

**MINISTRY OF JUSTICE**

**PROPOSALS FOR REFORM OF CIVIL LITIGATION FUNDING AND  
COSTS IN ENGLAND AND WALES**



**A response by the Association of Personal Injury Lawyers**

**FEBRUARY 2011**

The Association of Personal Injury Lawyers (APIL) is a not-for-profit organisation with a 20-year history of working to help injured people gain access to justice they need and deserve. Our 4,800 members are committed to supporting the association's aims and all sign up to APIL's code of conduct and consumer charter. Membership comprises mostly solicitors, along with barristers, legal executives and academics.

APIL has a long history of liaison with other stakeholders, consumer representatives, governments and devolved assemblies across the UK with a view to achieving the association's aims, which 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;
- To provide a communication network for members.

Thanks go to APIL's executive committee who have all contributed to this response.

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## **Executive summary**

- We do not support the primary recommendations made by Jackson LJ in his report which we believe are misconceived and which have already been overtaken by reforms such as the RTA claims process. Nevertheless we do recognise that further change is needed. We agree that there is scope to further improve the personal injury claims process and that to do so can work for the benefit of the injured person. Improvements in process and further efficiencies will also lead to an even greater reduction in costs than that already brought about by the RTA claims process. Our single biggest concern is that changes must not lead to a reduction in access to justice for those injured through the fault of others.
- We therefore support alternative recommendation one with minor refinements.
- The rights of the injured person must be safeguarded, ensuring access to justice.

## **Conditional fee agreements and success fees**

- Success fees and ATE insurance should be regulated and should remain recoverable.
- Where the case is successful the success fee's purpose is to compensate solicitors for the losses incurred as a result of those cases that are unsuccessful. The success fee is therefore like an insurance premium and the cost of the risk is paid for by the wrongdoer.
- Success fees are fixed for the vast majority of cases. They are also incorporated into the MoJ streamlined process for lower value claim. Recent discussions with the NHSLA have shown willingness on their part to incorporate fixed recoverable success fees into a streamlined process for lower value clinical negligence cases.

- Clinical negligence claimants have the potential to be hit with a 'double whammy' if the removal of legal aid and non-recoverability of success fees and ATE is implemented.
- Capping success fees to a percentage of damages where recoverability is abolished is going to prevent the more difficult cases being taken on. It will also encourage satellite litigation over the level of general damages.
- Leading counsel suggests that the primary proposals for reform could discriminate against the disabled and infringe their human rights. There are also issues surrounding the Equality Act 2010 and Disability Discrimination Act 1995.
- We remain concerned about the viability of the appeals process if these reforms are brought in. Limiting success fees to 25 per cent will make it uneconomic for cases to be appealed.

#### **After the event insurance**

- ATE is an essential part of ensuring access to justice and should remain recoverable. We would support working with the ATE insurance industry to make the cost of ATE more proportionate and see merits in moving towards staged ATE premiums.
- ATE should not be limited to circumstances where it can be shown that there is no other funding.
- An ATE policy that covers only disbursements could result in the market contracting. The fundamental principle of insurance is that the many pay for the few; to restrict the market by introducing an ATE policy that covers disbursements only could result in the market contracting.

#### **Counsel's fees**

- It is essential that injured people retain the right to representation from an independent Bar.

- If Jackson LJ's primary proposals are implemented then there will be very limited success fees and it will become impractical for counsel to enter into a CFA, thus leaving the more favourable option for them to be instructed on a disbursement only basis.

### **10 per cent increase in damages**

- As a matter of principle damages should not pay for legal costs.
- Other procedural changes can be implemented to reduce costs whilst ensuring access to justice and retention of damages.
- General damages remain too low in any event.
- A 'basket of cases' approach for an individual pursuing a claim is unjust. One claimant should not be expected to subsidise another.
- The mean figure of 10 per cent does not take into account the new process for low value RTA cases. Under that process three quarters of all claims are now being dealt with more cost effectively.
- We would encourage the MoJ to look at any options that reduce the impact of Jackson LJ's primary proposals on the injured person, and recognise that the MoJ's refinements at paragraph 100 and 101 are designed to go some way towards this.

### **Part 36**

- Proposals to offer additional sanctions against defendants who fail to beat or equal a claimant's Part 36 offer at trial, by way of an award equal to 10 per cent of the total damages awarded, will drive the right behaviours and encourage early settlements. This should apply across the board, even on higher awards, as this is part and parcel of the trade off.
- Additional sanctions must also apply to liability offers.
- Formulaic proposals made in the paper are extremely complicated and it would be very difficult to properly advise clients on all the permutations.

- If QOCS is not to apply to Part 36 offers then the damages will be eroded further where the claimant fails to equal or beat their own offer.

### **Qualified one way cost shifting**

- True one way cost shifting where the claimant is never at risk on costs could work for personal injury claims, including clinical negligence and multi-party actions.
- The current proposals drafted by Jackson LJ are flawed.
- The lack of clarity around the definition of 'sufficiently wealthy' will lead to challenges in the courts and is likely to lead to satellite litigation.
- The lack of certainty around the test for conduct is likely to discourage claimants from pursuing meritorious claims. The phrase 'claimants will only have costs protection where they have acted reasonably' will lead to satellite litigation.

### **Alternative recommendations on recoverability**

- A more workable solution is to adopt alternative package one, provided there are a number of refinements.
- Fixed recoverable success fees could be extended to public liability and clinical negligence cases with relative ease.
- Introducing staged success fees would offer further certainty for defendants and drive the right behaviours.
- If staged success fees were to be introduced the decision in *Lamont v Burton*<sup>1</sup> would be at odds with this and we would accept a reversal of the decision.
- We would accept the reversal of the decision in *Crane v Cannons Leisure Centre*<sup>2</sup> as part of the implementation of package one.

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<sup>1</sup> [2007] EWCA Civ 429

<sup>2</sup> [2007] EWCA Civ 1352

- We do not accept the reversal of the *Kilby v Gawith*<sup>3</sup> decision as this would open up further debate and lead to satellite litigation.
- If recoverability of success fees is to be retained then the self insured element of the success fee for membership organisations should be retained also.
- We suggest retaining ATE and moving towards staged premiums rather than abolishing recoverability of ATE during the protocol period.
- We do not support abolishing the recoverability element of the ATE premium relating to Part 36 offers, as this will shift the benefit in favour of the defendant.

### **Proportionality**

- We maintain that cases should be run on the basis that cases are proportionate to issues and not value. Altering this approach will allow defendants to pump money into claims whilst limiting claimants' right to claim.
- Changes to the courts' approach in *Lownds*<sup>4</sup> is not necessary or justified.

### **Damage based agreements**

- The contingency fee agreement model proposed in the paper would not be attractive to injured people.
- Additional regulation will create an unlevel playing field between claimants on a CFA and DBA.
- If QOCS is introduced then it must apply equally to CFAs and DBAs.

### **Litigants in person**

- We agree with proposals to increase the prescribed rate recovered by litigants in person who cannot prove financial loss of earnings to £20 an hour.
- We also support an increase by Average Earnings Index to £82.23 for any loss of earnings in a small claim.

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<sup>3</sup> [2009] WLR 853

<sup>4</sup> *Lownds v Home Office* (2002) EWA Civ 365



### **Predictable damages**

- There is no single correct award from a particular injury as an injury can affect different people in different ways.
- It is impossible to produce an unbiased computerised assessment tool which fairly caters for every injury and the effects every injury will have on different claimants.

### **Clinical negligence**

- The right solution for reform in this area is one which encourages the right behaviours whilst still preserving access to justice. This can save unnecessary costs but ensure that the claimant's rights are preserved against the wrongdoer.
- Our own proposals put to the MoJ in early 2011 will encourage the right behaviours and therefore save costs.

### **Impact assessments**

- There is a significant lack of evidence upon which the Government has based its radical proposals in the green paper.
- The impact assessments do not consider the increased cost to Government where claims are not pursued and the cost of care, rehabilitation and benefits are not recovered from the wrongdoer.
- There is no consideration of the potential implications on the injured person if court fees rise.
- The potential impact on the ATE or BTE insurance market if the primary proposals are implemented is not explored either.

## Introduction

The rights of vulnerable injured people must be safeguarded, ensuring access to justice and the provision of an accessible and affordable civil justice system even in these difficult political and economic times.

It must be remembered that Jackson LJ's work largely ignores the impact of the work being undertaken by the Ministry of Justice (MoJ) at the time his review was being conducted, to streamline the process for lower value fast track road traffic accident cases. During Jackson LJ's year-long review the Ministry was working with both sides of the industry to improve the speed at which injured people received their compensation and to fix the amount of work involved in pursuing these claims in return for fixing the fees recoverable. Since the introduction of this process only 25 per cent of claims remain outside of a fixed cost and streamlined process<sup>5</sup>. The cases remaining outside of the system will be by their very nature complex.

Jackson LJ's primary recommendations were a product of their time. The introduction of the claims process has brought about real change and in time could become an efficient procedure for dealing with lower value claims efficiently and at reduced cost. We recognise that change is needed in other areas but that change must not result in a reduction of access to justice. We therefore support alternative recommendation one with a number of minor refinements.

The Government must remain aware of the fact that it faces a conflict of interest. It is responsible for the National Health Service, local authorities, armed forces and the police through allocation of resources. At the same time the Government is responsible for guarding the civil justice system to ensure that citizens have access to justice and recover full and proper compensation for injury caused by the negligence of others.

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<sup>5</sup> Page 38, "Case track limits and the claims process for personal injury claims summary of responses".

It is essential that we maintain individual human rights by preventing injury where possible through social responsibility. When someone is harmed through negligence our system must provide access to treatment, care and full redress to ensure, so far as possible, that the injured person is put back into the position he was in before the negligence occurred<sup>6</sup>. Defendants are quick to put the needs of the person they have injured negligently second to profit and cost saving. This explains their ceaseless efforts to always lay the rising cost of personal injury claims at the door of the claimant, thus inhibiting the injured person's right to obtain proper and full redress through effective representation. It must be remembered that a defendant is a wrongdoer. If a court finds them liable it means that they have acted unlawfully. Whilst any defendant has the right to a fair trial their interests cannot be put on the same level as that of the victim of their acts. If a defendant breaks the law they have to pay the price.

Explaining funding to a client who has little knowledge of the legal process is already time consuming and complex. The proposals being consulted upon are far from simple, and a whole new raft of regulations will be required to implement the changes decided upon. Any of the changes proposed will have the effect of adding further complications to those discussions with clients at the outset of a claim, when they are bewildered and only seeking compensation for their injuries.

This does not mean that there is no room for improvement. We will continue to support improvements to the system but only where they are to the benefit of the injured person.

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<sup>6</sup> Lord Blackburn in *Livingstone v Rawyards Coal* (1880) 4 App Cas 25 : "I do not think that there is any difference of opinion as to it being a general rule that, where any injury is to be compensated by damages, in settling the sum of money to be given for reparation of damages you should as nearly as possible get that sum of money which will put the party who has been injured or who has suffered, in the same position as he would have been if he had not sustained a wrong..."

## **Conditional fee agreements and success fees**

Success fees and ATE insurance should remain recoverable but be regulated. Access to justice should not be prevented by an injured person being unable to fund a claim for personal injury. Nor should damages that have been carefully calculated be reduced to pay for legal costs.

ATE premiums and success fees were introduced on the basis that the many pay for the few. They are not a bounty or windfall to the lawyer, but have been carefully calculated and are evidenced based. They are an intrinsic part of ensuring that access to justice is available to those with meritorious claims. They are not recovered in isolation from cases that are investigated and do not proceed, nor are they recovered in isolation from cases that are pursued but are unsuccessful or withdrawn. Where the case is successful the success fee's purpose is to compensate solicitors for the losses incurred as a result of those cases that are unsuccessful. The success fee is therefore like an insurance premium and the cost of the risk is paid for by the wrongdoer. This is consistent with the principle of loser pays.

Success fees are less frequently used by defendants as they often prefer business models where they are paid on a reduced hourly rate. Such a model is adopted by the NHSLA and ensures that defendants get paid during the life of the claim whether they win the claim or not, thus offering no incentive for them to settle cases early.

Success fees are fixed for the vast majority of cases, including disease cases, and were done so on a cost neutral model<sup>7</sup>. They are also incorporated into the MoJ streamlined process for lower value RTA claims. Recent discussions with the NHSLA have shown willingness on their part to incorporate fixed recoverable success fees into a streamlined process for lower value clinical negligence cases.

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<sup>7</sup> Paul Fenn and Neil Rickman "Calculating reasonable success fees", September 2003.

### **Fixing success fees**

There is no reason why success fees could not be fixed for clinical negligence and public liability claims. Clinical negligence claimants have the potential to be hit with a double whammy if the removal of legal aid and non-recoverability of success fees and ATE are implemented. Fixing success fees whilst retaining recoverability would save cost, reduce disputes about the level of success fee recoverable on conclusion of cases and most importantly retain full damages for injured people. Jackson LJ himself recognised that if removal of recoverability is unacceptable, fixing success fees in all areas where CFAs are regularly used should be considered.

In our paper “Improving the process for dealing with clinical negligence claims”, presented to government officials in January 2011, we made recommendations after consultation with our specialist clinical negligence practitioners that success fees should not only be fixed for clinical negligence cases but should also be staged. This would produce a simpler and more predictable solution to the problems identified by Jackson LJ. It would also produce a more level playing field for claimants and defendants. The Green Paper suggests that claimants are currently at too much of an advantage; someone injured through negligence is not done so through choice, and removing recoverability coupled with the other proposals in our view swings the position too far in favour of defendants.

We see no reason in principle why staged success fees could not be adopted into all areas of personal injury litigation. Many of our specialist clinical negligence practitioners already operate a staged success fee framework based on in-house models. These models offer defendants clear incentives to settle cases early, rewarding good behaviour and penalising bad. Fixing percentages also saves defendants money and creates certainty. Any framework for fixing success fees would, however, need to

be modelled on sound data. Cases settling early would attract little or no success fee, with cases that are most risky and proceed to trial attracting 100 per cent.

### **Access to justice**

Capping success fees to a percentage of damages where recoverability is abolished is going to prevent the more difficult cases being taken on and may lead to solicitors 'cherry picking' only the cases that are most obviously going to be successful. Certain types of case that are by their very nature difficult to pursue, such as horse riding accidents, stress claims and slip and trip cases are going to become impossible to pursue if the risks outweigh the success fee that can be claimed. This could lead to a hierarchy of desirable cases, with RTA passenger claims being most desirable and the least desirable cases being those such as stress at work.

Solicitors will become more risk aware, meaning that meritorious but difficult cases will not be taken on. The only way we envisage that 50/50 cases would be pursued under this model is if there was no cap to ensure that there is sufficient money in the war chest for winners to pay for losers, but we view this as abhorrent.

APIL along with PIBA<sup>8</sup> obtained advice<sup>9</sup> from leading counsel in September last year, who advised on the implications of the Jackson proposals to reverse the recovery of CFA success fees; cap success fees at 25 per cent of general damages and damages for past losses; and increase general damages by only ten per cent. The advice expresses considerable doubts about whether the proposals could be defended under the European Convention of Human Rights, if applied to seriously or catastrophically injured claimants. Specifically, counsel has advised that the proposed changes would affect the right of access to justice of such claimants, which is guaranteed by Article 6 of the Convention (in conjunction with case law which deals with the issue of

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<sup>8</sup> Personal Injury Bar Association is a specialist bar association for barristers who practice in the field of personal injury law. Members act for both claimants and defendants.

<sup>9</sup> See Appendix A

adequate means of funding) because they would become reliant on finding a suitable legal team prepared to forgo payment for the financial risk of conducting the claim on a CFA. Article 14 of the Convention protects such individuals who may be at a disadvantage in this way<sup>10</sup>. Counsel was also of the view that the vast majority of claims affected by these changes could be vulnerable to challenge under section 21D of the Disability and Discrimination Act 1995 and section 19 of the Equality Act 2010. It is also questionable whether costs can be deducted from past losses, which are often held in trust on account by the claimant for family members in respect of care.

Data obtained by APIL from its members and analysed by the Statistical Services Unit at the University of Sheffield showed that implementing Jackson LJ's proposals<sup>11</sup> would result in a decrease in total damages of 64 per cent for the successful cases in our dataset<sup>12</sup>. To reduce the number of cases experiencing a decrease in damages as a result of Jackson LJ's proposals the general damages would have to be increased by a greater amount. Our data showed that for only 50 per cent of cases to experience a decrease in damages, general damages would need to increase by 21 per cent. To achieve a situation where only one per cent of cases experienced a decrease in damages, general damages would need to be increased by 67 per cent. This report was submitted separately to the MoJ for consideration.

### **Government refinements**

The Government's suggested refinement to Jackson LJ's proposals for complex cases, which includes the possibility of retaining some element of recoverable success fee for specific categories of case<sup>13</sup> as such clinical negligence, recognises that cases could

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<sup>10</sup> A copy of the advice was sent to the Secretary for State for Justice.

<sup>11</sup> Taking into account the proposed 10% increase in general damages, offset against a cap on the success fee of 25% of general damages plus past loss

<sup>12</sup> Average reduction from damages for success fee (solicitor only) if Jackson was implemented (either the 25 per cent he recommended or the actual success fee claimed in the cases whichever is the lowest).

<sup>13</sup> Proposals for Reform of Civil Litigation Funding and Costs in England and Wales page 27 paragraph 70

become uneconomic. Whilst we accept that there are likely to be real access to justice issues for complex cases such as disease claims, clinical negligence cases, fatal accidents and child abuse, cases under Jackson LJ's proposals do not simply become uneconomic to run because they are defined as 'complex'. In fact any cases where costs are more than one quarter of damages will be uneconomic to run under these primary proposals. Defining 'complex' is in itself complex and if this is not got right will cause satellite litigation for years.

If success fees are to remain recoverable then it is our view that the maximum success fee recoverable from the losing party should remain at 100 per cent where the claim proceeds to trial. Less than 100 per cent would limit winners paying for losers, the principle on which success fees are founded.

## **Appeals**

We are further concerned about the viability of the appeals process if these primary proposals are brought in. Success fees limited to 25 per cent will make it uneconomic for cases to be run to appeal. Personal injury cases are risky and complex; many personal injury cases have been considered by the Court of Appeal and Supreme Court in the last year alone, e.g. *Threlfall v Hull City Council*<sup>14</sup>, *Maga v Trustees of the Birmingham Archdiocese of the Roman Catholic Church*<sup>15</sup>, *Bhamra v Dubb (t/a Lucky Caterers)*<sup>16</sup>. This problem will be compounded by the suggested reform to proportionality test<sup>17</sup>.

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<sup>14</sup> [2010]EWCA Civ 1147

<sup>15</sup> [2010] EWCA Civ 256

<sup>16</sup> [2010] EWCA Civ 13

<sup>17</sup> See page 33 on proportionality



## **After the event insurance premiums**

After the event (ATE) insurance is an essential part of ensuring access to justice and should be recoverable. We can see merits in moving towards staged ATE premiums whilst reducing the premium during the protocol period.

There is real value in ATE insurance both for claimants and defendants. For claimants it guards against risk and acts as a break on unmeritorious claims. ATE providers are reluctant to allow any case covered by ATE to proceed without reasonable prospects of success. Many ATE providers carry out their own risk assessments on cases and have reporting requirements on the continuing prospects of a case's success that must be complied with by the claimant solicitor. ATE also promotes accurate risk assessment of a case for the same reasons. Defendants benefit from the break on unmeritorious claims and from accurate risk assessments, however if a claim does proceed and is unsuccessful the defendant will also recover their costs under an ATE policy.

We do not believe that ATE insurance should be limited to circumstances where it can be shown there is no other funding. There are restrictions on other methods of funding, like BTE insurance, which may provide little or no protection to the injured person. Before 2005 there was extensive litigation to tighten up the law governing the inter-relationship between conditional fee agreements and before the event legal expenses insurance.

## **Disbursements**

We expect that it would be difficult to cover only disbursements with ATE insurance. The fundamental principle of insurance is that the many pay for the few, and to restrict the ATE to disbursements will make the market contract. Disbursements are often very heavy in disease cases and higher value complex cases, so we expect that this would result in much higher premiums for these cases.

Solicitors firms conducting personal injury cases are often already reliant on bank overdrafts to assist with the funding of disbursements. Removing ATE and the insurance that protects against the risk of this loan not being paid off would mean that solicitors would no longer be able to fund such costs on behalf of injured people. By restricting the market in this way the 'pot of money' to fund cases would also diminish.

We note with interest the recent Court of Appeal decision of *Sibthorpe v Southwark Borough Council*<sup>18</sup>. We do not believe that it provides the answers in cases where ATE is unavailable.

### **Counsels' fees**

There is also the separate issue of counsels' fees which is not addressed in any great detail in the Green Paper. It is essential that injured people retain the right to representation from an independent Bar. Counsel provide independent advice on liability, causation and evidence, they draft pleadings, prepare schedules, advise on offers and provide advocacy. It is essential that counsel remain part of the process. We are concerned that if Jackson LJ's primary proposals are adopted it will become impractical to split the small proportion of success fee available between counsel and solicitor. The winners will simply not pay for the losers. The unintended consequence of this maybe that solicitor's choose not to instruct the Bar. If success fees are not capped in cases where counsel is required, the injured person's damages will be hit harder. The only solution to this may be to instruct counsel on a disbursement basis, paid win or lose.

If recoverable ATE is not retained then the injured person or his legal advisors will have to fund the disbursement. Whilst this will add to the risk for the injured person in bringing a claim and to the cost of disbursements they will have to fund, we believe it is preferable to the situation where solicitors and barristers will have to share the

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<sup>18</sup> *Sibthorpe and another v Southwark London Borough Council* [2011] EWCA Civ 25

capped success fee proposed by Jackson. It is in the Government's interest to retain an independent Bar; however, the commercial viability of retaining the Bar as a disbursement must be explored. Legal expense providers would need to be contacted to ensure that they would recognise the Bar as a disbursement.

If recoverability of ATE is to be abolished we do not see how recoverability of the self-insured element of the success fee for unions should be recoverable.

Our data was also analysed<sup>19</sup> to consider the affects that non-recoverable ATE premiums would have on an injured person's damages<sup>20</sup>. The percentage of cases where the damages would be decreased is higher 84 per cent; compared with 65 per cent the average reduction from damages for success fees<sup>21</sup>.

### **10 per cent increase in general damages**

We do not believe as a matter of principle that damages should pay for legal costs. We agree with the Government in the Green Paper that it would "represent a fundamental change in the nature of the general damages award and would create a precedent for calls to depart from the compensatory principle in other circumstances"<sup>22</sup> if damages were increased expressly for the purposes of helping claimants meet their legal costs.

Damages are purely compensatory and have been carefully calculated by the courts. This is a long standing principle of our legal system dating back to 1880<sup>23</sup> and should not be overturned simply because defendants argue that the cost of litigation is too

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<sup>19</sup> Analysed by the Statistical Services Unit at the University of Sheffield

<sup>20</sup> Assuming that general damages were increased by 10 per cent and the success fees were capped as per Jackson's recommendation and then the success fees and ATE premium were both deducted from the total damages

<sup>21</sup> Average reduction from damages for success fee (solicitor only) if Jackson was implemented (either the 25 per cent he recommended or the actual success fee claimed in the cases whichever is the lowest).

<sup>22</sup> Proposals for Reform of Civil Litigation Funding and Costs in England and Wales page 37 paragraph 98

<sup>23</sup> *Livingstone v Rawyard Coal* (1880) 4 App cas 25

high. Other procedural changes can be implemented to reduce costs whilst ensuring access to justice and retention of damages.

### **Increasing general damages**

If the Government accepts that damages are too low then they should be increased in line with the Law Commission recommendations from the 1990s<sup>24</sup> but not simply to pay costs. We have consistently campaigned at every opportunity for an increase in damages in line with the Law Commission recommendations that included:

*(1) Damages for non-pecuniary loss for serious personal injury should be increased.*

*We recommend that:*

*In respect of injuries for which the current award for non-pecuniary loss for the injury alone would be more than £3,000, damages for non-pecuniary loss (that is for pain and suffering and loss of amenity) should be increased by a factor of at least 1.5, (.ie. 50%) but by not more than a factor of 2 (i.e. 100%);*

*In respect of injuries for which the current award for non-pecuniary loss for the injury alone would be in the range £2,001 to £3,000, damages for non-pecuniary loss (that is for pain and suffering and loss of amenity) should be increased by a series of tapered increases of less than a factor of 1.5 (so that, for example, an award now of £2,500 should be uplifted by around 25 per cent).*

*Finally, if the increases recommended by us are not implemented until over a year after publication of this report, the recommended increases should*

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<sup>24</sup> Commission Report No 257 April 1999

*be adjusted to take into account any change in the value of money since the publication of this report. (paragraphs 3.40 and 3.110)<sup>25</sup>*

## **The proposals**

The fact that these recommendations have not been fully implemented<sup>26</sup> means that general damages remain too low in any event. An increase of 10 per cent on general damages only to offset the abolition of the recoverability of additional liabilities in our view will not ensure that claimants are no worse off under the Jackson proposals than they are now. Jackson LJ was of the view, following advice from economist Paul Fenn, that “an increase in general damages will in the great majority of cases leave claimants no worse off. Indeed the great majority of claimants (whose claims settle early) will be better off”<sup>27</sup>. Our own data shows that in road traffic accident cases a decrease in damages would be seen in about one third of cases, whereas in employers’ liability and public liability cases a decrease in damages would be seen in 90 per cent and 96 per cent of cases respectively<sup>28</sup>. The Fenn data also fails to recognise that defendants very often hold the key to resolving cases early and that a ‘basket of cases’ approach for an individual pursuing a claim is unjust.

The additional reasoning produced by Professor Fenn for Jackson LJ’s presentation to the Legal Action Group annual lecture in November 2010 suggests that 61 per cent of claimants will be better off and 39 per cent will be worse off under the proposal. The full report and data has not been made available. However, what the more detailed graphs show is that the majority of those claimants making a gain will be victims of road traffic accidents. What the graphs do not show but what is undoubtedly the case is that those better off claimants in other categories will be those with lower value

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<sup>25</sup> The Law Commission 257. Damages for personal injury: non-pecuniary loss. Item 2 of the Sixth Programme of Law Reform. Page 108 paragraph 5.8

<sup>26</sup> Heil v Rankin [2000] All ER 386 did not achieve the outcome.

<sup>27</sup> Review of Civil Litigation Costs: Final Report page 112 paragraph 5.4

<sup>28</sup> Average reduction from damages for success fee (solicitor only) if Jackson was implemented (either the 25 per cent cap on success fees as he suggested or the actual amount claimed in the case whichever is the lowest).

claims. We already know from the Ministry's analysis that 75 per cent of all claims are lower value RTA<sup>29</sup> cases now being run under a streamlined process at a fixed cost. Therefore three quarters of all claims are now being dealt with more cost effectively and the only cases left are those that by their very nature are more complex, for example involving disputes over liability or contributory negligence.

The mean figure of 10 per cent does not take into account the new process for low value RTA cases. The figures therefore will go little way to compensate those with more complex cases that take longer to resolve, for example industrial disease and clinical negligence cases, and will have no effect on fatal accident claims where there is often no or very little award for pain and suffering. It can be seen from the APIL data in 59 per cent of RTA cases the proposed increase of 10 per cent in damages will meet or exceed the success fee, but in employers' liability or public liability cases only 3 per cent and 7 per cent will meet or exceed the success fee, showing that the injured person will be short changed by these proposals. Not only have damages not been increased by the Law Commission's recommendations, the majority of injured people will not be better off under these proposals as Jackson LJ suggests.

Further we do not believe that an 'averages' approach is workable or just for individual claimants. The averages approach is more acceptable when dealing with solicitor's costs as they deal with a range of cases, of differing values. This approach assumes that overall there is no loss. Taking the same approach for an individual claimant who is a onetime user of the system produces unjust consequences. One claimant should not be expected to subsidise another. Under the proposals 25 per cent is the maximum success fee that lawyers will be able to charge a client and deduct from their damages. Jackson LJ suggests that lower success fees are likely to be agreed between solicitors and clients<sup>30</sup>. It is therefore very possible that those clients with strong prospects of success will become unwilling to pay success fees at all. For

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<sup>29</sup> Case track limits and the claims process for personal injury claims, summary of responses page 38

<sup>30</sup> Review of Civil Litigation Costs: Final Report page 113 paragraph 5.9

example a passenger in a car injured in a road traffic accident will not want to contribute to the 'pot' to enable the lawyer to fight a claim for a pedestrian hit by a car or someone making a claim for stress at work. Under the current scheme every case on a CFA pays into the pot, just like taking an insurance policy out. If this isn't paid on every case it will create further access to justice issues.

General damages are assessed by reference to the Judicial Studies Board Guidelines and to case law. A bracket giving the potential range of award is usual practice. If the 10 per cent uplift was applied, leaving aside all the additional difficulties, because there is a range or bracket of potential awards being considered an increase as low as 10 per cent will be lost within that range, particularly but not exclusively in the lower value cases. In practice many claimants would never receive any increase at all. There would be little evidence of whether the award had been up-rated or not. The JSB Guidelines could be up-rated at a stroke, but in most claims, for example RTA neck injury claims, the guidelines are so vague and wide that they are almost meaningless. This uncertainty may lead to a significant increase in quantum-only hearings, increasing the work of the courts. One solution for dealing with this is to provide through the Civil Procedure Rules that the 10 per cent is added after the negotiation of an award for general damages has taken place and a figure is agreed or awarded.

### **Government refinement**

The Government recognises some of these concerns in the Green Paper and offers a possible refinement at paragraph 100. The suggestion mooted is that an element of the success fee is recoverable by the claimant but is calculated as a sum equal to 10 per cent of general damages in each case. On the face of it this appears to offer a more workable solution to the other recommendations, however it does give rise to a number of new issues that will need to be addressed. Damages are already too low and by offsetting against success fees there will be no benefit for injured people. Additionally most offers are made on a global basis and general and special damages

are not broken down. This will cause difficulty when calculating what the 10 per cent should be. One alternative is to apply the recoverable 10 per cent success fee to all damages, thus ensuring that arguments over what constitutes general damages or special damages do not lead to satellite litigation. The application of the 10 per cent recoverable success fee would need to be carefully considered; it would be essential to ensure that damages are not driven down, that damages are negotiated and settled first and the 10 per cent applied during the costs calculation thereafter. The rules would need to state this explicitly. There would also need to be further statistical analysis on the economic impact of this suggestion. It is our view that the MoJ is clearly concerned about whether this refinement will achieve the desired result. We would encourage the MoJ to look at any options that reduce the impact for the injured person.

### **Part 36 offers**

The proposal to offer an additional sanction for a defendant who fails to equal or beat a claimant's Part 36 offer at trial, by way of an award equal to 10 per cent of the total damages awarded by the court, will we believe drive behaviours and encourage early settlement of cases. This in turn will deliver quicker access to justice for injured people, ensure that defendants properly risk assess cases and in turn reduce cost for defendants.

Any additional sanctions must not only apply to offers on quantum but must also apply to liability offers. Encouraging narrowing of the issues as early as possible in a case will help settle the case early and thus ensure that the claimants get their compensation more quickly.

### **Government refinement**

Under the new proposals in the Green Paper the defendant is incentivised to make a sensible offer or face a penalty of paying the additional payment equivalent to 10 per



cent increase in damages. The formulaic proposals made in the paper are extremely complicated and it would be very difficult to properly advise clients on all the permutations. The sanction must be simple and easy to calculate and therefore the uplift must be a single rate.

During claims process discussions the defendants put forward suggestions similar to the refinement suggested at paragraph 125 of the Green Paper. They made the suggestion on the basis that lower value cases sometimes go to court over very small amounts. In their arguments they fail to recognise that disputes over damages are usually in the lower value cases, largely due to Colossus<sup>31</sup> type offers being made followed by a refusal from insurers to deviate from those offers despite them being unrealistic. Lawyers found the formulas difficult to understand and, given most injured people are one-time users of the system, they would probably find it impossible to understand. We voiced our concerns at the time, which remain that the law of unintended consequences must not be allowed to operate, whereby the claimant will be forced to accept a downward pressure on damages rather than be permitted to go to a hearing where there is a genuine dispute. Defendants would make an offer to settle close to an award but less than that which was ultimately expected to be made by the court, so that it would almost be impossible to advise the client to take the risk as there would be no measure of certainty as to what the court would award. That would then create settlements which inform the statistics that govern future offers (Judicial Studies Board Guidelines on damages). A difference of a few hundred pounds may seem small to a commercial insurer, but it is not to an injured victim on the minimum wage.

The system proposed seems to put undue emphasis on the decision in *Carver*<sup>32</sup>. The case of *Morgan*<sup>33</sup> and the *Multiplex*<sup>34</sup> case, which were decided subsequent to *Carver*,

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<sup>31</sup> Computerised damages assessment tool

<sup>32</sup> *Carver v BAA plc* [2008] EWCA Civ 412

<sup>33</sup> *Morgan v UPS* [2008] EWCA Civ 1476

have suggested that *Carver* was only intended to deal with the situation where one party was trying to settle the case and the other was not co-operating, and where the party guilty of non-cooperation is also guilty of exaggeration. Given the decisions in the *Morgan* and *Multiplex* cases we believe that it would be right to reverse the effect of *Carver*.

During the consultation period it has been suggested that the sum of 10 per cent increase on damages where the defendant fails to beat the claimant's offer in higher awards will be disproportionate. The figure is part and parcel of the trade off. The higher the value the bigger the risk for claimants. Defendants will always have the right to put forward sensible Part 36 offers.

### **Qualified one way cost shifting and Part 36**

If qualified one way cost shifting (QOCS) is not to apply to Part 36 offers then the claimant's liability in costs to the defendant if they fail to beat the defendant's offer must be capped. There is a danger if this is not the case that damages will be eroded further. Part 36 needs to be certain and we would suggest that limiting the recoverable element of defendant's costs in these circumstances to 25 per cent of damages is fair.

### **Qualified one way cost shifting**

True one way cost shifting, where a claimant is never at risk on costs, could work for personal injury claims including clinical negligence and multi-party actions. It would also need to apply across the board to all methods of funding and not just CFAs. The current proposals drafted by Jackson LJ:

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<sup>34</sup> *Multiplex Constructions (UK) LTD (Claimant/Part 20 Defendant) v (1) Cleveland Bridge UK Ltd (First Defendant/Part 20 Claimant) (2) Cleveland Bridge Dorman Long Engineering Ltd (No 7) (Second Defendant) (2008) [2008] EWHC 2280*

*“Costs ordered against the claimant in any claim [covered by QOCS] shall not exceed the amount (if any) which is a reasonable one for him to pay having regard to all the circumstances including:*

- (a) the financial resources of all the parties to the proceedings, and*
- (b) their conduct in connection with the dispute to which the proceedings relate”<sup>35</sup>*

are flawed.

### **Financial resources**

Jackson LJ proposes that qualified one way cost shifting (QOCS) will not operate when the claimant is sufficiently wealthy to be able to easily pay the defendant’s costs if the case were to be successfully defended. Our concern is how ‘sufficiently wealthy’ would be defined under the process. If there is equity in a property, is it right that an individual might be forced to sell their home to fund a claim?

The intention behind this provision is to model the QOCS model on the legal aid scheme and adopt the provisions for the recovery of costs against a legally aided party<sup>36</sup>. Despite the provision within the Access to Justice Act the section was infrequently used as legal aided clients were never of sufficient means because of the low threshold for financial eligibility adopted in the scheme. Under the provision

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<sup>35</sup> Proposals for Reform of Civil Litigation Funding and Costs in England and Wales Page 48 Paragraph 135

<sup>36</sup> Access to Justice Act, Section 11 (1) Except in prescribed circumstances, costs ordered against an individual in relation to any proceedings or part of proceedings funded for him shall not exceed the amount (if any) which is a reasonable one for him to pay having regard to all the circumstances including—

(a) the financial resources of all the parties to the proceedings, and

(b) their conduct in connection with the dispute to which the proceedings relate;

and for this purpose proceedings, or a part of proceedings, are funded for an individual if services relating to the proceedings or part are funded for him by the Commission as part of the Community Legal Service.

drafted for QOCS the starting point is not the same. Under the legal aid scheme a merits test would have been applied by the Legal Services Commission (LSC) to every case, and a separate means test was also adopted. In the QOCS scheme suggested, claimants will not have been means tested and therefore the difficulty will remain of deciding what is a reasonable amount for the claimant to pay. Who is going to apply the financial eligibility criteria, the solicitor? Or some other organisation akin to the LSC?

### **Conduct**

It is proposed that the test will operate restrictively so that claimants are only required to meet the defendant's costs in exceptional circumstances. The problem we envisage with this proposal is that the test is so vague that it will be impossible to advise a claimant at the outset of their claim when they might become liable as they will only have cost protection where they have acted reasonably. The judge will not consider this point until conclusion of the claim, meaning that a claimant will be unsure for the duration of his case what liabilities he may become responsible for. Additionally the claimant will always be at risk of paying their own disbursements if they lose, which can be substantial. Such uncertainty and risk is likely to discourage claimants from bringing legitimate claims.

The vagueness of the phrase a 'claimant will only have cost protection where they have acted reasonably' will almost certainly lead to satellite litigation as the parties seek clarification from the courts over what reasonable means. When recoverability of success fees and ATE premiums was introduced defendant insurers began the costs wars, launching an avalanche of challenges to retainers, BTE inquiries and the level of success fees. It is very likely that defendants will behave in the same manner if one way cost shifting is introduced. The refinement to QOCS suggested in the Green Paper does not offer any further certainty on the issues raised above. It only offers a possible refinement that there is a presumption that the claimant is not able to pay the defendant's costs unless the defendant persuades the court otherwise. Such a

refinement will only lead to further uncertainty for the claimant from the outset, meaning that they will be unsure what liabilities they are responsible for.

### **Other concerns**

The Green Paper confirms that under the current proposal QOCS will not override cost sanctions set out in Part 36. Implementing such a rule will drive the wrong behaviours and make it very difficult for claimant solicitors to advise their clients on the risk of making a Part 36 offer and considering a Part 36 offer. We are already seeing increasing instances of defendants making pre-medical offers and not just in low value road traffic accident cases; these are also being seen more frequently in higher value clinical negligence cases. Offering claimants money to settle their claim where the prognosis is not known puts all the risk onto the claimant. The defendant in these circumstances has nothing to lose, but a claimant will be at risk on the Part 36 offer from the outset of the claim. The proposal in its current form does not drive the right behaviours. The claimant will be at risk of paying substantial defendant costs if they fail to beat this early offer, whereas the defendant will only be at risk of paying the claimant an additional 10 per cent on damages<sup>37</sup>. The unintended consequences would be to drive down damages as claimants will accept early Part 36 offers in order to reduce risk.

One method of dealing with this risk is to limit the claimant's cost liability to the defendant to 25 per cent of damages. ATE would also need to be retained to fund disbursements.

### **Alternative recommendations on recoverability**

Given the extent of the problems surrounding Jackson LJ's primary proposals highlighted in this paper, we believe that the more workable solution is to adopt

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<sup>37</sup> See earlier comments in Part 36 section on page 24

alternative package one, provided there are a number of refinements. Alternative two is less attractive to us.

### **Alternative package one**

#### **Fixing success fees**

Fixed recoverable success fees could be extended to public liability and clinical negligence cases with relative ease. Professors Fenn and Rickman have the skills and expertise to carry out this work with cooperation from both sides of the industry. APIL would go further, suggesting staged success fees. These would produce a simpler and more predictable solution to the problems identified by Jackson LJ. There are benefits to having a staged success fee model which does not offer a success fee within the protocol period. Such a model presents defendants with clear incentives to settle cases early, rewarding good behaviour and penalising poor behaviour by increasing the fees as the case progresses. Offering no success fee for the life of the claim if liability is accepted during the protocol period is more complex. Defining liability could lead to difficulties; additionally what would happen where disputes continued on quantum or causation? Exactly how this would work would need to be considered in conjunction with full economic modelling. Fixing percentages also saves defendants money and creates certainty. Any framework for fixing success fees would need to be modelled on sound data, which APIL would be prepared to assist with.

#### **Success fees and Part 36**

When determining fixed success fees Fenn and Rickman did not take into consideration the effect of Part 36 offers on their data; this was because they had no means of estimating the impact<sup>38</sup>. Therefore the success fee currently fixed for RTA, employers' liability and disease cases does not allow an element of success fee for Part 36 offers. If success fees are to be fixed for clinical negligence and public liability cases we would expect the same model to be followed as that adopted by Fenn and

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<sup>38</sup> See Paul Fenn and Neil Rickman "Calculating reasonable success fees", September 2003.

Rickman. Therefore suggesting no recoverability for the Part 36 element of success fees does not alter the position from where it is at now.

We have considered again reversing the decision in *Lamont v Burton*<sup>39</sup> in light of this fundamental review of civil costs. If staged success fees were to be introduced the decision in this case (to allow recoverability of the success fee applicable at trial and not at the date that the part 36 offer applied) would be at odds with the desire to drive the right behaviours and to encourage settlement. We would therefore accept the reversal of this decision.

### **Success fees and detailed assessment hearings**

If the recoverability of success fees for detailed assessment hearings is to be abolished as part of the implementation of package one then we would accept this reversal of the current law<sup>40</sup>.

### **Recoverability of success fees where other funding was available**

We do not however accept the reversal of *Kilby v Gawith*<sup>41</sup>. The decision of this case is enshrined in the claims process and reversal of this decision would open up further debate and satellite litigation.

### **Membership organisations**

If recoverability is to be retained for success fees then the self insured element of success fees for membership organisations must also be retained to ensure fairness across the board.

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<sup>39</sup> [2007] EWCA Civ 429

<sup>40</sup> *Crane v Cannons Leisure Centre* [2007] EWCA Civ 1352

<sup>41</sup> [2009] WLR 853

## **After the event insurance**

### **Protocol period**

APIL advocates the retention of ATE insurance for personal injury cases. We can see merits in moving towards staged ATE premiums whilst reducing the premium during the protocol period; this would follow similar lines to the model now adopted for the claims process. Staged premiums are becoming more common and we believe that the ATE market would develop to accommodate such a change if implemented. We do not believe that abolishing recoverability of ATE altogether during the protocol period will work. There is a danger that people will refrain from taking out an ATE policy until the pre-action protocol period has expired. This will drive up the cost of ATE insurance overall as the many pay for the few, and those cases that insure after the protocol period will be the disputed ones and thus by their very nature riskier and will result in more expensive premiums. The MoJ also needs to be clear on what constitutes an admission of 'liability'<sup>42</sup> during the protocol period.

### **Part 36**

We do not believe that abolishing recoverability of the element of ATE premiums relating to Part 36 offers is justified either. Such a change will shift all the benefits totally in favour of the defendant. Defendants will be free to make early pre-medical offers again and they will be free to make whatever offer they like, and as soon as that offer is made the claimant is potentially at risk for costs. Offering claimants money to settle their claim where the prognosis is not known puts all the risk onto the claimant. The defendant in these circumstances has nothing to lose but a claimant will be at risk on the offer from the outset of the claim. The proposal in its current form does not drive the right behaviours. The claimant will be at risk of paying substantial defendant costs if they fail to beat this early offer whereas the defendant will only be at risk of paying the claimant an additional 10 per cent on damages. The unintended

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<sup>42</sup> An admission of liability encompasses the three elements of a cause of action: duty, breach and causation; leaving the only outstanding issue as one of quantum. Admissions of "negligence" or "breach of duty" do not encompass an admission on causation and would not, be considered admissions of liability.



consequence would be to drive down damages as claimants will accept the early Part 36 offers.

### **Capping recoverable ATE**

Further consultation with ATE insurance providers needs to be made about capping recoverable ATE insurance premiums to 50 per cent of damages awarded. We cannot see that this will be a workable model as insurance premiums are calculated on risk. The amount of damages recovered is only one small element of the risk of a case.

### **Proportionality**

Our civil justice system must allow cases to be run on the basis that an injured person has a right to bring a claim which is proportionate to the matters at issue and not limited solely to the value of the claim. This was the approach of Lord Woolf when drafting the Civil Procedure Rules and is provided for in part one.

To alter the approach to proportionality to value rather than issues will further limit access to justice. It will also allow defendants to pump money into claims whilst limiting claimants' right to claim. Lower value cases but with complex issues at stake will not be brought. Take for example the case of *Baker v Quantum Clothing Group*<sup>43</sup>; the compensation at stake was not substantial compared to the costs in the case. The case was fought by the defendant insurers on the basis that any success by the claimant would have far reaching effects for employers' liability across all industries. It took two years for the case to get to appeal, during which time there were interlocutory hearings before the full Court of Appeal. The defendants sought at every opportunity to limit the costs of the claimant. The financial implications for the claimant's legal team who were acting under CFAs were substantial. However, it was essential that this case be heard as it changed the law for noise induced hearing loss claims. The case has been appealed to the Supreme Court and a decision is awaited.

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<sup>43</sup> [2009] EWCA Civ 499

Another example is the case of *Threlfall v Hull City Council*<sup>44</sup>. The claimant sustained an injury to his hand whilst working as a street scene operative for the council. He argued that the injury could have been prevented if his employer had provided him with suitable gloves, and that the gloves provided constituted a breach of regulation 4 of the Personal Protective Equipment at Work Regulations 1992. His claim failed at first instance and on appeal to the High Court, but permission was granted to appeal to the Court of Appeal. The Court of Appeal criticised both judgments and firmly restated the importance of proper risk assessment:

*For the last 20 years or so, it has been generally recognised that a reasonably prudent employer will conduct a risk assessment in connection with his operations so that he can take suitable precautions to avoid injury to his employees. In many circumstances, a statutory duty to conduct such a risk assessment has been imposed. Such a requirement (whether statutory or not) has to a large extent taken the place of the old common law requirement that an employer had to consider (and take action against) those risks which could be reasonably foreseen. The modern requirement is that he should take positive thought for the risks arising from his operations. Such an assessment is, as Lord Walker of Gestingthorpe said in *Fytche v Wincanton Logistics* [2005] PIQR 975, 'logically anterior' to the taking of safety precautions. I said something similar, in rather less elegant language, in paragraph 58 of *Allison v London Underground Ltd* [2008] ICR 719.<sup>45</sup>*

The Council's assessment processes were described as 'manifestly defective' and the judge said it was impermissible for the trial judge to base his conclusions on the result of so inadequate a risk assessment. Again damages in this case were of relatively low value compared to the cost involved in appealing two decisions which were wrong in law.

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<sup>44</sup> [2010] EWCA Civ 1147

<sup>45</sup> Paragraph 35 of the judgment.

In every claim for personal injury the burden of proof rests with the injured person. Nothing about a case is presumed and the individual must prove each element of his claim, the facts of his case, duty of care, breach of duty, causation and quantum. There is no level playing field between an injured claimant pursuing a 'one off' legal case and a well resourced and experienced defendant insurer. Defendants are able to pump money into claims and take every point on a case, making claimants run up costs.

It is essential in these cases that the innocent victim should have the right to bring the claim which has, after all, arisen out of the negligence of another. Professor Dame Hazel Genn, who is a leading authority on civil justice, in her presentation at the Review of Civil Litigation Costs seminar on 26 June 2009 made the point that she was not convinced by the data supplied by the judiciary or insurers to Lord Justice Jackson as part of his review of civil costs, as it was not representative. She recognised that the vast majority of PI claims involve lower damages and these claims have an irreducible minimum amount of cost, which means that without improving procedure and the system for dealing with claims at the very lowest levels of damages, costs may be equal to or more than the damages recovered. This is due to the burden of proof and the need for claimants to prove their case, the requirements of the protocol and of securing the most basic evidence. She said every case regardless of value would incur a certain unavoidable cost. We have now addressed 75 per cent of all claims by developing the streamlined process for dealing with road traffic accident cases up to a value of £10,000.

We do not accept therefore that proportionality is such an issue and therefore any change to courts approach in *Lownds*<sup>46</sup> is not necessary or justified.

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<sup>46</sup> *Lownds v Home Office* (2002) EWA Civ 365

## Damage based agreements

Damages that have been carefully calculated should not be reduced to pay for legal costs. However, if the proposals are to be implemented there are a number of issues that need to be given further consideration. For personal injury and clinical negligence we have difficulty in seeing how a contingency fee in the form proposed in the Green Paper would be attractive. In the majority of cases solicitors will recover nothing by way of success fee under a DBA. In higher value cases there is the risk that they would be unattractive to the injured person as there would be the risk of a large reduction being made from their damages and paying more on a contingency fee agreement than they would under the modified CFA agreement proposed. This is because under the contingency fee model mooted by Jackson LJ the claimant recovers reasonable base costs from the unsuccessful defendant in the usual way, but **where the success fee claimed under the DBA is more than the base cost recovered** the solicitor is entitled to deduct those from the clients' damages (limited to 25 per cent). The impact is explained below basing the calculations on damages and base costs recovered in real employers' liability cases, but success fees in this example have been limited to 25 per cent to reflect the draft proposals:

Damages recovered	General damages	Past loss	Base costs	Jackson CFA success Fee	Jackson DBA success fee	DBA success fee recovered from the client's damages?
£1,200	£1,200	-	£2,200	300 <sup>47</sup>	300	No. Less than the base costs recovered
£6,000	£5,826.54	£173.46	£3,160	790	£1,500	No. Less than

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<sup>47</sup> Cap applied

						the base costs recovered
£35,000	£21,000	£14,000	£9,642	£2,410.50	£8,750	No. Less than the base costs recovered
£67,000	£40,000	£5,000	£22,593	£5,648.25	£16,750	No. Less than the base costs recovered
£600,000	£50,000	£90,000	£26,447	£6,611.75	£185,000	£158,553 deduction from damages

From these examples there is no advantage for claimant lawyers to take on the majority of cases on a DBA. This will leave a difficulty of obtaining the success fee element to build up a 'pot' for winners to pay for losers. Nor would there be any advantage to the clients in the higher value cases as the reduction from their damages could be far more extensive than if their case were funded on a CFA.

The further risk with any cap is that it will become the norm and setting a cap too low would mean that cases would not be taken on. There is little evidence in the Green Paper or in the Final Report to suggest how the 25 per cent figure has actually been arrived at. Any percentage must reflect the risk of potential failure; that said a percentage of more than 25 per cent would mean an extensive reduction in an injured person's damages.

In addition when Jackson LJ set the figure of 25 per cent it was not clear if this included VAT or not.

### **Additional regulation**

There are already extensive professional regulations governing the conduct of solicitors, barristers and legal executives. For example the Solicitors Regulation Authority code of conduct 2007 rule 1.04 states “You must act in the best interests of each client”. Adding to the administrative responsibility by stipulating that a client must obtain independent advice on a DBA is unnecessary and will incur additional cost for the injured person. Requiring such an obligation for DBAs and not new CFAs will also create an inequality between those clients entering into a CFA and those entering into a DBA.

Further specific regulation for DBAs could create double regulation and this would not be of benefit to the consumer. Lawyers must already comply with detailed rules on costs. These rules will apply whatever funding arrangement is entered into. If DBAs are to be introduced then our concerns around “reserved legal services” need to be considered. The problem has been recently highlighted by the SRA in the consultation paper<sup>48</sup>:

*one major area for discussion that remains outstanding is the definition of reserved legal services.*

According to the glossary of terms in the Legal Services Act (LSA), reserved legal services is defined as:

*at present, certain legal services (litigation, advocacy, conveyancing, probate, etc.) are reserved to solicitors, barristers and certain other persons under the Solicitors Act 1974 and/or the Courts and Legal Services Act 1990; once the LSB is up and running (probably about 2010), such activities, as well as work reserved to notaries and some work reserved to certain persons under the Immigration and Asylum Act*

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<sup>48</sup> *The Architecture of change Part 2 – the new SRA Handbook – feedback and further consultation*, Solicitors Regulation Authority, page 5 paragraph 34.

*1999, will be re-defined under the Act, re-designated as reserved legal activities and reserved to various categories of authorised person.*

Reserved legal activities is then defined as:

*specified in section 12 of the Act as the exercise of a right of audience, the conduct of litigation, reserved instrument activities, probate activities, notarial activities and the administration of oaths.*

Conduct of litigation is defined within Schedule 2 of the Act as:

- (a) the issuing of proceedings before any court in England and Wales,*
- (b) the commencement, prosecution and defence of such proceedings, and*
- (c) the performance of any ancillary functions in relation to such proceedings (such as entering appearances to actions).*

Paragraph 34 continues to state that:

*Entities that provide legal services will only be able to be regulated as ABSs under the LSA if they undertake one or more reserved activities, as defined above. If they provide only unreserved legal activities, such as will-writing, legal advice and mediation services, they will be able to do so, as they can at present, on an unregulated basis and with no client protection in place.*

In only a small minority of personal injury cases are proceedings issued. Indeed, there is pressure from the courts and the operation of pre-action protocols to treat the issue of court proceedings as a “last resort”.

The definitions above have the ability to create a loophole whereby individuals or organisations, such as claims management companies (CMCs), will be able to run personal injury cases all the way up to the issue of court proceedings whilst being completely unregulated. This leaves the injured person in a completely inadequate situation with no client protection.

It may be that under the current regulatory regime, unregulated individuals or organisations could deal with personal injury claims up to the point of issuing proceedings. However, the current costs structure makes it difficult for any person or organisation doing so to get paid for undertaking such work. This is particularly so when most regulated firms, namely solicitors, are able to act for personal injury claimants whilst offering to ensure that they receive 100 per cent of any compensation received. Furthermore, solicitors are able to do this whilst acting for a client under the terms of a conditional fee agreement together with the benefit and protection of ATE. Other clients may be members of trade unions, whose legal services also provide for full recovery of compensation for the client. Whilst not all personal injury clients will be aware of what all solicitors' firms offer, there is a general market expectation to obtain full recovery of damages for personal injury clients.

However if DBAs are permitted in relation to personal injury claims, it may be open for anyone to act for an injured person on that basis. If they settle the claim without issuing proceedings, they would have settled the claim without carrying out a regulated activity, as per the definition above, and without protection for the consumer.

This would offer a clear commercial incentive for an unregulated organisation conducting personal injury claims to settle the claim before and without the issuing of proceedings. That pressure is likely to lead to claims conducted by unregulated organisations being under settled. But the injured people whose claims are



undersettled would have no consumer protection because the organisation dealing with their claim would be unregulated.

If QOCS is to be introduced we recommend that it applies equally to DBAs and CFAs.

### **Litigants in person**

We agree with the proposal to increase the prescribed rate recoverable by a litigant in person who cannot prove financial loss to £20 an hour. We also agree that the small claims track rate for any loss of earning or loss of leave by a party or witness due to attend a hearing should be increased by Average Earnings Index to £87.23.

### **Other reforms**

#### **Predictable damages**

The purpose of general damages is to compensate injured people for their pain, suffering and loss of amenity. There is no single 'correct' award from a particular injury as an injury can affect different people in different ways, so for example a healthy young adult living at home with his parents will be much less affected by a broken arm than an elderly person who lives alone, for whom basic tasks will obviously prove a problem.

APIL remains of the view that it is impossible to create an unbiased computerised assessment tool which fairly caters for every injury and the effects every injury will have on different claimants. A short test run, instigated by Lord Justice Jackson and conducted by Insurance Services Office Limited (ISO) and Computer Science Corporation (CSC), using fourteen cases of differing values (up to £5,000), generated variances in awards of up to 13 per cent. Given the many different IT platforms used it would be difficult for any damages software to work on all systems. All these problems coupled with the fact that the approach is unfair for individual victims with varying levels of damages, indicates that a 'one size fits all' approach does not work.

Tariff systems are inflexible and will not benefit the injured person who, in each case, is an individual who suffered injuries whose effects or consequences will not be directly comparable with the effects of those same injuries suffered by other claimants.

Our 4,700 members consistently tell us that the courts always award more than defendants have offered on the basis of calculations carried out by, for example, Colossus. This assertion has recently been verified by a survey conducted by the Personal Injuries Bar Association (PIBA) which surveyed its members on cases they had handled in the preceding six months. The survey criteria involved cases where the main issue was quantum; the defendant's offer had been made based on details entered into a computer programme and the defendant insurer had an actual or apparent policy of refusing to increase such offers. The survey results were emphatic: in the 1,349 cases which fitted these criteria, there were a mere 19 (1.3 per cent) cases where the claimant failed to beat the defendant's computer generated offer.

While we agree that calculation of damages may necessarily be complicated dependent on the nature of the injuries involved, we do not accept the introduction of further electronic processes such as a calibrated damages assessment tool.

We do however welcome the introduction of technology where practitioners find this helpful. Indeed, many of the sources that are currently used to calculate general damages, such as Kemp and Kemp and the Judicial Studies Board's Guidelines, are currently available in a digital format. In addition, a majority of law firms subscribe to extensive searchable case law databases such as Lawtel, Westlaw and Lexis PSL. Lawtel currently has over 80,000 practitioner users and for personal injury awards alone contains the searchable electronic details of over 2,800 quantum reports, reported and unreported, in an archive spanning the past 25 years. Westlaw is more commercially orientated, but has a formidable database of reported cases and legislation. Lexis PSL provides access to a searchable quantum database of over 2,000

cases. These databases are run by Thomson Reuters and Lexis Nexis respectively and claim to have no claimant, defendant or insurer bias in their content and provide excellent resources for personal injury lawyers who, using their skill and judgment, can calculate the correct amount of a likely award already.

There is a concern that such databases should not become 'swamped' by decisions with either claimant or defendant bias. We are aware that Kemp and Kemp, another quantum calculation publication (which has paper and digital formats) found itself receiving inordinate numbers of county court decisions on quantum from defendant sources, and had to introduce procedures to ensure that its valuations are not biased one way or the other in the future.

Another concern regarding the introduction of software to assess damages relates to the development of the law in general. The law of personal injuries does not stand still. Any system must allow lawyers to take on cases which include a degree of risk, otherwise injured people whose cases involve a degree of risk will not be able to find a solicitor willing to represent them, and only the cases that are more certain to be successful will be taken on.

Systematic calculation of the award in the way suggested would lead to the death of reported case law for those types of claims included in the scheme. No advances in the law would be possible. For example, in the 1980s, while representing fire-fighters, Andrew Dismore (APIL member) persuaded the courts to accept a new head of damages for "loss of congenial employment", now established in personal injury law. As Lord Rodger recently said at APIL's annual conference, cases such as *Corr v IBC*<sup>49</sup> and *Savage v South Essex Partnership Foundation NHS Trust*<sup>50</sup> (liability for suicide) and the case of *Gray v Thames Trains (ex turpi causa)*<sup>51</sup> show that the law relating to personal

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<sup>49</sup> [2008] UKHL 13

<sup>50</sup> [2008] UKHL 74

<sup>51</sup> [2009] UKHL 33

injuries continues to develop. While it is accepted that settlement and avoidance of trials is a good thing in the modern litigation process, Lord Rodger ensured that his view of any changes to the claims process was made clear. He said, “I think it is right to remember that we need new cases if the law is to be refreshed and kept up to date. Those of you who bring and fight those new cases perform a service from which all members of our society ultimately stand to benefit.”

The use of the JSB guidelines, which are regularly updated using awards made by the courts, along with reported and unreported quantum reports, remains the most effective way of ensuring that claimants receive the correct and most up to date sum for their injuries. Further work would be helpful in providing greater guidance within these guidelines, particularly in relation to the lower value claims.

### **Clinical negligence**

APIL has produced a separate paper *“Improving the process for dealing with clinical negligence claims”*<sup>52</sup> which was presented to government officials in January 2011. We recommended, after consultation with our specialist clinical negligence practitioners, that the right solution to reform was one which encourages the right behaviours and therefore saves costs whilst still preserving access to justice. This could be achieved by:

1. Immediately introducing the revised draft of the Pre-action Protocol for the Resolution of Clinical Disputes brokered by the Civil Justice Council, the Law Society and the Clinical Disputes Forum and which has industry-wide agreement;
2. Developing a “best practice” guide for clinical negligence cases in conjunction with the NHSLA and other interested stakeholders;
3. Adapting the personal injury multi-track code pilot to work in conjunction with higher value clinical negligence claims;

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<sup>52</sup> Appendix B

4. Developing a streamlined process for straightforward, lower value clinical negligence claims;
5. Introducing regulated, staged success fees for clinical negligence litigation.

## **Impact assessments**

There is a significant lack of evidence on which the Government has based its radical proposals in the green paper. If the proposals are implemented the effect of the reform on claimants, defendants and society in general will not have been sufficiently considered.

The analysis<sup>53</sup> of the proposals so far suggests that there will be real access to justice issues for those claimants bringing a case that is not straight forward. There is a very real possibility that more difficult claims like disease claims will not be pursued if the primary package of proposals is brought in. What will the cost be to the state if these injured people do not seek to obtain redress from the wrongdoer for their care? Loss of earnings and treatment costs will fall to be dealt with by the Government through benefits and the NHS. There will also be a reduction in recoupment through CRU if claims are not pursued. There has been no recognition of this potential cost to the Government in the assessments.

Additionally the Government has failed to consider the implications of the possible rise in court fees; whilst the point is noted in the impact assessment what does not appear to have been measured is the effect that this will have on those bringing a claim. If disbursements have to be funded by the injured person, and there is no recoverable ATE insurance premium to insure them against the risk of paying these inflated costs if the claim fails, claimants may well be dissuaded for pursuing meritorious claims. What are the potential wider affects of these proposals on the ATE insurance and BTE insurance market? Are these markets likely to survive? In our view

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<sup>53</sup> APIL commissioned independent analysis of the Impact Assessments by Nottingham Economics see appendix C for the conclusions.

the ATE market is unlikely to survive and BTE insurers will find it difficult to justify a premium if QOCS is implemented.

The impact assessments acknowledge that Jackson LJ's proposals will put claimants in a worse position, as there will be some that are unable to pursue meritorious claims. This will benefit defendants significantly, as the number of meritorious claims will drop. We are disappointed that this Government is not putting the needs of the innocent injured person over and above those of the wrongdoer.

## **Appendices**

**Appendix A- Counsel's Opinion.**

**Appendix B- Improving the process for dealing with clinical negligence claims.**

**Appendix C- Report from Nottingham Economics on the economic impact assessments.**

## **Appendix A- Advice from counsel.**



**IN THE MATTER OF PROPOSALS RECOMMENDED IN THE FINAL REVIEW  
OF CIVIL LITIGATION COSTS IN THE FIELD OF PERSONAL INJURY LAW**

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**OPINION ON IMPACT OF REFORMS  
ON SERIOUS/CATASTROPHIC INJURY CLAIMS  
AND ARTICLES 6 AND 14 OF THE EUROPEAN CONVENTION  
ON HUMAN RIGHTS**

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**Introduction**

1. We have been asked to consider the recommendations in the final Jackson Review of Civil Litigation Costs, as they impact upon persons with disability.
2. The proposals encompass, so far as material:
  - 2.1. The placing of a cap on conditional fee uplifts as between a Claimant and his or her legal team, proposed to be set at 25% of PSLA and Past Loss damages – i.e. excluding future loss and expenses;
  - 2.2. The reversal of legislation permitting recovery of conditional fee uplifts and After the Event (ATE) insurance premiums from defendants in successful claims, so that such uplifts and premiums become irrecoverable from defendants;
  - 2.3. The enhancement of general damages awards by 10% in an attempt to mitigate the impact of the first two proposals.
3. Particular concerns have been raised by consultees as regards the impact of these changes upon persons who have suffered serious or catastrophic injuries. In so far as it is necessary to be more specific in relation to such adversely affected persons, they can be further identified as claimants with ongoing disabilities such that they are likely to have substantial claims for future loss and expenses. We consider that this is a readily

identifiable category of claimants, well known to lawyers and judges experienced in personal injury cases.

4. The first concern expressed is that the imposition of the cap on the CFA fee uplift could render it difficult, if not impossible, for persons seriously disabled by an accident to secure the necessary legal assistance to bring a claim. We are informed that there will be a tendency for lawyers (who would currently act in such cases) to refuse instructions in cases which either (i) involve serious injuries and (as a result) complex medical issues, or (ii) are less than “sure-fire” winners, whether on liability or on quantum, either because of the complex issues referred to at (i) or otherwise. Thus while cases which are simple and “very likely to win” may well not be affected by the proposed changes, problems in obtaining representation will tend to arise in cases that raise serious and complex issues – which are the ones that are most expensive and also most risky, to run – particularly where there is any doubt about ultimate outcome. (As to the latter, we are reminded that few litigated cases appear at the outset to be sure-fire winners, particularly where they give rise to complex issues, and that many wholly meritorious cases raised doubts as to outcome at the outset ) This class of case is very likely to include the persons referred to above. In such claims, the imbalance between (a) the sum necessary to compensate the legal team for the risk incurred in acting on a conditional fee basis and (b) a sum constituting no more than 25% of general and past loss awards is particularly stark. This (we are instructed) is likely to be considered inadequate to compensate the legal team for the risk of acting on a CFA basis.<sup>1</sup>
5. The second concern is that the removal of either After the Event Insurance (“ATE”), or of recoverability of the ATE insurance premium – which would for many Claimants amount to the same thing - will impact particularly adversely upon those who are catastrophically or seriously injured. Such claimants are argued to suffer particular anxiety about the exposure to costs liabilities, and are generally less able to face the consequence of incurring irrecoverable disbursement debts. In addition, the outlay in disbursements

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<sup>1</sup> The thinking underpinning the CFA mechanism of litigation funding is that the success fees on the winning cases have to fund the shortfalls because of non-recovery on the losing ones. We are advised (and can see the force of the concern) that the relationship between those two features will be radically undermined by the cap on the CFA uplift, such that in order to maintain the balance between the two, lawyers acting in this area of practice are bound to have to apply a much more conservative test to what instructions they accept.

required to pursue such a claim, with numbers of experts potentially running into double figures, was highlighted.

6. The third concern is that the shortfall in damages actually received could cause particular hardship to claimants in serious and catastrophic injury claims. The ring-fencing of certain heads of claim (including future losses themselves) would be inadequate mitigation. Shortfalls elsewhere would bear upon the availability of ring-fenced sums for their allocated purpose. Such claimants may lack the capacity to make up any shortfall through economic activity. The 10% enhancement of general damages will be unlikely, in a case of serious injury (we are advised) to ameliorate the position; either the lawyers would decline to be compensated from the claimant's damages (again impacting on the likelihood of the lawyer accepting instructions at all), or the claimant's retained damages will be reduced, producing a disproportionate and harmful impact on such claimants.
7. PIBA's response to the report estimates that the proposals will result in a severe reduction in the prospects of finding a reputable lawyer to act on the basis that he will not be properly remunerated for work done, and risk incurred.

#### **Summary of Views**

8. The impact of the funding changes proposed by the Jackson review has been considered, we understand, against the framework of the "majority" of claims, in value and complexity.
9. For the reasons given below, we have considerable doubts as to whether the proposed changes could be defended on ECHR grounds as they apply, not to the majority of claims, but to a catastrophically injured claimant.
10. Any ECHR Article 6 complaint, or complaint premised upon Article 14 in conjunction with Article 6 will, of course, turn upon its individual circumstances.
11. The Final Report changes would, we understand, leave the safeguarding of a catastrophically injured claimants' right of access to justice guaranteed by Article 6 of the Convention reliant, in broad terms, upon finding a suitable legal team prepared to forego payment for the financial risk undertaken in entering a conditional fee agreement.

12. At best, this leaves access to justice for such claimants on a precarious basis. We further consider that the imposition of a one size fits all regime upon even the most serious and complex of claims would require separate analysis, and justification under Article 14 of the Convention.
13. It may prove difficult to defend the proposals (if implemented) as a proportionate response to the requirement to balance the interests of seriously injured claimants and the insurance industry

## **Discussion**

### **1. Article 6 and Access to Justice**

14. The European Court of Human Rights has considered the requirement of funding to secure effective access to a court in the context of legal aid, rather than conditional fee agreements. The Court has, however, emphasised that Article 6 § 1 leaves to the State a free choice of the means to be used in guaranteeing litigants access to justice. The institution of a legal aid scheme constituted one of those means but there were others, (see *Airey v Ireland*, October 1979, Series A, No 32, pp. 14-16, § 26).
15. In *Steel & Morris v UK* (February 15, 2005, ECHR 2005- II), the ECtHR considered a challenge to the Legal Aid Act 1988 arising from the 'McLibel' trials. Under Schedule 2, Part II, paragraph 1 of that Act, "[p]roceedings wholly or partly in respect of defamation" were exempted from the scope of the civil legal aid scheme. The Court emphasised that:
  - 15.1. the Convention was intended to guarantee practical and effective rights. This was particularly so as regards the right of access to a court in view of the prominent place held in a democratic society by the right to a fair trial
  - 15.2. it was central to the concept of a fair trial, in civil as in criminal proceedings, that a litigant was not denied the opportunity to present his or her case effectively before the court and that he or she is able to enjoy equality of arms with the opposing side
  - 15.3. whether legal aid may be required for effective access to court depended on the particular circumstances of each case and, in particular, upon the importance of

what is at stake for the applicant in proceedings, the complexity of the relevant law and procedure and the applicant's capacity to represent him or herself adequately

15.4. the right of access to a court was not, however, absolute and could be subject to restrictions, provided that these pursue a legitimate aim and are proportionate. It could be acceptable to impose conditions on the grant of legal aid based, *inter alia*, on the financial situation of the litigant or his or her prospects of success in the proceedings

15.5. it was not incumbent on the State to seek through the use of public funds to ensure total equality of arms between the assisted person and the opposing party, as long as each side is afforded a reasonable opportunity to present his or her case under conditions that do not place him or her at a substantial disadvantage *vis-à-vis* the adversary

16. In that case, the Court noted that the applicants had received some help on the legal and procedural aspects of the case from barristers and solicitors acting *pro bono*, and had been able to raise a certain amount of money by donation. For the bulk of the proceedings they had acted alone (para 68). It reasoned:

"...the Court considers that, in an action of this complexity, neither the sporadic help given by the volunteer lawyers nor the extensive judicial assistance and latitude granted to the applicants as litigants in person was any substitute for competent and sustained representation by an experienced lawyer familiar with the case and with the law of libel." (para 69)

17. The ECtHR was critical of the disparity between the respective levels of legal assistance enjoyed by the applicants and McDonald's. It considered that this was

"...of such a degree that it could not have failed, in this exceptionally demanding case, to have given rise to unfairness, despite the best efforts of the judges at first instance and on appeal." (ibid)

18. We consider it significant that in *Steel and Morris*, the ECtHR highlighted the lack of choice the applicants had as regards their participation in defamation proceedings, acting as defendants to protect their right to freedom of expression, a right accorded considerable importance under the Convention (*supra*, para 63). It seems to us that an

analogy may be drawn between this element of compulsion and what is at stake in a claim brought by a catastrophically injured claimant, dependent upon access to proceedings to facilitate a return to active life.

19. The reform proposals, as we understand them, leave the availability of legal assistance dependent in contested cases upon the claimant's ability to find a legal team prepared to act with no real prospect of securing the fees concomitant with the conditional fee funding risk incurred (this being the consequence of imposing the cap on uplifts).
20. This may follow, consultees suggest, either from (a) the traditional reluctance of personal injury lawyers to insist upon any payment of fees derived from sums awarded to the claimant in damages or (b) the sheer imbalance, in a personal injury claim, between the financial risk undertaken by the claimant's legal team and the non-ring fenced damages award.
21. We note the concerns expressed by consultees that there are bound to be a substantial number of meritorious cases concerned with serious injury where suitable legal assistance will be unavailable.
22. This is a risk which is likely to be exacerbated by the specialist expertise and experience required to bring a serious or catastrophic injury claim to a successful conclusion.

## **2. Article 14 and persons suffering from a severe injury/disability**

23. An applicant challenging the funding reforms proposed would further invoke Article 14, in conjunction with Article 6. This provides:

The enjoyment of the rights and freedoms set forth in this Convention shall be secured without discrimination on any ground such as sex, race, colour, language, religion, political or other opinion, national or social origin, association with a national minority, property, birth or other status.

24. Karen Reid describes its approach in her *Practitioner's Guide to the European Convention on Human Rights*:

“While violations of Art 14 have generally concerned situations where the State has treated differently persons in analogous situations without providing a reasonable or

objective explanation, the Court has extended the provision to situations where a State without an objective and reasonable justification fails to treat differently persons whose situations are significantly different.”  
(3<sup>rd</sup> edn (2007), page IIB-273 and see *Thlimmenos v Greece*, April 6, 2000, ECHR 2000-IV, *Chapman v UK*, January 18, 2001, ECJR 2001-I).

25. This dual approach reflects the domestic rule of equality. It has been described as “one of the building blocks of a democracy”<sup>2</sup>, and a “cardinal principle” of the UK’s administrative law<sup>3</sup>:

“Indeed, their Lordships would go further and say that treating like cases alike and unlike cases differently is a general axiom of rational behaviour”.<sup>4</sup>

26. The domestic courts have, consistently with this reasoning, been astute to examine not just formal compliance of administrative measures with the principles of equal treatment, but also whether apparently neutral rules in fact have discriminatory effects.<sup>5</sup> Thus formally neutral rules which disadvantage a particular class have been struck down.<sup>6</sup>

27. A particular difficulty underpinning the reasoning supporting the current reform proposals, as we understand it, is its imposition of a funding regime calibrated upon the “great majority” of claims on victims of catastrophic injuries claimants. This seems to us a *prima facie* breach of the requirements of equal treatment in securing access to courts.

28. We note in this context that the reasoning within the Review of Litigation Costs is, in this respect, sparse. It is suggested simply:

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<sup>2</sup> *Mantadeen v Pointu* [1999] 1 AC 98 (PC) at 109C per Lord Hoffmann.

<sup>3</sup> See *R v Hertfordshire CC ex p Cheung* The Times, April 4, 1986 per Donaldson MR, and for academic discussion see de Smith, Woolf and Jowell, “Judicial Review of Administrative Action” (5<sup>th</sup> edn, 1998) at paras 13-036 to 13-045, Craig, “Administrative Law” (5<sup>th</sup> edn 2005) at pages 681-6, Jowell, “Is Equality a Constitutional Principle?” [1994] 2 CLP 1, Lester “Equality and United Kingdom Law: Past, Present and Future” [2001] PL 77.

<sup>4</sup> *Mantadeen v Pointu*, note 25 above.

<sup>5</sup> *R v General Medical Council ex parte Virik* [1996] ICR 433 For more recent equality analysis, see *R (Association of British Civilian Internees- Far East Region) v Secretary of State for Defence* [2002] EWCA Civ 473, [2003] QB 1397 at paras 83-6 per Dyson LJ and *Great North Eastern Railway v Office of Rail Regulations and Others* [2006] EWHC 1942 (Admin) at paras 86-90 per Sullivan J.

<sup>6</sup> See *R v Immigration Appeal Tribunal ex p Manshoora Begum* [1986] Imm AR 385. Immigration regulations restricted admission of dependent relatives to those having a standard of living “substantially below their own country”. Indirectly, the rule benefited affluent country immigrants. Simon Brown J classed its unequal operation “manifestly unjust and unreasonable.”

"In order to assist personal injury claimants in meeting the success fees out of damages, I recommend that:

- (i) The level of general damages for pain, suffering and loss of amenity be increased by 10% across the board.
- (ii) The amount of success fee which lawyers may deduct be capped at 25% of damages, excluding any damages referable to future care or future losses.
- (iii) The reward for making a successful claimant's offer under CPR Part 36 (i.e. an offer which the defendant fails to beat at trial) be enhanced.

I am advised by Professor Paul Fenn (economist assessor) that such an increase in general damages will in the great majority of cases leave claimants no worse off. Indeed the great majority of claimants (whose claims settle early) will be better off. At the same time proper incentives for all parties to personal injuries litigation will have been restored."

29. It would seem to us necessary at least to engage with the distinct prejudice the reforms will result in for catastrophic accident victims. The pool of lawyers able to provide the specialist assistance required is likely to be small. The financial and the time commitment necessary to pursue such a case to a successful conclusion is not comparable to that involved in a standard personal injury claim.

30. By reason of the potential imbalance between

30.1. litigation costs, and

30.2. the 25% of non-ring fenced damages available to pay for additional liabilities in a complex or catastrophic injury claim,

the consequence of this funding shortfall may be experienced particularly acutely by such claimants.

31. It follows that on the hypothesis, which we consider likely, that the victims of catastrophic and disabling injuries will be considered a distinct "class" for Article 14 purposes, this constitutes a further argument which could be prayed in aid by a severely disabled claimant unable to secure specialist legal assistance required to pursue his claim.

32. It further seems to us that distinct justification would be required as regards the failure to make accommodation for

32.1. the particular hardship caused to a seriously injured claimant by any substantial deduction in damages awarded to mitigate the disability sustained.



32.2. the financial risk occasioned by the disbursement expenditure not recoverable should the claim fail.

### **Conclusion**

33. The present advice is, inevitably, of a provisional and qualified nature. The proposed funding reforms to civil litigation remain at a consultation stage.

34. As presently drafted, however, they seem to us to place claimants who have suffered the most complex personal injury at a particular disadvantage as regards their prospects of securing adequate legal representation, financial protection from adverse costs consequences, and adequate compensation to permit a return to active daily life.

35. In respect of the reduced availability of access to justice, in particular, it seems to us there is a real prospect of a successful challenge under Article 6 of the Convention.

36. As regards a challenge under Article 14, it seems to us that a proportionality challenge would have to be met with substantial justification, and that such justification would need to address in particular the position of claimants in this class of claim.

37. This analysis seems to us still to be outstanding.

38. It follows that there are real prospects of a Convention based challenge to the funding reform proposals as they impact upon catastrophic claims succeeding.

NIGEL PLEMING QC

COLIN THOMANN

39 Essex Street Chambers

9<sup>th</sup> September 2010

**Appendix B- Improving the process for dealing with clinical negligence claims.**

## **Improving the process for dealing with clinical negligence claims**



**The Association of Personal Injury Lawyers**

**November 2010**

The Association of Personal Injury Lawyers (APIL) is a not for profit organisation formed by claimant lawyers with a view to representing the interests of personal injury victims. The association is dedicated to campaigning for improvements in the law to enable injured people to gain full access to justice, and promote their interests in all relevant political issues. Our members comprise principally practitioners who specialise in personal injury litigation and whose interests are predominantly on behalf of injured claimants. APIL currently has around 4,700 members in the UK and abroad who represent hundreds of thousands of injured people a year.

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;

APIL's executive committee would like to acknowledge the assistance of members of our clinical negligence special interest group and in particular the following specialist practitioner members in preparing this response:

Muiris Lyons- President

John McQuater- Immediate Past President

Christopher Limb- Treasurer

Stephanie Code – Coordinator of the clinical negligence special interest group

David Body – Past executive committee member

Russell Levy- Past executive committee member

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## Principles

NHS treatment and care is a cornerstone of our society and it is therefore deeply worrying to read the latest statistics that indicate an increase in the number of patients who have been harmed during treatment<sup>1</sup>. Prevention of negligence and higher standards of care are in the interests of everyone; no-one wants to see a loved one suffer needlessly. Our members are there to assist those who receive substandard treatment or are the victims of medical negligence.

Every individual has the right to bodily integrity, and this right is protected in law.<sup>2</sup> People must have confidence in the legal system so if they or a loved one are injured they know they have a right to full and fair redress.

APIL recognises that there is always room to improve process and procedure and those efficiencies will lead to costs savings. However, this must not be to the detriment of the person who has been needlessly injured. Procedural change cannot be used as a means of reducing access to justice. Those who are injured through others carelessness must be able to bring a claim before the courts and receive full and fair compensation. The Government must remain aware of the fact that it faces a conflict of interest. It is responsible for the National Health Service and overall allocation of its resources. At the same time the Government is responsible for guarding the civil justice system to ensure that citizens have access to justice and recover full and proper compensation for injury caused by the breach of duty of others.

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<sup>1</sup> 486,449 incidents in October 2008 to March 2009 and 536,010 incidents between April 2009 to September 2009 National Patient Safety Agency Annual report 2009/2010

<sup>2</sup> Hale LJ in *Parkinson v St James and Seacroft University Hospital NHS Trust* [2001] EWCA Civ 560 para 56 said "The right to bodily integrity is the first and most important of the interests protected by the law of tort, listed in Clerk & Lindsell on Torts, 18th edition, para 1-25. "The fundamental principle, plain and incontestable, is that every person's body is inviolate" see *Collins v Willcock* [1984] 3 All ER 374, at p 378. Included within that right are two others. One is the right to physical autonomy: to make one's own choices about what will happen to one's own body. Another is the right not to be subjected to bodily injury or harm. These interests are regarded as so important that redress is given against both intentional and negligent interference with the".

Early resolution of the issues in a case brings it to a quicker conclusion, delivering compensation more quickly to the injured person, and also saving the defendant money. At present defendants argue that they are paying out too much in costs. However, the remedy is in their hands. In cases that do not resolve early and where the defendant contests liability or quantum issues at a late stage or takes every point and proceeds to trial, costs will be significant. Defendants have the ability to risk assess cases at an early stage and to do so more accurately than claimants because of the information they hold at the outset of a claim and because of their significant resources and medical expertise. In clinical negligence cases they are notified at a very early stage of all potential claims when the medical records are first requested. They have the opportunity to carry out a risk assessment at that stage but in the main they choose not to.

APIL's view is that efficiencies can be achieved and processes streamlined. Costs can be reduced but the way to achieve this is for the process to shape behaviour, rewarding or incentivising good behaviour and penalising poor behaviour. Any reforms should focus on shaping the process to improve the conduct of claims, not restricting the injured person's access to justice or reducing his compensation. If we can get this right, then the benefit to both the injured person and the defendant will be clear.

## **Background**

The objective of Lord Justice Jackson's year long review on civil costs was to "make recommendations in order to **promote access to justice at proportionate cost**"<sup>3</sup>. Our members recognise that improvements can be made to the procedure for dealing with clinical negligence claims. We do not believe that the proposals made in the report fulfill the objective of the review. Access to justice should not be defined by the cost of bringing a claim, but by the cost to society of an effective civil justice system that is accessible by all with a meritorious claim. It is unjust to penalise those who

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<sup>3</sup> Page 2 Review of Civil Litigation Costs: Final Report December 2009

have been injured by abolishing the principle of full compensation, particularly those with the most serious injuries who would suffer the most under Lord Justice Jackson's proposals, as he himself recognises that his proposals will not benefit all claimants<sup>4</sup>. Without full compensation it will fall to the state to fund the care of those who are seriously injured or the victim will simply not receive the appropriate care at all.

Lord Justice Jackson was appointed by the Master of the Rolls to undertake a quasi-judicial inquiry into costs in civil claims. His terms of reference were fixed at the outset on the presumption that costs were excessive and that something needed to be done. With the benefit of hindsight it was unfortunate for Lord Justice Jackson that whilst his year-long consultation was underway, a separate Ministry of Justice-led incentive was working towards a new claims process for road traffic accident claims worth less than £10,000. That claims process was developed and introduced with broad industry consensus in April 2010. It is clear that there have been a number of teething problems with the process and that there is still a lot of work to do but it has provided a framework for a modern, efficient, streamlined and cost effective process that now encapsulates 75 per cent<sup>5</sup> of all personal injury claims. The significance of this cannot be overestimated. Whilst Sir Rupert was drafting his recommendations to deal with costs in personal injury cases, the personal injury industry was already putting in place a scheme that would ensure three-quarters of all personal injury claims fell within a new fixed costs process. In the circumstances, we say that Lord Justice Jackson's proposals have to a large extent been overtaken by developments. Any reference to costs should concern only those 25 per cent of cases outside of the new claims process. We fully accept that refinements are needed to other areas of personal injury, including clinical negligence, but sweeping reforms are not required.

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<sup>4</sup> Ibid Page 112 "an increase in general damages will in the great majority of cases leave the claimants no worse off."

<sup>5</sup> Page 38 Case track limits and the claims process for personal injury claims – summary of responses

## **Our Proposals**

A simpler solution, one which encourages the right behaviours and therefore saves costs but still preserves access to justice would be to:

1. Immediately introduce the revised draft of the Pre-action Protocol for the Resolution of Clinical Disputes brokered by the Civil Justice Council, the Law Society and the Clinical Disputes Forum and which has industry-wide agreement;
2. Develop a “best practice” guide for clinical negligence cases in conjunction with the NHSLA and other interested stakeholders;
3. Adapt the personal injury multi-track code pilot to work in conjunction with higher value clinical negligence claims
4. Develop a streamlined process for straightforward, lower value clinical negligence claims;
5. Introduce regulated, staged success fees for clinical negligence litigation.

### **Pre-action protocol**

At the request of the Civil Justice Council and with the assistance of the Law Society, the Clinical Disputes Forum was asked to review, revise and update the pre-action protocol for clinical negligence. The work was conducted by a stakeholder group representing all sides of the industry (claimants, defendants, experts). Changes were achieved by consensus and some radical innovations introduced to streamline the process, reduce the areas for potential dispute and reduce costs. The end result is a revised draft protocol that has industry wide support and is ready to be introduced by the Civil Procedure Rules Committee. The agreed draft is appended at A.

The most significant change proposed is the introduction of a new intermediate stage involving an early notification letter to give defendants more time to investigate claims and a greater opportunity to admit liability at an earlier stage therefore saving significant costs. Other proposals seek to resolve current areas of dispute over the



disclosure of medical records and other documents by prescribing more clearly what the duties of all the parties are, which will reduce duplication of effort and save costs as well as saving significant time. Another key change is the introduction of a duty on the parties to consider rehabilitation with a view to providing the injured patient with earlier support and assistance.

Two of the agreed changes have already been implemented in the 53rd update of the Civil Procedure Rules: the extension of the period of time for the defendant to reply to a letter of claim, and the provision that any letter of claim to an NHS Trust or Independent Sector Treatment Centre is copied to the NHS Litigation Authority.

### **Best practice guide**

APIL has met with the NHSLA and representatives from its panel firms, on a number of occasions this year to share concerns about blockages in the system and possible ways of addressing these. One of the ideas mooted by this working group has been the possible development of a “best practice” guide. With the introduction of claims management companies selling claims to non-specialist firms there is an increasing need for such a publication. Both the NHSLA and APIL have agreed that this warrants further consideration.

### **Multi-Track Code Pilot**

The code was developed to help parties involved in higher value multi-track personal injury claims resolve liability. It puts in place a system that meets the reasonable needs of the injured person and works to settle the case by narrowing the issues in dispute before settlement or trial.

The code is a collaborative approach between APIL, Forum of Insurance Lawyers (FOIL) and major insurers and was launched in July 2008. For historical reasons clinical negligence claims were never included in the pilot. Early feedback from the pilot is positive and there is broad agreement from the NHSLA at this stage to consider an

extension of the pilot to cover clinical negligence claims. That said, there is recognition from both sides that it will need to be adapted to be suitable for clinical negligence claims.

The key objective of this scheme is to resolve liability as quickly as possible, help claimants to gain access to rehabilitation when appropriate and resolve their claims in a cost effective manner whilst still meeting the needs of the injured person.

Full details of the code are appended at B.

### **Streamlined process for straightforward clinical negligence claims**

There is currently limited access to justice in lower value clinical negligence cases. The Legal Services Commission funding criteria denies funding to claims where the value of the damages is less than £10,000 or where the case does not meet the cost benefit criteria. The result is that potential claimants with meritorious but low value claims are turned away from specialist panel firms as those cases are uneconomic to run.

There is real merit in exploring a streamlined process to promote quick and fair resolution for straightforward clinical negligence cases, where liability is admitted and injuries have resolved within a relatively short period of time, while still ensuring that the individual has access to independent legal advice from a specialist lawyer. This process would create swift access to justice at a fixed and proportionate cost. We would suggest that any such process should exclude fatal accidents and stillbirths as lessons should be learned from an incident which has been so serious as to cause death and a streamlined process may not allow for this.

### **Success fees**

We will continue to oppose the abolition of the recoverability of success fees and ATE premiums on the grounds that it will erode the injured person's damages. Such a proposal simply shifts some of the costs of litigation from "guilty" defendants to

injured claimants. That cannot be fair or just and is likely to have the most significant adverse impact on those who have been most severely injured - arguably those whose needs are the greatest.

Success fees are not a bounty or a windfall to the lawyer. They are an intrinsic part of ensuring access to justice is available to those with meritorious claims. They are not recovered in isolation from cases that are investigated and don't proceed nor are they recovered in isolation from cases that are pursued but are unsuccessful or withdrawn.

Our members recognise the need for efficiency and certainty and suggest that the answer is not to abolish success fees but to regulate them (as has been done successfully in other areas of personal injury, most notably the new claims process for road traffic cases). Fixing or regulating success fees is the only solution if access to justice is to be retained.<sup>6</sup> Jackson LJ's primary proposal to increase general damages by 10 per cent whilst abolishing recoverability produces a small windfall for some and massively penalises others: this is not justice. It would also provide a disincentive to legal practitioners to take on higher risk cases that still have real merit. Jackson LJ recognises in his report that his own suggestion may not work.

Producing a framework for staged, fixed success fees would produce a simpler and more predictable solution to the problems identified by Jackson LJ. There are real benefits to all in fixing success fees. Many of our members already operate staged success fee models in-house. This initiative has been swiftly embraced by the NHSLA and its panel firms and as a result our members have seen a significant increase in early admissions of liability by the NHS as a consequence. This reinforces our submission that the way to reduce costs is to encourage and reward good behaviour whilst penalising poor behaviour. Staged success fees offer clear incentives to defendants to settle cases early, and fixing those percentages would give defendants certainty.

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<sup>6</sup> Interestingly, this option was considered by Lord Justice Jackson who suggested it as an alternative to abolition. Review of Civil Litigation Costs: Final Report December 2009 page 113 para 5.12

Any framework for fixing success fees would need to be modelled on sound data, the basic principle being that cases settling early would attract a fairly modest success fee, with the highest percentage attaching to the most risky cases – those that proceed to trial.<sup>7</sup> Intermediate staging would be considered once data had been analysed and considered in conjunction with the aim of driving cases to settle swiftly and for both parties to be proactive. Whilst fixed success fees operate in other areas of personal injury such as road traffic accident, employers' liability and disease cases to provide certainty and reduce costs, they do not promote early settlement and encourage good behaviour through the use of stages and we suggest this approach could be extended to those areas leading to significant further efficiencies in those areas too.

## **Conclusion**

Whilst efficiency of process is important it must not be to the detriment of the injured person. This paper highlights what has already been achieved by consensus through discussion between claimant and defendant representatives. Such a process can continue to bring improvements to the civil justice system for all.

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<sup>7</sup> Only 47% of cases received by the NHSLA in the last ten years have been successful, NHSLA Factsheet 3: Information on claims dated August 2010.

## Appendix A

### FINAL DRAFT (14) PRODUCED BY THE CDF WORKING GROUP FOR THE LAW SOCIETY

## THE CLINICAL NEGLIGENCE PROTOCOL

### A. INTRODUCTION

#### 1 THE BACKGROUND TO THIS PROTOCOL

1.1 The first Protocol for the Resolution of Clinical Disputes was produced by the Clinical Disputes Forum, a multi-disciplinary body (now a registered charitable company) which was formed in 1997 in response to Lord Woolf's Access to Justice reports. One of the aims of the Forum is to find less adversarial and more cost-effective ways of resolving disputes about healthcare and medical treatment, and the Clinical Disputes Pre-Action Protocol was its first major initiative, drafted after extensive consultation. At the request of the Civil Justice Council and the Law Society, the Forum has again taken the lead in consulting widely to draft this updated Protocol.

1.2 This Protocol (which is set out in Sections 4 to 13 inclusive below)

- encourages a **climate of openness** when something has gone wrong with a claimant's<sup>8</sup> treatment or the claimant is dissatisfied with that treatment and/or the outcome. This reflects the requirements for clinical governance within healthcare;
- provides **general guidance** on how this more open culture might be achieved when disputes arise, in accordance with a "cards-on-the-table" approach;
- recommends a **timed sequence** of steps for claimants and healthcare providers<sup>9</sup>, and their advisers, to follow when a dispute arises. This should facilitate and speed up exchanging relevant information and increase the prospects that disputes can be resolved without resort to legal action.

1.3 This new version of the Protocol also takes into account developments in civil procedure since the Civil Procedure Rules 1998 (the CPR) were implemented, and in particular the terms of the Pre-Action Conduct Practice Direction introduced in April 2009 (the PACPD)<sup>10</sup>.

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<sup>8</sup> Although no assumption can or should be made that a patient will definitely turn into a claimant, we have chosen to use the word "claimant" (instead of "patient") throughout this Protocol, which is after all about behaviour in relation to the bringing of claims. It must be remembered that the claim may be on behalf of a patient without capacity, or be triggered by the death of the "patient", so that a litigation friend or relative will be the "claimant".

<sup>9</sup> In this protocol the phrase "healthcare provider" means those who are registered with or members of the General Medical Council, the Nursing and Midwifery Council, General Dental Council, Health Professions Council and the United Kingdom Public Health Register; and also any body or organisation, public or private, which employs such people or for whom such people work in providing healthcare services in England & Wales. No such definition appeared in the previous protocol. It may be preferred to set out the content of this and the previous footnote in the body of the revised protocol rather than leave these remarks as footnotes.

<sup>10</sup> Jackson recommends repeal of the PACPD. If this happens, references will have to be deleted or amended to refer to any replacement PD.

## 2 THE AIMS OF THIS PROTOCOL

2.1 The **general** aims of the Protocol are –

- to maintain and/or restore the claimant/healthcare provider relationship; and
- to resolve as many disputes as possible without litigation.

2.2 Its **specific** objectives are –

### ***Openness***

- to encourage early communication of the perceived problem between claimants and healthcare providers;
- to encourage claimants to voice any concerns or dissatisfaction with their treatment as soon as practicable;
- to encourage healthcare providers to develop systems of early reporting and investigation for serious adverse treatment outcomes and to provide full and prompt explanations, including an apology where appropriate, to dissatisfied claimants: such expressions of regret do not constitute an admission of liability in part or in full (the National Health Service Litigation Authority (NHSLA) guidance dated 1 May 2009 on apologies and explanations, as endorsed by other medical organisations, is set out at **Annex C** below);
- to ensure that sufficient information is disclosed by both parties to enable each to understand the other's perspective and case, and to encourage early resolution.

### ***Timeliness***

- to provide an early opportunity for healthcare providers to identify cases where an investigation is required and to carry out that investigation promptly;
- to encourage primary and private healthcare providers to involve their defence organisations or insurers at an early stage;
- to ensure that all relevant medical records are provided to claimants or their appointed representatives on request within 40 days as required by the Access to Health records Act 1990 and the Data Protection Act 1998;
- to ensure that relevant records which are not in healthcare providers' possession are made available to them by claimants and their advisers at an appropriate stage;
- to identify a stage before issue of proceedings at which the parties should consider whether settlement discussions, whether by alternative dispute resolution (ADR) or otherwise, are appropriate;
- where a resolution is not achievable, to lay the ground to enable litigation to proceed on a reasonable timetable, at a reasonable and proportionate cost, and to limit the matters in contention;
- to discourage the pursuit of unmeritorious claims and the prolonged defence of meritorious claims.

### ***Awareness of Options***

- to ensure that claimants and healthcare providers are made aware of the available options to pursue and resolve disputes and what each might involve.

2.3 This Protocol does not attempt to be prescriptive about a number of related clinical governance issues which will have a bearing on any healthcare provider's ability to meet the standards within the Protocol. Good clinical governance requires the following to be considered:

- (1) **Clinical risk management:** the Protocol does not provide any detailed guidance to healthcare providers on clinical risk management or the adoption of risk management systems and procedures. These are matters for the NHSLA, individual trusts and providers, including GPs, dentists and the private sector, including the Medical Defence Organisations. In Wales these are matters for the Welsh Risk Pool, Local Health Boards and Welsh Health Legal Services (WHLS). Effective, co-ordinated and focused clinical risk management strategies and procedures are essential for the management of risk and the early identification and investigation of adverse outcomes.
- (2) **Adverse outcome reporting:** the Protocol does not provide any detailed guidance on which adverse outcomes should trigger an investigation. However, healthcare providers should have in place procedures for such investigations, including recording of statements of key witnesses. These procedures should also cover when and how to inform claimants that an adverse outcome has occurred. Providers should also work with the National Patient Safety Agency on data collection on adverse incidents.
- (3) **The professional's duty to report:** in his final report, Lord Woolf suggested that the professional bodies might consider changes to their codes of conduct to impose duties to report adverse incidents.. The General Medical Council has published guidance to doctors about their duties to report adverse incidents to the relevant authorities and co-operate with inquiries.

### ***Where the Protocol fits in***

2.4 Protocols serve the needs of potential litigants in setting out a code of good practice, and assisting with:

- predictability in the time needed for necessary steps early in a dispute;
- standardisation of the requirements for relevant information, including records and documents to be disclosed;
- creating an expectation that steps will be taken before issue of proceedings to facilitate early resolution of cases and/or to minimise the number of issues to be litigated.

2.5 It is recognised that contexts differ significantly. For example:

- claimants tend to have an ongoing relationship with a general practitioner, more so than with a hospital;
- clinical staff in the National Health Service are often employees, while those in the private sector may be contractors;
- providing records quickly may be relatively easy for GPs and dentists, but can be a complicated procedure in a large multi-department hospital.

2.6 This Protocol is intended to be sufficiently broadly based and flexible to apply to all sectors of healthcare, both public and private.

### **3 ENFORCEMENT OF THE PROTOCOL AND SANCTIONS FOR NON-COMPLIANCE<sup>11</sup>**

3.1 This Protocol – when read with the CPR and the PACPD - is now regarded by the courts as setting the standard of normal reasonable pre-action conduct for clinical disputes.

3.2 If proceedings are issued, it is for the court to decide whether non-compliance with a Protocol merits sanctions. The PACPD explains and supports the Protocols, and sets out a list of sanctions which might be considered for non-compliance with any Protocol (see Section II paragraph 4 of the PACPD).

3.3 If the court has to consider the question of compliance after proceedings have begun, it may be less concerned with minor infringements, e.g. failure by a short period to provide relevant information. One minor breach will not entitle the ‘innocent’ party to abandon the procedure set out in this Protocol. The court looks at the effect of non-compliance on the other party when deciding whether to impose sanctions. Additionally, the court can itself order a stay of proceedings where **both** parties have failed to observe the requirements of any Protocol, for example by failing unreasonably to consider ADR.

## **B. THE PROTOCOL**

### **4 THE SHAPE OF THE PROTOCOL**

4.1 This Protocol is not a comprehensive code governing all the steps in clinical disputes. Rather it attempts to set out **a code of good practice** which parties should follow when litigation might be a possibility.

4.2 The **commitments** section (Section 5 below) of the Protocol summarises the guiding principles which healthcare providers and claimants and their advisers are invited to endorse when dealing with claimant dissatisfaction with treatment and its outcome, and with potential complaints and claims.

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<sup>11</sup> Jackson proposes pre-action applications to allege non-compliance. Such a move would apparently need primary legislation. If introduced, this will need amendment.



4.3 The **steps** section (Sections 7 to 10 below) sets out a recommended sequence of actions to be followed if litigation is in prospect, in a more prescriptive form.

## 5 GOOD PRACTICE COMMITMENTS

### 5.1 Healthcare providers should –

- (1) ensure that **key staff**, including complaints, claims and risk managers, are adequately trained and have knowledge of healthcare law, complaints procedures, risk management and civil litigation practice and procedure appropriate to their roles;
- (2) develop an approach to **clinical governance** that ensures that clinical practice is delivered to commonly accepted standards and that this is routinely monitored through a system of clinical audit and clinical risk management (particularly adverse outcome investigation);
- (3) set up **adverse outcome reporting systems** in all specialties to record and investigate unexpected serious adverse outcomes as soon as possible. Such systems can enable evidence to be gathered quickly, which makes it easier to provide an accurate explanation of what happened and to defend or settle any subsequent claims;
- (4) use the results of **adverse incidents and complaints positively** as a guide to how to improve services to claimants in the future;
- (5) ensure **that claimants receive clear and comprehensible information** in an accessible form about how to raise their concerns or complaints;
- (6) establish **efficient and effective systems of recording and storing claimant records**, notes, diagnostic reports and X-rays, and to retain these in accordance with Department of Health guidance (currently for a minimum of eight years in the case of adults, all obstetric and paediatric notes for children until they reach the age of 25, and indefinitely for claimants lacking mental capacity);
- (7) **advise claimants** of a serious adverse outcome and provide on request to the claimant or the claimant's representative an oral or written explanation of what happened, information on further steps open to the claimant, including where appropriate an offer of future treatment to rectify the problem, an apology, changes in procedure which will benefit claimants and/or compensation.

Procedures for handling NHS complaints **in Wales** are under review and may be different.<sup>12</sup>

### 5.2 Claimants and their advisers should –

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<sup>12</sup> Wales currently proposes to introduce the NHS Redress Scheme effectively and its complaints system as from a date to be decided later in 2010. Whether this will indeed come about is still unclear, hence the guarded reference here to complaints systems in Wales

- (1) **report any concerns and dissatisfaction** to the healthcare provider as soon as is reasonable to enable that provider to offer clinical advice where possible, to advise the claimant if anything has gone wrong and take appropriate action;
- (2) consider the **full range of options** available following an adverse outcome with which a claimant is dissatisfied, including a request for an explanation, a meeting, a complaint, and other appropriate dispute resolution methods (including mediation) and negotiation, not only litigation;
- (3) **inform the healthcare provider when** the matter will not be pursued further or has been concluded: legal advisers should also notify the provider when they are no longer acting for the claimant, particularly if proceedings have not started.

## 6 REHABILITATION

6.1 The claimant or the healthcare provider or both shall consider as early as possible whether the claimant has reasonable needs that could be met by rehabilitation treatment or other methods.

6.2 The parties shall consider in such cases how those needs might be addressed. The rehabilitation code (which is attached as **Annex D**) may be helpful in considering how to identify the claimant's needs and how to address the cost of providing for those needs.

6.3 The time limits set out in Sections 7 to 10 of this Protocol shall not be shortened to allow these issues to be addressed, except by consent.

6.4 The provision of any report obtained for the purposes of assessment of provision of a party's rehabilitation needs shall not be used in any litigation arising out of the subject-matter of the claim, save by consent.

## 7 OBTAINING THE HEALTH RECORDS<sup>13</sup>

7.1 Any request for records by the claimant should

- **provide sufficient information** to alert the healthcare provider where an adverse outcome has been serious or had serious consequences;
- be as **specific as possible** about the records which are required.

7.2 Requests for copies of the claimant's clinical records should be made using the Law Society and Department of Health approved **standard forms** (**Annex A** to this Protocol), adapted as necessary.

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<sup>13</sup> Note that Jackson proposes financial penalties where healthcare providers delay in providing records.

7.3 The copy records should be provided **within 40 days** of the request and for a cost not exceeding the charges permissible under the Access to Health Records Act 1990 and the Data Protection Act 1998. Payment may be required in advance by the healthcare provider.

7.4 The claimant may also make a request under the Freedom of Information Act 2000.

7.5 Disclosable documents include those created by the healthcare provider in relation to any relevant adverse incident or complaint made by or on behalf of the claimant. They also include any relevant guidelines, protocols or policies. The claimant should make a specific request for all documents reasonably required for the initial investigation of the case. In birth injury cases, it is good practice for the healthcare provider to ensure that a continuous copy of the CTG trace is provided as part of the disclosure of health records. This should not result in any additional charge.

7.6 In the rare circumstances that the healthcare provider is in difficulty in complying with the claimant's request within 40 days, the **problem should be explained** quickly and details given of what is being done to resolve it.

7.7 It will not be practicable for healthcare providers to investigate in detail each case when records are requested, **particularly where insufficient detail is supplied in the request for records**. But healthcare providers should **adopt a policy as to which cases will be investigated** (see paragraph 5.1 above on clinical governance and adverse outcome reporting and note also the provisions regarding commencing investigations in Sections 8 and 9 below).

7.8 If the healthcare provider fails to provide the health records within 40 days, the claimant can then apply to the court under the CPR Part 31.16 for an **order for pre-action disclosure**. The court has the power to impose costs sanctions for unreasonable delay in providing records. The claimant may also refer the matter to the Information Commissioner for a potential breach of the Data Protection Act 1998.

7.9 If either the claimant or the healthcare provider considers that **additional health records are reasonably required from a third party**, in the first instance these should be requested by or through the claimant. Third party healthcare providers are expected to co-operate. The claimant should provide to the defendant, within 40 days of a request, copies of relevant third party records in their possession. CPR Part 31.17 enables claimants and healthcare providers to apply to the court for pre-action disclosure by third parties.

7.10 Legible copies of the claimant's medical records should be placed in an indexed and paginated bundle by the claimant at the earliest opportunity and kept up to date. If the healthcare provider requests copies of the claimant's records including copies of relevant third party records the claimant should where requested provide the healthcare provider with a copy of the indexed and paginated bundle. The healthcare provider should agree to pay a reasonable copying charge in respect of the provision of the bundle.

## 8 THE LETTER OF NOTIFICATION<sup>14</sup>

8.1 This Section of the Protocol introduces a new intermediate stage, which follows on from obtaining the medical records, but is likely to arise before the claimant is in a position to send a Letter of Claim in accordance with Section 9 of this Protocol. This Section recognises that a healthcare provider may not be in a position to investigate every potential claim where the records have been requested. The aim of this new intermediate stage is to provide the claimant with an opportunity to send to the healthcare provider a Letter of Notification confirming that the case is one which is proceeding and to enable the provider(s) to consider whether this is a case in which they should now commence their investigations, if they have not done so already.

8.2 **Annex B1** to this Protocol provides a **template for the recommended contents of a Letter of Notification**. The level of detail will need to be varied to suit the particular circumstances.

8.3 Following the receipt and analysis of the records, and the receipt of an initial supportive medical report dealing with breach of duty and/or causation, the claimant should give consideration to sending a Letter of Notification to the healthcare provider as soon as practicable.

8.4 This letter should confirm that the case is one which is still being investigated and that it is premature to send a Letter of Claim in accordance with Section 9 below. It should however advise the healthcare provider that this is a case where the claimant has obtained supportive independent expert evidence about breach of duty and (if this has been obtained) causation and that the case is one which is likely to result in a Letter of Claim being sent in due course in accordance with Section 9. The claimant should at the same time send a copy of the Letter of Notification to the NHSLSA, WHLS or other relevant Medical Defence Organisation or indemnity provider (where known).

8.5 The healthcare provider (and any defence organisation sent a copy of the Letter of Notification) should **acknowledge** any Letter of Notification **within 14 days of receipt** and should identify who will be dealing with the matter.

8.6 On receipt of a Letter of Notification the healthcare provider should then consider whether or not to undertake its own investigations into the case and whether or not to obtain its own factual and independent expert evidence, in anticipation of its having to respond to a Letter of Claim in due course<sup>15</sup>.

8.7 When subsequently considering whether any request by a healthcare provider for an extension of the time limit for a Letter of Response under Section 9 is reasonable, the claimant should have regard to whether a Letter of Notification was sent to the provider.

8.8 When considering the extent to which either party has complied with its obligations under this Protocol, including the extent to which it is reasonable for a healthcare provider to

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<sup>14</sup> Jackson decided not to recommend a stage like this: see Final Report chapter 23, para 4.10 (p.240). We had already decided to propose it, and after debate still think that such a step will indeed be a good way for reducing both unnecessary defence investigations while promoting timely responses from the defence where claimants do decide to proceed with a case, even if they cannot yet compile a comprehensive Letter of Claim.

<sup>15</sup> Jackson suggests that receipt of a Letter of Claim should trigger independent expert advice being sought by the defence. The purpose of a Letter of Notification is to bring the start of defence investigations earlier, for the benefit of both sides.

have an extension of time for its Letter of Response, the court should have regard to whether or not the claimant sent a Letter of Notification and to whether or not the healthcare provider initiated investigations upon receipt of any Letter of Notification. There should be a reasonable lapse of time between a Letter of Notification, which should only be sent where supportive expert evidence as to breach of duty and/or causation has been obtained, and any later Letter of Claim. Attempts to misuse this two-stage process may be met with costs sanctions.

## **9 THE LETTER OF CLAIM**

**9.1 Annex B2** to this Protocol provides **a template for the recommended contents of a Letter of Claim**. The level of detail will need to be varied to suit the particular circumstances.

**9.2** If, following the receipt and analysis of the records, and the receipt of any further advice (including from experts if necessary – see Section 12 below), the claimant/adviser decides that there are grounds for a claim, they should then send, as soon as practicable, to the healthcare provider/potential defendant, a **Letter of Claim**. The claimant should at the same time send a copy of the Letter of Claim to the NHSLA, WHLS or other relevant Medical Defence Organisation or indemnity provider (where known).<sup>16</sup>

**9.3** This letter should contain a **clear summary of the facts** on which the claim is based, including the alleged adverse outcome, and the **main allegations of breach of duty and causation**. It should also describe the **claimant's injuries**, and **present condition and prognosis**. The **financial loss** incurred by the claimant should be outlined, with an indication of the heads of damage to be claimed and the scale of the loss, unless this is impracticable.

**9.4** It is expected that the claimant will have obtained independent expert evidence as to the breach of duty and causation of damage alleged in the Letter of Claim.

**9.5** In lower value claims, where total damages are likely to be less than £25,000, particularly where claimants have recovered from their injuries, details of the injuries and losses should be provided as soon as is practicable, including where appropriate an expert's condition and prognosis report.

**9.6** In more complex cases, a **chronology** of the relevant events should be provided, particularly if the claimant has been treated by a number of different healthcare providers.

**9.7** The Letter of Claim **should refer to any relevant documents**, including health records, and if possible enclose copies of any of those which will not already be in the potential defendant's possession with an index of those records, e.g. any relevant general practitioner records if the claimant's claim is against a hospital.

**9.8** Sufficient information must be given to enable the healthcare provider defendant to **commence investigations** (if not already started following a Letter of Notification) and to put an initial valuation on the claim.

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<sup>16</sup> Sending copies of any Letter of Notification and Claim to the NHSLA or relevant MDO was something we had already suggested before it was recommended in Jackson.

9.9 Letters of Claim are **not** intended to have the same formal status as Particulars of Claim, nor should any sanctions necessarily apply if the Letter of Claim and any subsequent statement of case in the proceedings differ.

9.10 **Proceedings should not be started until at least four<sup>17</sup> months from the letter of claim**, unless there is a limitation problem and/or the claimant's position needs to be protected by early issue.

9.11 Claimants or their advisers may want to make an **offer to settle** the claim at this early stage by putting forward an amount of compensation which would be satisfactory (possibly including any costs incurred to date). If an offer to settle is made, generally this should be supported by a medical report which deals with the injuries, condition and prognosis, and by a schedule of loss and supporting documentation. The level of detail necessary will depend on the value of the claim. Medical reports may not be necessary where there is no significant continuing injury, and a detailed schedule may not be necessary in a low value case. CPR Part 36 sets out the legal and procedural requirements for making offers to settle.

9.12 Every claimant who has Legal Services Commission funding, or has entered into any funding arrangement, should comply with the obligations to serve notices thereof as set out in the CPR and Practice Directions.

## 10 THE RESPONSE

10.1 **Annex B3** provides a template for the suggested contents of the **Letter of Response**.

10.2 The healthcare provider (and any defence organisation sent a copy of the Letter of Claim) should **acknowledge** any Letter of Claim **within 14 days of receipt** and should identify who will be dealing with the matter.

10.3 The healthcare provider should, **within four<sup>18</sup> months of receipt of the Letter of Claim** (or such other further period as may be agreed with the claimant) provide a reasoned answer. The claimant should generally agree to a reasonable extension of time if the healthcare provider puts forward good reasons for such an extension, particularly in a claim that is of high value and/or of a complex nature.

10.4 It is good practice for the healthcare provider to have obtained independent expert evidence where either breach of duty and/or causation are denied in its Letter of Response.

10.5 If the **claim is admitted** the healthcare provider should say so in clear terms and in particular which alleged breaches of duty and causation are admitted and why.

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<sup>17</sup> The time limit of four months tallies with the recommendation in the Jackson report for the Letter of Response – see Section 10.3 below. In view of the new Letter of Notification procedure, coupled with the earlier reporting by independent experts, the four month limit may be achievable in appreciably more cases, without an extension being required.

<sup>18</sup> The CDF Working Group debated the Jackson recommendation and finally agreed on the Jackson recommendation of four months: see footnote 8 above.

10.6 If only **part of the claim is admitted** the healthcare provider should make clear which issues of breach of duty and/or causation are admitted and which are denied and why. CPR Part 14.1A applies to the status of admissions made before commencement of proceedings.

10.7 If a healthcare provider wishes to explore **settlement without any admission of liability**, then this should be conveyed to the claimant and/or his/her representatives, who should consider agreeing a reasonable request for a period of time in order to try to resolve the claim without the need for legal proceedings to be issued<sup>19</sup>.

10.8 If the **claim is denied**, this should include specific comments on the allegations of negligence, and if a synopsis or chronology of relevant events has been provided and is disputed, the healthcare provider's version of those events.

10.9 The Letter of Response is not intended to have the same formal status as a defence, nor should any sanctions necessarily apply if the Letter of Response and any subsequent defence in the proceedings differ.

10.10 Where additional documents are relied upon, e.g. an internal protocol or documents in relation to an adverse incident or a relevant complaint concerning the same claimant/ incident, copies should be provided.

10.11 If the claimant has made an offer to settle, the healthcare provider should **respond to that offer** at the same time as the Letter of Response, preferably with reasons. The healthcare provider may make its own offer to settle at this stage, either as a counter-offer to the claimant's, or of its own accord, but should accompany the offer with any supporting medical report which deals with the injuries, condition and prognosis, and/or with any counter-schedule of loss and supporting documents which are in the healthcare provider's possession.

10.12 If the parties do not reach agreement on liability, they should discuss whether the claimant should start proceedings and whether the court might be invited to direct an early trial of a preliminary issue or of breach of duty and causation.

10.13 If following receipt of the Letter of Response the claimant and their adviser is aware that there may be a delay of six months or more before the claimant decides if, when and how to proceed, they should keep the healthcare provider generally informed.

10.15 If the parties reach agreement on liability, but time is needed to resolve the value of the claim, they should aim to agree a reasonable period.

10.16 In any event, where comprehensive settlement (as to breach of duty, causation and quantum) does not take place as a result of receipt of the Letter of Response and before the issue of proceedings, the parties should consider the use of ADR.

## 11 ALTERNATIVE DISPUTE RESOLUTION (ADR)

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<sup>19</sup> We inserted this before Jackson proposed it and agree with his recommendation, though we have not proposed his suggested three month moratorium

11.1 Starting proceedings should usually be a step of last resort, and proceedings should not normally be started when a settlement is still actively being explored. Although ADR is not compulsory, the parties should consider whether some form of ADR procedure might enable them to settle the matter without starting proceedings. The court may require evidence that the parties considered some form of ADR.

11.2 It would not be practicable for this Protocol to address in any detail how a claimant or their adviser, or healthcare provider, might decide which method to adopt to resolve the particular problem. But the courts increasingly expect parties to try to settle their differences by agreement before issuing proceedings.

11.3 Summarised below are the main alternative processes for resolving clinical disputes:

- **In England**, the **NHS Complaints Procedure**, which is designed to provide claimants with an explanation of what happened and an apology if appropriate. It is not designed to provide compensation for cases of negligence<sup>20</sup>. However, claimants might choose to use the procedure if their only, or main, goal is to obtain an explanation, or to obtain more information to help them decide what other action might be appropriate. A complaint may be pursued at the same time as or in addition to a claim for negligence;
- **In Wales**, its own relevant NHS complaints procedure;
- **Discussion and negotiation**, including **round-table meetings**<sup>21</sup>;
- **Mediation**, which is a form of facilitated negotiation assisted by an independent neutral party. It is suitable in many cases, including on occasions pre-action. The CPR give the court the power to stay proceedings for one month for settlement discussions or mediation and sometimes the courts go further at a case management conference and recommend parties to attempt mediation. The CDF has published a Guide to Mediation which will assist: this is generally available on the CDF website at [www.clinicaldisputesforum.org.uk](http://www.clinicaldisputesforum.org.uk).
- Other methods of resolving disputes, which include **arbitration, determination by an expert, and early neutral evaluation** by a medical or legal expert.

11.4 The Legal Services Commission has published a booklet on "**Alternatives to Court**" (LSC August 2000, CLS information leaflet number 23) which lists a number of organisations that provide alternative dispute resolution services. The National Mediation Helpline on 0845 603 0809 or at [www.nationalmediationhelpline.com](http://www.nationalmediationhelpline.com) and mediation providers can provide information about mediation.

11.5 The parties should continue to consider the possibility of reaching a settlement at all times. This still applies after proceedings have been started, up to and during any trial or final hearing. Most disputes are resolved by agreement, even after proceedings have been issued. Parties should bear in mind that carefully planned face-to-face meetings,

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<sup>20</sup> Jackson recommends implementation of NHS Redress, and indeed this is due to be introduced in Wales. Future amendment may become necessary to this sentence.

<sup>21</sup> Also often called joint settlement meetings, though sometimes they are convened to debate discontinuance rather than settlement.



with or without a mediator, may be particularly helpful in exploring further treatment for the claimant, in reaching understandings about what happened and over both parties' positions, in narrowing the issues in dispute, perhaps in involving the relevant clinicians, and, if the timing is right, in helping to settle the whole matter, especially if the claimant wants an apology, explanation, or assurances about how other claimants will be affected.

## **12 EXPERTS**

12.1 In clinical negligence disputes, **expert opinions** may be needed:

- on breach of duty and causation;
- on the claimant's condition and prognosis;
- to assist in valuing aspects of the claim.

12.2 The CPR encourage **economy in the use of experts** and a **less adversarial expert culture**. It is recognised that in clinical negligence disputes, the parties and their advisers will require flexibility in their approach to expert evidence. The parties should cooperate about decisions on whether and which experts might be instructed jointly, and on whether reports might be disclosed sequentially or by exchange and at what stage. The Protocol does not require the claimant to disclose expert evidence with the letter of claim-the claimant and their adviser may choose to do so when they wish to rely upon that evidence, particularly a report on the claimant's condition and prognosis. Sharing expert evidence will often be appropriate on issues relating to the value of the claim.

12.3 Obtaining expert evidence will often be an expensive step and may take time, especially in specialised areas of medicine where there are limited numbers of suitable experts. Claimants and healthcare provider and their advisers, will therefore need to give careful and early consideration as to how best to obtain any necessary expert help quickly and cost-effectively.

12.4 **In Wales**, expert reports may be obtained through the Speedy Resolution Scheme introduced in 2005.

## **13 LIMITATION OF ACTIONS**

13.1 If by reason of complying with any part of this Protocol a claimant's claim may be time-barred under any provision of the Limitation Act 1980 or any other legislation which imposes a time limit for bringing an action, the claimant may commence proceedings without complying with this Protocol, but should then apply to the court on notice at the time that proceedings are issued for directions as to the timetable and form of procedure then to be adopted. The court will then consider whether to order a stay of the whole or part of the proceedings pending compliance with the provisions of this Protocol.

## **ANNEX A: LAW SOCIETY AND DEPARTMENT OF HEALTH STANDARD FORMS FOR OBTAINING HEALTH RECORDS**

[the current versions of these documents for both England and (where different, as they currently are) Wales will need to be inserted here in any final published version.]

## ANNEX B: TEMPLATES FOR LETTERS OF NOTIFICATION, CLAIM AND RESPONSE

### B1 Template for the Letter of Notification

#### ESSENTIAL CONTENTS

The Letter of Notification should confirm:

- 1      **The claimant's name**, address, date of birth, etc.;
- 2      **Dates** of allegedly negligent treatment;
- 3      **Events giving rise to the claim**, including:
  - a clear summary of the facts on which the claim is based;
  - details of other relevant treatments to the claimant by other healthcare providers.
- 4      Which **medical records** have been obtained by the claimant. Where possible, details of the medical records obtained should be provided in the form of a document index in accordance with para 6.1 (if not provided previously)
- 5      Whether a supportive **expert opinion** has been obtained on either or both of breach of duty and causation.
- 6      That this is a case which is proceeding, but that it is premature for the claimant to send a Letter of Claim at this stage while further investigations remain pending. Where possible the claimant should give an approximate time estimate for provision of the Letter of Claim.
- 7      That the claimant may have reasonable needs that could be met by **rehabilitation** treatment or other measures. The Rehabilitation Code may be helpful in considering how to identify the claimant's needs and how to address the cost of providing for those needs.
- 8      An invitation to the healthcare provider to consider commencing investigations into this case at this stage.
- 9      That failure to do so will be a factor that can be taken into consideration when considering the reasonableness or otherwise of any subsequent application for an extension of time for the Letter of Response.
- 10     When the claimant has Legal Services Commission funding or has entered into a funding arrangement (a conditional fee agreement within the meaning of CPR43.2(1)), details of this should be provided.

## **B2     Template for the Letter of Claim**

### **ESSENTIAL CONTENTS**

**The Letter of Claim should set out:**

1.     **The claimant's name**, address, date of birth, etc.
2.     **Dates of allegedly negligent treatment**
3.     **Events giving rise to the claim**, including:
  - a clear summary of the facts on which the claim is based;
  - details of other relevant treatments to the claimant by other healthcare providers.
4.     **Allegations of breach of duty and causal link with injuries**, including
  - an outline of the main allegations or a more detailed list in a complex case;
  - an outline of the causal link between the allegations and the injuries complained of;
  - Whether a supportive **expert opinion** has been obtained on either or both of breach of duty and causation
5.     **Details of the claimant's injuries, condition and future prognosis** with a condition and prognosis report, if appropriate
6.     **Request all clinical records (if not previously provided)**
  - use the Law Society form if appropriate or adapt;
  - specify the records required;
  - if other records are held by other providers, and may be relevant, say so;
  - state what investigations have been carried out to date, e.g. information from the claimant and witnesses, any complaint and the outcome, if any clinical records have been seen or experts advice obtained.
7.     **The likely value of the claim**, including
  - an outline of the financial loss incurred by the claimant together with the main heads of damage to be claimed;
  - the scale of the loss, or, in lower value claims likely to be under £25,000 particularly where the claimant has recovered from their injuries, details of the injuries and losses should be provided as soon as practicable to enable the healthcare provider to commence investigations and put an initial valuation on the claim..
- 8     **Documents relied upon**
  - In more complex cases a chronology of the relevant events should be provided particularly if the claimant has been treated by a number of different healthcare providers.
  - Any relevant documents should be referred to, including health records, and if possible enclose copies of those which will not already be in the healthcare provider's possession.
9.     **Funding information**

When the claimant has Legal Services Commission funding or has entered into a funding arrangement (a conditional fee agreement within the meaning of CPR43.2(1)) details of this should be provided.

#### **10. Costs incurred**

An estimate of the claimants costs incurred to the date of the letter of claim should be included.

#### **OPTIONAL INFORMATION**

- What investigations have been carried out
- An offer to settle (open for acceptance until the Letter of Response is due to be served) with supporting medical evidence and / or a schedule of loss with supporting evidence if possible
- Suggestions for obtaining expert evidence
- Suggestions for meetings, negotiations, discussion or mediation
- Any reasonable needs not hitherto notified that could be met by rehabilitation treatment or other measures. The Rehabilitation Code may be helpful in considering how to identify the claimant's needs and how to address the cost of providing for those needs.

#### **Additional enclosures**

- Clinical records request form and claimant's authorisation
- Expert report(s)
- Schedules of loss and supporting evidence, even where an offer is not being made.

## **B3     Template for the Letter of Response**

### **ESSENTIAL CONTENTS**

#### **The Letter of Response should:**

- 1.     Provide requested records and invoice for copying:**
  - explain if records are incomplete or extensive records are held and ask for further instructions;
  - request additional records from third parties.
- 2.     Comment on the events alleged and/or chronology:**
  - if events are disputed or the healthcare provider has further information or documents on which they wish to rely, these should be provided, e.g. an internal Protocol;
  - details of any further information needed from the claimant or third party should be provided.
- 3.     (If this is so) set out that breach of duty and causation are accepted wholly or in part:**
  - this should be set out in clear terms and in particular which alleged breaches of duty and causation are admitted or denied and why;
  - suggestions might be made for resolving the claim and/or requests for further information.
- 4.     (If this is so) set out that breach of duty and/or causation are denied:**
  - a bare denial will not be sufficient. Specific responses to the allegations of breach of duty and causation should be given. If the healthcare provider has other explanations for what happened, these should be set out as fully as possible;
  - confirm whether any denial is based on receipt of independent expert evidence;
  - suggestions might be made for the next steps, e.g. further investigations, obtaining expert evidence, meetings/negotiations or mediation, or an invitation to issue proceedings.
- 5.     (If this is so) set out that breach of duty and causation are denied but the healthcare provider nevertheless wishes to explore settlement,** together with any proposals for a time period to be agreed by the parties to try and resolve the claim without the need for the issue of legal proceedings
- 6.     The response to any offer to settle** made by the claimant's Letter of Claim should be given.
- 7.     Costs**

If the claimant has requested details of the healthcare provider's costs incurred to the date of the letter of response the healthcare provider should provide these details

### **OPTIONAL MATTERS**

- Make an offer to settle if the claimant has not made one, or a counter-offer to the claimant's offer with supporting medical evidence and /or a counter-schedule of loss if appropriate

**Possible enclosures:**

- Clinical records
- Annotated chronology
- Expert reports.

**ANNEX C: GUIDANCE OVER APOLOGIES BY DEFENDANTS****May 1st 2009****To: Chief Executives and Finance Directors All NHS Bodies**

Dear Colleagues

**Apologies and Explanations**

I am pleased to report that the Authority's letter of 15 August 2007, on providing apologies and explanations to patients or their relatives, has been updated and endorsed widely by other organisations, so it seemed appropriate to reissue it with those endorsements included. To ensure the widest possible distribution to staff in the NHS and beyond, the co-signatories have all incorporated links to this letter on their own websites. To reduce the possibility of misunderstandings by front-line staff, the original letter has been reworded slightly in places.

**Apologies**

It is both natural and desirable for clinicians who have provided treatment which produces an adverse result, for whatever reason, to sympathise with the patient or the patient's relatives; to express sorrow or regret at the outcome; and to apologise for shortcomings in treatment. It is most important to patients that they or their relatives receive a meaningful apology. We encourage this, and stress that apologies do not constitute an admission of liability. In addition, it is not our policy to dispute any payment, under any scheme, solely on the grounds of such an apology.

**Explanations**

Patients and their relatives increasingly ask for detailed explanations of what led to adverse outcomes. Moreover, they frequently say that they derive some consolation from knowing that lessons have been learned for the future. In this area, too, the NHSLA is keen to encourage both clinicians and NHS bodies to supply appropriate information whether informally, formally or through mediation.

Explanations should not contain admissions of liability. For the avoidance of doubt, the NHSLA will not take a point against any NHS body or any clinician seeking NHS indemnity, on the basis of a factual explanation offered in good faith before litigation is in train. We consider that the provision of such information constitutes good clinical and managerial practice. To assist in the provision of apologies and explanations, clinicians and NHS bodies should familiarise themselves with the guidance on Being Open, produced by the National Patient Safety Agency and available at: [www.npsa.nhs.uk/nrls/alerts-and-directives/notices/disclosure/](http://www.npsa.nhs.uk/nrls/alerts-and-directives/notices/disclosure/)

**Formal Admissions**

In keeping with our financial and case management responsibilities, the NHSLA will make or agree the terms of formal admissions within or before litigation. This circular is intended to encourage scheme members and their employees to offer the earlier, more informal, apologies and explanations so desired by patients and their families.



### **Medical Defence Organisations**

It is critically important to note that all of the above applies to the provision of NHS indemnity to NHS bodies and employees. Should any individual clinicians wish to adopt a particular policy *vis-à-vis* apologies and explanations, in a matter which might expose them to an action brought against them as an individual, they should seek the advice of their medical defence organisation and/or professional body.

### **Staff Support**

We should not lose sight of the traumatic effect that adverse outcomes, and their aftermath, might have on NHS staff as well as on patients and their relatives. Some may find compliance with these recommendations cathartic or therapeutic; others will not. None will find compliance easy. Recognising this, employers should do whatever is necessary by way of offering training, support, counselling or formal debriefing.

Yours sincerely

**Stephen Walker CBE** Chief Executive NHSLA

We endorse the NHSLA guidance on apologies and explanations. For many years we have advised our members that, if something goes wrong, patients should receive a prompt, open, sympathetic and above all truthful account of what has happened. Any patient who has had the misfortune to suffer through an error of whatever nature should receive a full explanation and a genuine apology. We encourage members to adopt this approach. There are no legal concerns about taking this course of action: it is quite different from admitting liability.

### **Dr Michael Saunders**

Chief Executive  
Medical Defence Union

### **Dr Stephanie Bown**

Director of Policy and Communications  
Medical Protection Society

### **Dr Jim Rodger**

Head of Professional Services  
Medical and Dental Defence Union of Scotland

### **Dr Peter Carter**

Chief Executive and General Secretary  
Royal College of Nursing

### **Martin Fletcher**

Chief Executive  
National Patient Safety Agency

### **Dr Hamish Meldrum**

Chairman of Council  
British Medical Association

The GMC fully supports this advice from the NHSLA. If something goes wrong, patients deserve an apology and a full explanation. In *Good Medical Practice* we say ‘if a patient under your care has suffered harm or distress, you must act immediately to put matters right, if that is possible. You should offer an apology and explain fully and promptly to the patient what has happened and the likely short-term and long-term effects.’

**Finlay Scott**

Chief Executive

General Medical Council

## **ANNEX D: THE 2007 REHABILITATION CODE**

*While the Rehabilitation Code was put together primarily by claimants and insurers in relation to personal injury claims, it still has relevance for clinical disputes of all kinds and is thus reproduced as an Annex to the Clinical Disputes Protocol. Additions relating specifically to the Clinical Negligence Pre-action Protocol are in italics.*

The aim of this code is to promote the use of rehabilitation and early intervention in the compensation process so that the injured person makes the best and quickest possible medical, social and psychological recovery. This objective applies whatever the severity of the injuries sustained by the claimant. The Code is designed to ensure that the claimant's need for rehabilitation is assessed and addressed as a priority, and that the process of so doing is pursued on a collaborative basis by the claimant's lawyer and the compensator.

Therefore, in every case, where rehabilitation is likely to be of benefit, the earliest possible notification to the compensator of the claim and of the need for rehabilitation will be expected.

### **1 Introduction**

1.1 The purpose of the personal injury claims process is to put the individual back into the same position as he or she would have been in, had the accident not occurred, insofar as money can achieve that objective. The purpose of the Rehabilitation Code is to provide a framework within which the claimant's health, quality of life and ability to work are restored as far as possible before, or simultaneously with, the process of assessing compensation.

1.2 Although the Code is recognised by the Personal Injury Pre-Action Protocol (*and now also the Clinical Disputes Pre-action Protocol*), its provisions are not mandatory. It is recognised that the aims of the Code can be achieved without strict adherence to the terms of the Code, and therefore it is open to the parties to agree an alternative framework to achieve the early rehabilitation of the claimant.

1.3 However, the Code provides a useful framework within which claimant's lawyers and the compensator can work together to ensure that the needs of injured claimants are assessed at an early stage.

1.4 In any case where agreement on liability is not reached it is open to the parties to agree that the Code will in any event operate, and the question of delay pending resolution of liability should be balanced with the interests of the injured party. However, unless so agreed, the Code does not apply in the absence of liability or prior to agreement on liability being reached.

1.5 In this code the expression "the compensator" shall include any loss adjuster, solicitor or other person acting on behalf of the compensator (*and any healthcare provider, the NHSLA, WHLS, the Welsh Risks Pool, any MDO or any other indemnifying organisation*)

### **2 The claimant's solicitor**

2.1 It should be the duty of every claimant's solicitor to consider, from the earliest practicable stage, and in consultation with the claimant, the claimant's family, and where

appropriate the claimant's treating physician(s), whether it is likely or possible that early intervention, rehabilitation or medical treatment would improve their present and/or long term physical and mental well being. This duty is ongoing throughout the life of the case but is of most importance in the early stages.

2.2 The claimant's solicitor will in any event be aware of their responsibilities under section 4 of the Pre-Action Protocol for Personal Injury Claims *and the Pre-Action Protocol for Clinical Negligence*.

2.3 It shall be the duty of a claimant's solicitor to consider, with the claimant and/or the claimant's family, whether there is an immediate need for aids, adaptations, adjustments to employment to enable the claimant to keep his/her existing job, obtain suitable alternative employment with the same employer or retrain for new employment, or other matters that would seek to alleviate problems caused by disability, and then to communicate with the compensators as soon as practicable about any such rehabilitation needs, with a view to putting this Code into effect.

2.4 It shall not be the responsibility of the solicitor to decide on the need for treatment or rehabilitation or to arrange such matters without appropriate medical or professional advice.

2.5 It is the intention of this Code that the claimant's solicitor will work with the compensator to address these rehabilitation needs and that the assessment and delivery of rehabilitation needs shall be a collaborative process.

2.6 It must be recognised that the compensator will need to receive from the claimants' solicitors sufficient information for the compensator to make a proper decision about the need for intervention, rehabilitation or treatment. To this extent the claimant's solicitor must comply with the requirements of the Pre-Action Protocol to provide the compensator with full and adequate details of the injuries sustained by the claimant, the nature and extent of any or any likely continuing disability and any suggestions that may have already have been made concerning the rehabilitation and/or early intervention.

2.7 There is no requirement under the Pre-Action Protocol, or under this code, for the claimant's solicitor to have obtained a full medical report. It is recognised that many cases will be identified for consideration under this Code before medical evidence has actually been commissioned or obtained.

### **3 The Compensator**

3.1 It shall be the duty of the compensator, from the earliest practicable stage in any appropriate case, to consider whether it is likely that the claimant will benefit in the immediate, medium or longer term from further medical treatment, rehabilitation or early intervention. This duty is ongoing throughout the life of the case but is most important in the early stages.

3.2 If the compensator considers that a particular claim might be suitable for intervention, rehabilitation or treatment, the compensator will communicate this to the claimant's solicitor as soon as practicable.

3.3 On receipt of such communication, the claimant's solicitor will immediately discuss these issues with the claimant and/or the claimant's family pursuant to his duty set out above.

3.4 Where a request to consider rehabilitation has been communicated by the claimant's solicitor to the compensator, it will usually be expected that the compensator will respond to such request within 21 days.

3.5 Nothing in this or any other code of practice shall in any way modify the obligations of the compensator under the Protocol to investigate claims rapidly and in any event within 3 months (except where time is extended by the claimant's solicitor) from the date of the formal claim letter. It is recognized that, although the rehabilitation assessment can be done even where liability investigations are outstanding, it is essential that such investigations proceed with the appropriate speed.

## **4 Assessment**

4.1 Unless the need for intervention, rehabilitation or treatment has already been identified by medical reports obtained and disclosed by either side, the need for and extent of such intervention, rehabilitation or treatment will be considered by means of an assessment by an appropriately qualified person.

4.2 An assessment of rehabilitation needs may be carried out by any person or organisation suitably qualified, experienced and skilled to carry out the task. The claimant's solicitor and the compensator should endeavour to agree on the person or organisation to be chosen.

4.3 No solicitor or compensator may insist on the assessment being carried out by a particular person or organisation if (on reasonable grounds) the other party objects, such objection to be raised within 21 days from the date of notification of the suggested assessor.

4.4 The assessment may be carried out by a person or organisation which has a direct business connection with the solicitor or compensator, only if the other party agrees. The solicitor or compensator will be expected to reveal to the other party the existence of and nature of such a business connection.

## **5 The Assessment Process**

5.1 Where possible, the agency to be instructed to provide the assessment should be agreed between the claimant's solicitor and the compensator. The method of providing instructions to that agency will be agreed between the solicitor and the compensator.

5.2 The assessment agency will be asked to carry out the assessment in a way that is appropriate to the needs of the case and, in a simple case, may include, by prior appointment, a telephone interview but in more serious cases will probably involve a face to face discussion with the claimant. The report will normally cover the following headings:-

1. The injuries sustained by the claimant.
2. The current disability/incapacity arising from those Injuries. Where relevant to the overall picture of the claimant's needs, any other medical conditions not arising from the accident should also be separately annotated.
3. The claimant's domestic circumstances (including mobility accommodation and employment) where relevant.
4. The injuries/disability in respect of which early intervention or early rehabilitation is suggested.
5. The type of intervention or treatment envisaged.
6. The likely cost.

7. The likely outcome of such intervention or treatment.

5.3 The report should not deal with issues relating to legal liability and should therefore not contain a detailed account of the accident circumstances *or the circumstances giving rise to the alleged breach of duty*.

5.4 In most cases it will be expected that the assessment will take place within 14 days from the date of the letter of referral to the assessment agency.

5.5 It must be remembered that the compensator will usually only consider such rehabilitation to deal with the effects of the injuries that have been caused in the relevant accident *or incident* and will normally not be expected to fund treatment for conditions which do not directly relate to the accident *or incident* unless the effect of such conditions has been exacerbated by the injuries sustained in the accident *or incident*.

## **6 The Assessment Report**

6.1 The report agency will, on completion of the report, send copies on to both the claimant's solicitor and compensator simultaneously. Both parties will have the right to raise questions on the report, disclosing such correspondence to the other party.

6.2 It is recognised that for this assessment report to be of benefit to the parties, it should be prepared and used wholly outside the litigation process. Neither side can therefore, unless they agree in writing, rely on its contents in any subsequent litigation.

6.3 The report, any correspondence related to it and any notes created by the assessing agency to prepare it, will be covered by legal privilege and will not be disclosed in any legal proceedings unless the parties agree. Any notes or documents created in connection with the assessment process will not be disclosed in any litigation, and any person involved in the preparation of the report or involved in the assessment process, shall not be a compellable witness at Court. This principle is also set out in paragraph 4.4 of the Pre-Action Protocol *and is agreed also to be applicable to clinical disputes*.

6.4 The provision in paragraph 6.3 above as to treating the report etc as outside the litigation process is limited to the assessment report and any notes relating to it. Any notes and reports created during the subsequent case management process will be covered by the usual principle in relation to disclosure of documents and medical records relating to the claimant.

6.5 The compensator will pay for the report within 28 days of receipt.

6.6 This code intends that the parties will continue to work together to ensure that the rehabilitation which has been recommended proceeds smoothly and that any further rehabilitation needs are also assessed.

## **7 Recommendations**

7.1 When the assessment report is disclosed to the compensator, the compensator will be under a duty to consider the recommendations made and the extent to which funds will be made available to implement all or some of the recommendations. The compensator will not be required to pay

for intervention treatment that is unreasonable in nature, content or cost or where adequate and timely provision is otherwise available. The claimant will be under no obligation to undergo intervention, medical or investigation treatment that is unreasonable in all the circumstances of the case.

7.2 The compensator will normally be expected to respond to the claimant's solicitor within 21 days from the date upon which the assessment report is disclosed as to the extent to which the recommendations have been accepted and rehabilitation treatment would be funded and will be expected to justify, within that same timescale, any refusal to meet the cost of recommended rehabilitation.

7.3 If funds are provided by the compensator to the claimant to enable specific intervention, rehabilitation or treatment to occur, the compensator warrants that they will not, in any legal proceedings connected with the claim, dispute the reasonableness of that treatment, nor the agreed costs, provided of course that the claimant has had the recommended treatment. The compensator will not, should the claim fail or be later discontinued, or any element of contributory negligence be assessed or agreed, seek to recover from the claimant any funds that they have made available pursuant to this Code.

# **PERSONAL INJURY**

## **MULTI-TRACK CODE**

### **INTRODUCTION**

The multi track code is designed for personal injury cases (excluding clinical negligence and asbestos related disease cases) within the multi track arena and will be piloted to capture claims with a predicted value of more than £250,000.

The code is intended to help parties involved in these multi track claims to resolve liability, put in place a system that meets the reasonable needs of the injured claimant and then work towards settling the case by narrowing the issues before either settlement or trial.



This code creates a new environment for case planning, encouraging changes in behaviour on both sides, and will work in parallel with the Civil Procedure Rules. This code does not change the law, which requires a claimant to prove his case, and failure to comply with the code should not in itself be taken into account by the court when considering the conduct of the parties. Furthermore, nothing in the code affects a solicitor's duties to act in the best interests of the client and upon their instructions.

This multi track code document comprises the following:

- ❖ Objectives – a summary of the key aims of the code and the key actions required to meet these
- ❖ The Code - the main text of the code focuses on the behaviour consistent with efficient, cost proportionate and “claimant centred”, subject to liability, claim resolution. It is not to be used as a tactical weapon to “score” points and promote adversarial behaviour.

The concept of “mapping” is introduced, which is central to the behaviours expected of the parties. As the type of claim that may be handled under the route map is very wide ranging, it is up to the parties to sensibly identify what steps are needed according to the facts and issues in a case. Parties must consider proportionality and the appropriateness of each step in the case being handled.

- ❖ Guidelines - these provide guidance on “behaviour” in certain areas which is seen as conducive with the aims of the code and set out a standard which will generally be expected of parties working under it. The guidelines cover:
  - Guideline A: Managing cases where criminal proceedings arise
  - Guideline B: Rehabilitation and funding
  - Guideline C: Schedules of Loss
  - Guideline D: Admissions
  - Guideline E: Checklists
  - Guideline F: Costs
- ❖ The Pilot – details of the pilot scheme to be operated to ascertain whether the multi track code will work in practice.

## **OBJECTIVES**

**The following is a summary of the key objectives which should be referred to in all cases to illustrate the behaviour that is expected under the code, but in respect of each one the detail is in the code.**

**KEY OBJECTIVE:**

To resolve liability as quickly as possible, help claimants to access rehabilitation when appropriate and resolve their claims in a cost effective manner and within an appropriate time frame, meeting their individual needs, with all sides working together in an environment of mutual trust and collaboration.

The collaborative approach should produce a procedure and process for handling cases which bring tangible benefits to all sides. The key tenets of this approach are as follows:

- i. Early notification of claims to defendants or their insurers.
- ii. Prompt dialogue as to arrangements for the investigation of liability.
- iii. For cases handled within the pilot admissions to be binding except in the face of evidence of fraud which should not be determined differently from cases handled outside the pilot.
- iv. Discussion at the earliest opportunity by all parties to agree a care regime, accommodation, equipment and/or other forms of rehabilitation where reasonably required, and options for the funding thereof, to rehabilitate the injured person and resolve the case as quickly as possible, providing appropriate compensation.
- v. In all cases, a commitment to resolve liability by agreement or if necessary trial, with a view to being dealt with in a maximum period of six months from date of first notification.
- vi. A willingness to make early and continuing interim payments where appropriate.
- vii. No Part 36/Calderbank offers unless or until the parties have tried to agree an issue through dialogue and negotiation but cannot do so.
- viii. Appointment where necessary of an independent clinical case manager instructed by the claimant.
- ix. Commitment by all parties to obtain and disclose promptly all relevant information, i.e.
  - a. liability documents disclosable under the pre action protocol
  - b. police reports in road accident cases
  - c. accident report documentation
  - d. notes and records
  - e. documents relating to schedule of loss
  - f. regular reports of case manager
- x. Commitment by all parties to obtain evidence in such a way as to avoid duplication of effort and cost, and sharing the evidence obtained as soon as practicable.

- xi. Agreement that any challenges to the enforceability of the retainer can only be made within 28 calendar days of letter of claim and any such challenges will be discussed constructively by the parties.
- xii. A commitment to an early interim payment of disbursements (the subject matter of which has been disclosed) and those base costs relating to liability, once this issue has been resolved, with any such payment to be an interim payment as to costs and to be taken in to account on conclusion of the case.

## **THE CODE**

### **1. THE COLLABORATIVE APPROACH – AN OUTLINE**

- 1.1. The aims and objectives of this multi-track code will be achieved through the parties working together, allocating tasks and narrowing the issues throughout the claim, leading to a settlement or some means of dispute resolution at the earliest time.
- 1.2. Commencing with a commitment to early notification of a claim to the potential defendant, the parties will for each case agree a case specific 'route map' which will include a succession of review dates with a pre-defined agenda for each review, and mechanisms for resolving any disputes there may be as to the route map.
- 1.3. The route map should set out:-
  - 1.3.1. A resolution process in which there is a full and frank exchange of information as soon is practicable involving open exchange of information by both sides in accordance with the key objective
  - 1.3.2. An efficient and economical process that involves task allocation, avoids duplication of effort and expense wherever possible
  - 1.3.3. A process of case planning, agreed between the parties, and which is directed towards :-
    - liability resolution
    - maximising rehabilitation opportunities
    - making provision for early interim payments
    - emphasising restitution and redress, (rather than just compensation)
    - early identification of issues not in dispute
    - flexible approaches to resolution of issues in dispute.
  - 1.3.4. Throughout, an agreed timetable and action plan to resolve the case.
  - 1.3.5. Above all, a defined collaborative way of working between the parties that achieves the above.
- 1.4. The pre-defined agenda is to identify:
  - What issues are there?
  - What needs to be done to resolve them?
  - Who should take those steps?
  - By when should those steps be completed?
  - What was the outcome of any previous actions agreed?
  - What issues are capable of agreement?
  - What action needs to be taken over schedules of loss?

- When should the parties meet/talk next/again?
  - Who will update and share the route map?
  - If agreement is not possible, what steps need to be and have been taken to narrow down as far as possible the areas of disagreement?
  - The appropriate and most efficient way to resolve outstanding issues.
- 1.5. The collaborative approach is therefore one whereby the parties jointly agree a plan, a timetable and tasks, dates for review sessions with clear milestones for the progression of any claim towards resolution.
- 1.6. Parties will naturally continue contact between review dates. The reviews will be essential stock take and planning sessions which will define the way in which a case proceeds. In appropriate cases some or all of the reviews may take place face to face. In other cases, or on certain occasions, reviews by telephone will be acceptable.

## **2. DOCUMENTING THE PROCESS**

- 2.1. To promote the process the parties should exchange correspondence which:
- records agreed issues and identifies issues yet to be resolved
  - records which parties are tasked with what steps to progress the claim
  - records the timetable agreed for the resolution of those issues and steps.

## **3. THE “TRIGGER” PHASE – EARLY NOTIFICATION**

- 3.1. The claimant’s solicitor should ensure that defendants are given early notification of the claim. The benefits of the code can not apply until this step is taken – claimant representatives accept a commitment to trigger the code by making early contact with the defendant’s insurers. The recommended contents of this “trigger letter” are set out in 3.3 below. Compliance with paragraph 3.3 is fundamental to the code.
- 3.2. A full formal detailed letter of claim is not expected. The aim is to alert the proposed defendant or insurer to the potential claim and to enable:
- an initial view for the purpose of reserve
  - allocation of the case to an appropriate level of file handler within their organisation
  - liability to be resolved promptly without further investigation by the proposed claimant.

- 3.3. The claimant's solicitors should aim to send a written notification within 7 calendar days of instruction. This should convey (on a 'without prejudice' basis):
- Name, address, date of birth and NI number of claimant
  - Date, time and place of accident or date of onset of condition giving rise to the claim
  - Factual outline of accident and injury if available
  - Who is said to be responsible and relationship to claimant
  - Any other party approached
  - Occupation and approximate income
  - Name and address of employer if there is one
  - Current medical status in summary form (e.g. inpatient or discharged)
  - Any immediate medical or rehabilitation needs if known
  - Any other information the claimant solicitor feels comfortable to give in the spirit of the code.
- 3.4. In the trigger letter, the name of file handler and immediate line manager/supervisor conducting the claim should be identified. If it is practical relevant e-mail addresses and telephone numbers should also be included.
- 3.5. The solicitors representing the claimant should take all reasonable steps to locate the appropriate insurer, and notify that insurer. If unable to do so, a short notification letter should be sent to the proposed defendant with a request to pass it on to any relevant insurer. In RTA cases, the MIB should be approached in the absence of an alternative insurer.
- 3.6. The reasonable costs of the solicitor in complying with this section will not be challenged for the lack of a retainer at this point in time.

#### **4. THE "RESPONSE" PHASE – ROUTE PLANNING COMMENCES.**

##### **4.1. First contact call / meeting**

- 4.1.1. Within 28 calendar days of receipt of the trigger letter, the defendant or insurer shall make contact with the claimant solicitor. Generally this will be by telephone, though in appropriate cases, and if time is available, such meeting might take place in person.
- 4.1.2. For the purposes of this contact, the insurer should secure basic data regarding the claim from their insured. Both parties should consider what matters the case specific 'route map' should contain/address at this early stage.
- 4.1.3. The defendant or insurer's representative should also respond in writing, and this first response letter should include, the name of file handler and

immediate line manager / supervisor conducting the claim should be identified. If it is practical relevant e-mail addresses and telephone numbers should also be included.

- 4.1.4. The first meeting or discussion should take place and cover the pre-defined agenda (see 1.4)

#### 4.2. Planned Review sessions

- 4.2.1. It is an important part of this Code that the parties agree review sessions within the route map at appropriate points to ensure:-

- outstanding and unresolved issues be the subject of periodic review and reconsideration; and
- that the parties always have in mind a shared target date, by which the claim should reach claim conclusion whether negotiated or otherwise.

- 4.2.2. Accordingly resort to legal proceedings does not suspend this Code and it is recognised that it is proper for legal proceedings to be pursued so that a claim that has not settled under this Code, can be tried as promptly as the Court permits.

- 4.2.3. At each review session the pre-defined agenda should be reviewed and the route map developed in the light of the review session.

## 5. COSTS

- 5.1. The parties agree that any challenges to the enforceability of the retainer can only be made within 28 calendar days of letter of claim and any such challenges will be discussed constructively by the parties.
- 5.2. In the absence of any such challenges within the period of 28 calendar days it shall be conclusively and irrevocably presumed that the retainer is enforceable and will not be subject to challenge at any later stage of the claim.
- 5.3. The claimant's solicitors should accommodate all reasonable requests for information to enable the issue to be resolved conclusively within the longer of [a] 28 calendar days of the letter of claim, or [b] 14 calendar days after the challenge, recognising also that the claimant cannot be asked to disclose more than would be disclosable prior to a detailed assessment, and cannot disclose any information relating to risk assessment. In the event of a challenge remaining unresolved at the end of the stipulated period [a] or [b] the parties agree the case will not be dealt with, within the pilot.
- 5.4. Following resolution of liability a commitment to pay disbursements and base costs concerning liability and meet reasonable requests for interim

payments to meet disbursements in relation to outstanding issues, with any such payments being made on an interim basis on account of costs.

## **GUIDELINE A**

### **MANAGING CASES WHERE CRIMINAL PROCEEDINGS ARISE**

- A.1 The parties recognise the seriousness of criminal proceedings against a potential defendant and the need to ensure that no action is taken which compromises the defendant's defence of them.
- A.2 It is also recognised that valuable information which is material to the assessment of civil liability may not become available until criminal proceedings (potential or otherwise) are completed. In such circumstances, the defendant (or insurer) may not be able to complete liability enquiries until that time.
- A.3 Those considerations aside, defendants undertake not to regard the existence of outstanding criminal prosecutions as a bar to making early decisions on liability so that progress can be made to resolve a valid claim from an injured claimant. Defendants will conduct a realistic assessment of the facts. Should the outcome of a criminal prosecution be irrelevant to the validity of the claim, then the defendant will make known their views to that effect at the earliest time.
- A.4 In any case where a defendant is not able to progress liability pending completion of criminal prosecutions, the reasons for this will be explained to the claimant's solicitor and, to the extent reasonable to do so, will not prevent taking of any other steps which might be reasonable to move the claim along.
- A.5 The defendant should where practicable comply with disclosure obligations as agreed within the route map.
- A.6 This approach applies to inquest proceedings as well as criminal prosecutions.



## **GUIDELINE B**

### **REHABILITATION AND FUNDING**

Whether the guidance contained herein applies will depend on the extent and nature of the injuries sustained.

- B.1 All parties will aim to work within the 2007 Rehabilitation Code
- B.2 All parties recognise that rehabilitation should meet the reasonable requirements (including social, domestic and vocational) of the claimant. The choices of the claimant should be taken in to account. It is important that the parties co-operate to identify the statutory obligations that are owed to the claimant at an early stage.
- B.3 Consideration should be given to obligations imposed under statute, whereby the consideration of PCT and LA obligations take place prior to the point of discharge. This will ensure no delay arises in achieving the benefits set out above. At all times the full and early rehabilitation of the claimant should be a priority, by whatever means is reasonably available.
- B.4 The claimant's representative should, as soon as is practicable, obtain records and as much information as possible regarding the claimant's condition and treatment and will share relevant information with the defendant's representative.
- B.5 The claimant's representative should establish liaison with the treating consultant, and identify likely date of discharge and share that information with the defendant's representative. At that stage the parties should:
  - discuss whether to procure an immediate needs assessment,
  - if so discuss whether it should come from the treating consultant if possible or whether to seek it from another, and if so, what source
  - Otherwise, agree if possible on an appropriate course of action.
- B.6 If there is potential for involvement of social services and the National Health Service (NHS) and other agencies the parties or appointed representatives should give consideration to the involvement of these agencies and this may, where appropriate, include the instruction of a suitable expert for statutory services liaison
- B.7 If a clinical case manager is engaged by the claimant, whilst the parties should try to agree who that clinical case manager should be, it is recognised that ultimately it is the claimant who will finally decide who will be the clinical case manager and appoint direct.

- B.7.1 The case manager should provide records and regular reports to claimant's representative who, in turn, shall promptly disclose those documents that are not privileged to the defendant's representative. Where any information has been removed because it is privileged, the claimant's representative will promptly tell the defendant's representative of the removal and the reason for this.
- B.7.2 Invitations will be made by the claimant's representative to the defendant's representative to regularly review and discuss rehabilitation.
- B.7.3 The defendant may retain someone to advise on the case management aspects of the case
- B.8 The insurers will agree to pay agreed service providers directly.

## **GUIDELINE C**

### **SCHEDULES OF LOSS**

- C.1 The parties should agree a timetable for the exchange of schedules of loss, counter schedule and reviews thereof.
- C.2 Exchange should not be deferred until all heads of claim can be quantified with accuracy.
- C.3 The defendant should respond in respect of each loss, identifying those which are agreed and those required to be proven or for which further evidence is required.
- C.4 Past losses should be particularised by the claimant as soon as possible and these should be endorsed by a statement of truth.
- C.5 If a head of claim cannot be particularised, the claimant should, where practicable, give an approximate value in order to inform the proportionality of enquiries to be pursued.
- C.6 Updated schedules should be served as necessary in accordance with the agreed timetable and route map.
- C.7 Further to C4 above, witness evidence should not be obtained on any item of loss unless the defendant has required it to be proven or unless the claimant's representative reasonably believes that such evidence or the cogency or potency of the evidence will, in the opinion of the claimant's solicitors, be adversely affected if not captured prior to the defendant's compliance with C3 above.
- C.8 In respect of gratuitous care the care provider should endorse the section dealing with the care they have provided and for which a claim is made with a statement of truth. Witness evidence with regard to such care is not required unless specifically required by the Defendant.

## **GUIDELINE D**

### **ADMISSIONS**

- D.1 Good relations between the parties and the process of continually narrowing issues (a key objective of the code) depend on admissions being made by either side when it is appropriate to do so. It is essential, therefore that both parties are able to confidently plan their involvement in a claim in the light of admissions conveyed to them.
- D.2 However, it is also recognised by all parties, that a fundamental tenet of the compensation system is the delivery of compensation only to those who are entitled to receive it. Accordingly compensation should not be paid where no entitlement exists.
- D.3 It is essential that the parties conduct themselves in a way that balances these two principles.
- D.4 The following are guidelines that seek to promote good practice in this area:
  - D.4.1 Admissions are central to the code and the parties should make them wherever and whenever able to – a culture of never admitting anything is not acceptable.
  - D.4.2 It is a matter for each party to ensure that it obtains and handles information competently and that it makes admissions at the appropriate time.

## **GUIDELINE E**

### **CHECKLISTS**

The following is intended as a guide to the issues that may be discussed at each route map review. It is not exhaustive, not is it prescriptive and will need to be tailored in each case. When considering the checklists, thought should be given to the principles referred to in the introduction to the code, including considering each step being taken is proportionate.

#### **E.1 Insurance / indemnity issues**

E.1.1 The insurer should identify to the proposed claimant's solicitor any issues (subject to data protection and confidentiality issues) anticipated as to:

- Status of insurer
- Limit of indemnity
- MIB involvement
- Dual Insurance
- Doubtful / absence of policy cover.

E.1.2 If any of these issues are identified, the insurer should also detail:

- the steps that are proposed to resolve those issues
- the time scales proposed for resolution.

#### **E.2 Liability/Causation/Quantum**

E.2.1 Are immediate admissions/agreements possible in relation to:

- Primary breach of duty
- Causation
- Contributory negligence
- Quantum?

E.2.2 If such admissions are made or intimated, they should be put in writing.

E.2.3 If only a provisional concession is contemplated, this should be put in writing.

E.2.4 If such admissions are not made or intimated, the reasons are to be explained and put in to writing..

### **E.3 Factual liability and quantum evidence collection**

Parties should note objective ten, to obtain evidence in such a way as to avoid duplication of effort and cost. In order to achieve this, parties may wish to consider:

- What relevant factual information or evidence which is reasonably necessary to any outstanding liability issues in the case is or should be available?
- What steps should be taken to obtain or preserve that information / evidence?
- Who should take those steps?
- By when should those steps be taken? (usually before the next review date)
- Who should bear the costs of taking those steps?

### **E.4 Lay evidence regarding liability or quantum**

- Do the parties have material evidence that is considered decisive on any issue / issues?
- If so the parties should agree a timetable for exchange of evidence on an issue by issue basis as soon as exchange is practicable.
- If either party has access to documents which will come into the public domain (for example in criminal proceedings or an inquest), this evidence should be disclosed on a confidential basis, so as to encourage the parties to resolve liability issues as early as possible.

### **E.5 Expert evidence regarding liability or quantum**

- Parties will be at liberty to discuss how this evidence should be obtained
- Parties shall consider whether to agree to single joint instruction adopting CPR Part 35.8. If not, the parties should prepare a joint instruction letter to ensure all issues as identified by both parties are addressed by each expert instructed
- A timetable for exchange of information on a specialty by specialty basis should be agreed and should provide for exchange as soon as is practicable (usually before the review date);
- A timetable for asking and answering questions of experts pursuant to CPR Part 35 should be agreed and should allow for questions to be asked as soon as it is practicable.

### **E.6 Expert evidence regarding quantum alone**

- E.6.1 Any party considering instructing an expert should consider whether evidence from that expert is appropriate, taking account of the principles set out in Parts 1 and 35 of the CPR. (Parties are at liberty to obtain own expert evidence)

E.6.2 Does either party intend to secure expert evidence on any issue(s)? If so the parties should consider a discussion and endeavour to agree:

- A timetable
- The relevant issues
- The relevant specialties
- At what approximate cost and how does this compare to the importance of the issue to the resolution of the claim and to the potential value of the claim?
- To consider possible joint examination by experts in the same speciality (failing which the entitlement of the insurer to facilities for medical examination of the claimant by an expert of its choice is acknowledged and to achieve the aims of the protocol facilities will be granted

## **GUIDELINE F**

### **COSTS**

- F.1 All parties acknowledge that mutual trust and collaboration between the parties is a key objective. The issue of Costs is no exception to this objective and part 5 of the code contains detailed provisions with regard to how any retainer challenges are to be resolved. The parties recognise that claimants who have been injured will be best served by being able to focus on recovery and receiving prompt compensation rather than having to be concerned about the complexities of legal costs throughout the duration of a claim.
- F.2 By way of further guidance however the parties acknowledge that challenges to the retainer should not be regarded as “normal procedure” and it is only if there are particular concerns about the retainer that a challenge should be made . Any such concerns will be identified as a pre condition of the particular challenge being considered.
- F.3 The parties also recognise that it is in keeping with the claimant centred philosophy of the Code that claimants should receive their compensation promptly and without unnecessary deductions. Objective 12 goes some way towards promoting this philosophy but by way of further guidance it is acknowledged by the parties that, when the final amount of the claimant’s compensation has been ascertained (whether by agreement or court order), reasonable requests for payments on account of legal fees and disbursements will be regarded as routine procedure and that such payments will be made without the necessity of incurring the costs of a contested court hearing.



### **THE PILOT**

For the purposes of the Pilot only designated representatives in participating solicitor firms and insurers shall have authority to enter the Pilot.

<ends>

**Appendix C- Report from Nottingham Economics on the economic impact assessments.**

# **Report on the Economic Impact Assessments on the Proposals for Reform of Civil Litigation Funding and Costs in England and Wales**

## **Part 1: Impact Assessments (Conclusions)**

by

**Nottingham Economics**

February 2011

**Report on the Economic Impact Assessments on the  
Proposals for Reform of Civil Litigation Funding and Costs in  
England and Wales**

**Part 1: Impact Assessments  
(Conclusions)<sup>1</sup>**

**A report produced for the Association of Personal Injury  
Lawyers (APIL) by Nottingham Economics<sup>2</sup>**

February 2011

By

Dr Daniel Wheatley

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<sup>1</sup> Full report available on request.

<sup>2</sup> Nottingham Economics is a consultancy unit located in the Nottingham Business School at Nottingham Trent University. It undertakes a wide range of bespoke research according to client need, drawing its teams from a pool of committed researchers.

## Conclusions

### Overall Jackson Proposals

- 1 A range of Economic Impact Assessments have been conducted by the Government in order to assess the best course of action for implementing the recommendations of the 'Review of Civil Litigation Costs: Final Report' (the Jackson Report) (MoJ, 2010, 2010a). Each of these impact assessments has been analysed in this report in relation to the costs and benefits considered, the net impact of each of the proposals, and any missing data or aspects of the proposals which have not been considered.
- 2 It is acknowledged in all the impact assessments that the impacts discussed have not been quantified as many relate to behavioural responses. The impact assessments are all, in their current versions, non-monetised EIAs although some do contain some quantified data.
- 3 The impact assessment of the overall Jackson Proposals acknowledges that claimants are likely to be worse off, while defendants will be better off under the proposals, a finding which is echoed throughout the EIAs.
- 4 The statement that increased damages will offset the reduction in claims, therefore reducing any negative impact to claimants, does not hold. Those that still pursue will stand to make greater gains, but this does not adequately address the problem that a number of claimants will completely miss out on damages as they no longer pursue their case. This has access to justice implications.
- 5 There additionally seems to be an inconsistent argument about net increases or decreases in cases. Some statements suggest a net reduction in demand for legal services, and a reduction in cases being pursued, while other statements suggest increases in cases. There is, however, an acknowledgment of an overall reduction in cases resulting from the proposals.
- 6 The argument over the benefits for ATE insurers seem tenuous considering there are much clearer and substantial costs associated with the changes for ATE insurers as can be seen in paragraph 5.11 (of the full report).
- 7 Changing HMCS court fees to offset a reduction in cases should be considered a net cost for society as the cost of each individual case could increase in this respect.
- 8 Fairness, or at least perceived fairness, is also a major concern as it is acknowledged in a number of the EIAs that the proposals will result in reduced volumes of cases, and reduced legal spending on cases (and potentially reduced quality of legal services), all of which could result in reductions in the fairness of case outcomes, as well as having implications in regards to access to justice.

### CFAs and ATE Insurance

- 9 Options 1a, 1c and 2a are the Government's preferred choice. The overall effect of these proposals is uncertain, largely owing to a lack of quantification due to a lack of data. One of the key concerns relates to the impact on fairness that these recommendations may result in. Reductions

in the number of cases pursued and the work (and quality of work) performed on cases is likely to impact the fairness of cases outcomes. The main focus seems to be in reducing costs, which the proposals should successfully accomplish, but in doing so there is a potential economic welfare cost caused by reductions in fairness.

- 10 Earlier settlement of cases and lower damages awarded by losing defendants will be a net benefit to society if current levels are too high. However, without any source of data to measure and analyse current levels, it is uncertain whether proposals would actually result in a net benefit or net cost to society.
- 11 The recommendations are also likely to result in a net reduction in demand for ATE insurance reducing the size of the market for these products, with negative impacts for firms deriving income from ATE insurance. This could also result in a wider potential cost for society in relation to unemployment. Claimants may avoid purchasing ATE insurance, to avoid paying ATE insurance premiums under the proposed changes. If this occurs claimants will be putting themselves at significant financial risk. This could again potentially have wider impacts for society.

#### **Increase in General Damages**

- 12 Option 1 is the Government's preferred choice. Much of the impact of this proposal is dependent on the impacts of the above proposals dealing with CFAs and ATE Insurance. This proposal is designed to offset some of the net negative outcomes felt by claimants and defendants from changes to CFAs. However, the impact of this proposal on non-CFA cases is a concern given the EIA acknowledges that negative impacts will be felt.
- 13 Lack of data is again a key concern as much of the impact of this proposal, and indeed the severity of any negative impacts is unknown, and unquantified, at this time.

#### **Part 36 Offers**

- 14 The overall impact is uncertain, and additional uncertainty is created by the differing outcomes of each proposal. Currently, the Government has no preference as to which option should be pursued, owing largely to a lack of data and clarity as to the net impacts of the proposals.
- 15 Option 1 will likely increase the volume of cases settled. Option 2 will increase certainty of pursuing cases to trial resulting in possible increases in demand for legal services. However, the exact nature of the impacts for parties directly involved (claimants/defendants etc.) is unclear, as it is more broadly for society.

#### **Qualified One-Way Costs Shifting**

- 16 The proposal acknowledges the net negative impact for defendants, and the shift toward claimants. The level of fairness associated with this is questionable given the lack of data available and lack of understanding of the actual impacts the proposal would have should it be put into place.
- 17 ATE insurers are once again highlighted as potential losers, as discussed in paragraph 5.6 And 5.11 (of the full report), should the proposal be implemented, as they will face a net reduction in demand.

## **Proportionality**

- 18 Proportionality changes seem focused on cost reduction, even though acknowledgement is made that this may result in less time being given to each case, potentially resulting in less fair case outcomes.
- 19 Costs associated with the expected adjustment period (satellite litigation) and increased court time spent on cost hearings is not quantified. Data providing an estimate of the costs associated with both of these key aspects of the proposal is needed if greater understanding of net impacts is to be obtained.

## **Damage-Based Agreements**

- 20 Lack of data is a major problem in considering DBAs. This is especially important in considering the effect of switches from CFA and LiPs to DBA. Currently the impact assessment assumes costs of such cases remain the same owing to a lack of data.
- 21 There is also acknowledgment that the wider choice created by DBAs may create additional costs associated with parties making the 'wrong' choice if the correct path is uncertain. This is important as it is assumed that one of the key benefits arising from DBAs is that switches from LiP to DBA will result in increased net damages as the 'correct' choice will be made. Increased information and clarity for claimants and claimant lawyers over the exact nature of each choice will therefore be of significant importance if this recommendation is enacted.
- 22 Finally benefits for ATE insurers will only be possible if new insurance is developed. The costs associated with doing this are, however, not considered.

## **Litigants in Person**

- 23 As costs and benefits are not quantified, in part because there is limited data available and in part as the impacts are reliant on behavioural responses and market conditions, it is impossible to give a definitive best outcome for this recommendation.
- 24 The Government currently sees the decision over which option to choose – option 1 or 2 – as dependent largely on whether the initial 1995 rate was optimal (in which case option 1 should be chosen) or too low (in which case option 2 should be chosen). However, without any quantified values for costs and benefits, and with significant data limitations, there is a great degree of uncertainty as to the optimal hourly rate for LiPs.

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