pursuer must show that on the balance of probabilities, the negligent actions or omissions of the medical practitioner gave rise to the injury or death. If there is limited legal input, as there would be if a no-fault scheme was implemented, then lay people would be left to gather evidence regarding this complex area of the law without much, if any, legal knowledge or guidance. The injured person is not going to know what evidence they need to gather, whereas they will be up against the Central Legal Office, or a defence union such as MPS, who will have experience of dealing with these types of claims, and know exactly what kinds of evidence they will need to produce. This will lead to unjust outcomes. As Lord Ross stated in 2003, a no-fault scheme will leave people to tackle the complex issue of causation without the benefit of legal expertise[5]. It would surely be better to focus instead on improving the current system, where legal expertise is readily available.

A related issue is who will comprise the panel or tribunal that will be the decision maker in a no-fault scheme? The consultation does not provide any detail as to who this would be. Experienced judges currently have difficulty deciding these complex medical cases, so if the tribunal comprised of healthcare professionals or lay people, it is hard to see how they will cope and come to the correct conclusions. It seems

[5] http://www.scotland.gov.uk/Publications/2003/03/16844/20522

that the no-fault scheme would involve implementing an expensive structure to replace an experienced judge with a tribunal of lay people who will struggle to deal fairly with these complex issues.

A further problem is that there will still need to be expert evidence on causation- but again; the consultation paper does not detail who would pay for this, or how it would be obtained. It will be impossible for a lay person to identify the appropriate expert and to provide the appropriate level of instruction to ensure that an expert witness provides an appropriate report dealing with all of the issues. Nor would it be appropriate to have jointly instructed medical experts, as the burden of proof is on the pursuer to prove their claim and therefore they should have unrestricted opportunity to unilaterally investigate their case and select the evidence they intend to rely on.

If not, why not, and what alternative system would you suggest?

It is suggested that rather than implement a no-fault scheme that would suffer from the aforementioned issues, the current system should instead be improved. It has been suggested that comparatively modest changes could be made to effect a significant improvement in the operation of the existing system. For example, a Clinical Disputes Protocol (similar to the Pre-action Protocol already in place in England) could be brought into force to ensure speedier resolution of claims. A Protocol such as this would not involve any extra expense, but would bring about significant financial savings by reducing unnecessary delays and reducing the need for cases to be litigated. It is suggested that such a Protocol would incorporate some of the main features of the existing two Law Society of Scotland Protocols (which cover Professional Negligence and Personal Injury cases respectively), whilst also incorporating some of the features from the English Pre-action Protocol for the Resolution of Clinical Disputes. The main features of the Protocol would include an early and detailed disclosure as to the basis of the claim; early disclosure of records, statements and treatment information; early identification of relevant medical issues; timescales for resolution and an agreed scale of costs and expenses.

There is also potential for a voluntary simplified procedure for lower value claims. APIL is already in support of a similar scheme in England. A scheme such as this

would most likely be attractive to claimants and medical organisations alike. It is recognised that not all organisations would necessarily opt for a simplified scheme, and such a scheme need not be compulsory. Health Boards and defence organisations could then, if they wish, resolve lower value disputes in a more cost effective, practical and less adversarial manner. This will reduce the need for litigated cases where the costs are disproportionate in relation to the value of the claim.

A further potential reform could be the increased use of informal or formal mediation, comprehensively addressing all family issues (including issues of compensation), to reduce the need for Fatal Accident Inquiries. FAIs can be lengthy, stressful and cumbersome for those involved. It is suggested that the introduction of a scheme would at the very least be cost neutral, but in fact may result in considerable savings through avoiding unnecessary Fatal Accident Inquiries and reducing the requirement to pursue a claim for damages through litigation.

Q6. Would you support the approach in Recommendation 2? This would mean for example that where treatment carries a known risk and the patient has given consent to that treatment it would not be eligible. What other injuries would you consider should not be eligible?

We agree that eligibility for compensation should not be based on the "avoidability test", because there should be a presumption that all injuries are eligible unless specifically excluded. This would be expensive, but we have already pointed out the cost implications of a no-fault scheme, and feel that if it were still to be implemented, it should be implemented on the basis that all injuries are eligible unless specifically excluded. This will allow as many people as possible to have a potential claim should they suffer a clinical injury. An "avoidability" test may also lead to uncertainty in practice, as to what is avoidable and what is not.

Q7. Do you support the view that, if introduced, a no-fault scheme should cover all clinical treatment injuries (e.g. private healthcare and independent

contractors) and all registered healthcare professionals and not just those directly employed by NHS Scotland?

If the scheme is to be introduced, it is logical to extend the scope of it as broadly as possible- all claims relating to medical treatment should be included within the scheme. This is to avoid a bizarre multi-tier system, where a locum GP could be sued whilst working in a hospital A and E, but then they would not be sued for the same malpractice in their GP office. APIL fears however, that this would be difficult to enforce in practice, and more thought would need to be given as to how this could be done. More importantly, many cases of alleged negligence (such as failure to diagnose cancer timeously) can involve allegations that both the GP and the hospital clinician have been negligent. It is not uncommon for proceedings to be raised and claims made against both the GP and the Health Board. It would be wholly impracticable to have a system where a patient has to claim (under a no-fault scheme) in respect of a hospital failure to diagnose a tumour timeously, but has to make a completely separate claim (through the civil Courts) against the GP in respect of the GP's failure to refer the same patient timeously for that tumour.

What, if any, difficulties do you foresee in including independent contractors (such as GPs, dentists etc) and private practice?

There may be concerns for GP's, dentists and those in private practice regarding the costs of insurance for them under a no-fault scheme. Presumably a fund would be set up into which everyone pays (in the same way that the NHS does), which will then be used should those independent contractors be sued. Yet those who are paying in may not have control over how much they are contributing, and this could result in those independent contractors refusing to be a part of the no-fault scheme. A further difficulty with now including independent contractors is that the costings and feasibility of the scheme seem to have been worked out using the National Health Service Scotland Central Legal Office figures, which would not have taken into account independent contractors such as GPs or dentists, or those in private practice.

Q8. What are your views on how outstanding claims might be handled?

We suggest that a cut-off date will need to be implemented, where the old system tails off and the new system begins. We believe that the cut-off date should be applied to the date when the litigation is commenced- not from when the injury occurs. This will ensure that there is no unfairness in cases such as those where a parent delays coming forward with a claim on behalf of a child- they will have the choice to go down the no-fault scheme route. In addition, there needs to be a residual right to litigate once the no-fault scheme is implemented. If the no-fault scheme may result in smaller awards being made, it cannot be right to take away someone's right to litigate to get an award on a full basis, if they feel that this is the best option.

Q9. Do you support the approach in Recommendation 5?

APIL fully supports a needs-based system rather than a tariff-based system. There are problems with tariffs- as demonstrated by the CICA tariff, which leaves people under-compensated or in some cases not compensated at all because their injuries do not fall within the right boundary. Having a "one-size fits all" tariff based approach leads to unjust results. We submit that the quantification and assessment of damages should be based on the common law- people should not be put in a worse position if they decide to use the no-fault scheme, otherwise people will be forced to litigate in order to get the compensation that they deserve. People will not use the scheme if they can get the compensation they deserve by choosing litigation.

Q10. Do you support recommendations 6-9 as proposed by the review group?

APIL fully supports recommendations 6-9. We do not believe that having the right to litigate if one fails under the no-fault scheme (or vice-versa) is a problem. On the contrary, it will actually promote better access to justice. People will not be disadvantaged if they choose to go down one route but are unsuccessful, because they can always try the alternative route- people will not be forced into making the wrong choice. Recommendation 8 will ensure that there is not a risk of double-compensation if people are allowed to try both routes to gain the necessary compensation that they deserve. Appeals are also extremely important- on both law

and fact, as there needs to be a system of redress to prevent abuse of process or bias, for example.

Do you have any concerns that the Review Group's recommendations may not be fully compatible with the European Convention of Human Rights?

APIL believes that there would be no issue of potential violation of human rights if a no-fault system were to be adopted in full. As stated in *Vo v France*[6], there is a positive obligation to ensure that domestic law is adequate to make sure that medical staff could be called to account if they failed to protect patients' lives. Therefore if accountability is made a priority when implementing the scheme, human rights issues should not be a cause for concern.

Q11. Do you agree with the Review Group's suggestions for improvements to the existing system?

As mentioned above, APIL supports the adoption of a Clinical Disputes Protocol similar to the Pre-action Protocol currently implemented in England and Wales, but stresses that this must apply to clinical negligence if it is to be effective. This would include an early and detailed disclosure as to the basis of the claim, early disclosure of statements and information, relevant medical issues and facts and clearly agreed timescales for investigation by each side and responses by each side. This would therefore tackle the issues of delays in disclosure of information and the length of time that the process takes to complete as a whole.

Q12. Would you support the establishment of a scheme specific to neurologically impaired infants if a general no-fault scheme is not introduced?

We believe that although the establishment of a scheme specific to neurologically impaired infants would be ideal as it would allow for compensation in every case involving a neurologically impaired infant, we would fear that this is unrealistic, as these claims are hugely expensive. If every infant were compensated- whether negligently harmed or otherwise, then the amount of compensation that they would receive would be reduced drastically as it would be unfeasible to compensate all to the standard that these claims are compensated at present, and the compensation

[6] Application no. 53924/00

would simply not be enough to cover costs for care, home adaptation, medication and other expenses required for the rest of that individuals life.

12.1 What are your views on the Review Group's suggestion that the future care component of any compensation in such cases could be provided in the form of a guarantee of delivery of services (both medical and social care) to meet the needs of the child, instead of by way of a monetary sum?

APIL feels that this suggestion by the Review Group demonstrates how lacking the current welfare system in Scotland is to cope with these kinds of cases. There should already be a guarantee of delivery of services; this should not need to be included in the compensation award. In countries where the no-fault system is in place, the welfare system is well-equipped to care for the needs of people who have been injured in these kinds of situations with excellent rehabilitation and other after-care facilities. Therefore it does not leave the person suffering if they receive a smaller monetary sum as compensation under the no-fault scheme. The welfare system in Scotland is ill-equipped to cope with the care of patients in these situations, and so the adequate compensation level is higher to ensure that the patient has the finances available to enable them to get the care that they need.

- Ends -

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