Whiplash reform programme: consultation on independence in medical reporting and expert accreditation

A response by the Association of Personal Injury Lawyers

September 2014

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. We have over 5,000 members committed to supporting the association's aims and all of which 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.

Any enquiries in respect of this response should be addressed, in the first instance, to:

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Introduction

APIL supports the Government's objective to deter fraudulent, exaggerated and spurious claims whilst retaining access to justice for those with genuine claims. We are also sympathetic to the creation of a process for ensuring better diagnosis of whiplash injury in road traffic accident claims whilst also improving the quality of medico-legal reports through an accreditation scheme dependent on expertise and training.

For the delivery of these reforms to be a success there must be joined up governance, scrutiny of process and management information by one all encompassing board. It is important that the 'big picture' can be seen by one board in order to give proper feedback on the success of the proposals in delivering the objective of raising quality and deterring fraud.

Fraudulent claims

The Government has given a repeated commitment to tackling pre-medical offers, a practice that contributes to fraud and fuels the public's perception that some lower value compensation claims are 'money for nothing'. It is disappointing therefore, to see that it is no longer insisting on rules or legislation to ban insurers from making pre-medical offers in whiplash claims. It is a disreputable practice and contributes to fraud, as the necessary checks and balances within the legal process are bypassed to pay compensation as early as possible. Delivering this ban is one of the key stepping stones to building and delivering an improved scheme. Only by taking such a hard line will the Government show all involved that it is serious in tackling insurance fraud.

It was understood that fixed fees for medical reports would be introduced ahead of the accreditation process, on the basis that the provisions would be reviewed when the accreditation system had been devised and built. Simply cutting the fees for providing a medical report will not prevent fraud or tackle the perception of easy money. Simply reducing the fee that experts are paid without any regard to the cost of an improved medical examination and medico-legal report may drive down standards and prevent these reforms being a success. The fee clearly should be set following a proper evaluation of what is required in examining the claimant and providing a more detailed and robust report.

Independence

Eliminating financial links between the medical experts and the parties involved in the claims process, whilst supported by APIL, is difficult to achieve in light of Alternative Business Structures and the Government's free market commitment. The claims process

must not be restricted to such an extent that the claimant is unable to obtain the evidence on which he seeks to rely to prove his claim.

APIL remains supportive of the Government's aim to tackle the perception that some medical experts are beholden to those that instruct them. We also support severing links between the reporting expert and the treating medic. Greater transparency of the financial links between organisations involved in the claims process is also an important step to addressing the issue of independence.

Any scheme developed must preserve *real* freedom of choice for the injured person. One suggestion being canvassed is that the medical expert is appointed on a 'cab rank' type basis; APIL does not support this as it will not preserve freedom of choice for the claimant.

APIL has always supported a list of approved accredited experts from which the claimant can choose an accredited expert in their locality, who is best placed to examine them. The problem with random selection is that it removes all freedom of choice and limits best service for the claimant. There are also concerns that have yet to be addressed around the issue of fair trading. Both UK and EU competition law prohibit agreements, arrangements and business practices which considerably prevent, restrict or distort competition (or where this is the intended result). Limiting choice in this way is an unjustified distortion of the market.

Allowing true freedom of choice coupled with, robust examination and accreditation, the new rules and checks proposed on preventing inappropriate links between the commissioning and reporting party, along with severing links between reporting and treating medics, will tackle the issue of independence without unjustifiably distorting the free market or attacking injured people's rights. The disadvantages of random selection far outweigh the advantages. The problems which the Government seeks to tackle can be successfully addressed as we propose.

APIL proposes that *all* accredited experts be listed in order of proximity to the claimant. That way, claimants will be free to instruct *any* expert they choose. The list should provide all individual accredited experts names, followed by any association with a medical agency, followed by any restriction on instruction e.g delay in appointments being offered. This way the claimant is able to instruct the expert of choice and has all the information required to instruct that expert either directly or via an agency.

Question 1

APIL objects to the use of the word *allocated.* It removes the freedom for the claimant to choose and instruct the expert of choice. For all the reasons stated above this is wrong in our view. Such a model could well breach the Competition Act.

We suggest the new wording for paragraph 7.1 A could read: *must be a fixed cost medical report from a list of approved accredited medical experts provided via the MedCo portal....*
Regarding paragraph 7.32A, the same comments apply in relation to the use of the word *allocated.*

Question 2
Any litigant in person pursuing a claim for personal injury should be required to be medically examined. APIL objects to insurers settling claims without the claimant having been examined and a report prepared detailing the effect of the injured upon them. It should therefore follow that any litigant in person should be examined by an accredited expert under what we hope will be a new and improved process.

Providing the litigant in person is advised as to the risks of proceeding without legal representation when logging into MedCo, it is entirely appropriate that they are subject to the same rigorous process. We would hope to see the MedCo software written in such a way as to ensure that any litigant in person has to read and accept a message which should say "I understand that I have right to instruct a lawyer to assist me with the process of applying for compensation".

Question 3
As stated above. The list should, in APIL's view, provide the name of all individual accredited experts followed by any association with a medical agency, followed by any restriction on instruction e.g delay in appointments being offered. A*ll* accredited experts should be listed in order of proximity to the claimant. That way, claimant's will be free to instruct *any* expert they choose, subject to being prevented from instructing those experts with financial links with the commissioning party.

Dr J Smith	1 mile	Direct instruction and through MRO "A"	Appointments available in 28 working days
Dr J Bloggs	15 miles	Direct instruction	Appointments available in 14 working days

Accreditation

Criteria
Accreditation must be on an individual basis. We also agree that there are advantages of MRO's becoming accredited or subject to the same service level agreements if they are to listed in some way on the MedCo database. This must be in addition to and not an alternative to, the individual accreditation of the expert. The criteria for organisational accreditation would be different and would need to be thought out separately with

specific focus on the practicalities of policing and enforcement. The MRO's through whom the expert can be instructed should made apparent on the system.

Accreditation must include:
1. *Expertise* in the appropriate medical discipline and satisfactory completion of the training

2. *A relevant practising licence or certificate* from a recognised body (the subsequent withdrawal of this licence for any reason will result in immediate loss of accreditation)

3. *Experience* in treating / managing the types of injury or medical issue which fall to be dealt with under the definition provided for this scheme. (We would suggest it be appropriate for the expert to demonstrate a minimum relevant experience)

4. *Independence* - the expert must also be required to sign a declaration stating that he is independent, has no financial stake in the outcome of the process, nor any direct or indirect commercial involvement with any of the parties or organisations involved in the process, save that the expert is paid for the report which he/she delivers, irrespective of the outcome of the claim.

A good quality report will save time and money. This scheme should not become a tick box exercise, which encourages fraud, and there should be appropriate on-going training to maintain up to date knowledge of the medical issues. There will also need to be an element of legal training in relation to the duties and obligations of expert witnesses.

Reporting

APIL is fundamentally opposed to a drop down box medical report where an expert is unable to provide in his own words a description of how the claimant presented at the examination, their clinical findings, opinion and prognosis. Drop down boxes and forms that only allow experts to select an opinion and prognosis from a pre-populated box ignores and potentially encourages fraud. This is at odds with the Government's objectives to address fraud and exaggeration. There is already an optional from (RTA 3) for medics to complete in RTA portal case which confirms the information that the medic must provide. The contents of this were cross industry agreed.

Registering with MedCo

The MoJ plan to allow all current experts to register with MedCo initially without being accredited this undermines the whole principle of accreditation. APIL has advocated the need for robust accreditation with the proper checks and balances. It should not be automatic or a gift, it must be earned by demonstrating relevant criteria. It is a more effective approach to delay launch until a robust accreditation system is in place.

Audit/Peer review

Audit must be a key feature of accreditation if the scheme is to work in practice. APIL prefers the idea that audit takes the form of a peer review. We are cautious in agreeing to any method of audit that is solely based on management information (MI) generated through the medical report being returned through the IT hub, Medco. In our experience such an approach will leave gaps. An expert's ability to conduct a thorough examination and provide a robust medico-legal report should be based on demonstrating a competency to perform those individual tasks.

Management information/data

There are many unanswered questions about what to do with the management information that is available through MedCo. The following questions must be addressed: Who owns the data? Who collects it? Who can see it? What will it be used for? Particularly in light of Gavin Edmonson v Haven Insurance[1] This all links with the need for there to be balanced industry led governance.

Through Portal Co there could be a joined up approach to the portal, MedCo and CUE PI. APIL sees a real crossover of issues between the three databases and the representatives involved in those discussions. The natural fit therefore, seems to be that Portal Co extend its remit to incorporate a MedCo subgroup which also involves a representative number of medics and a further askCUE sub group to deal with the collection of fraud data and the sharing of data collected by the portal, Medco and askCUE. New data is created and will be collected from the claimant search, and by MedCo. This data will be used to cross reference any insurance fraud data. It will also contain new management data relating to medico-legal reports and accreditation. It is imperative that this is data managed by cross-industry representatives. Control by the paying party only of any element is wrong as a matter of public policy, just as it would be equally wrong if control was by the compensated party only.

Question 4

The amendments proposed at paragraphs 1.1(A1) and 1.1 (10A) create problems where a medical report is required from an expert whose medical discipline is not listed within the protocol at paragraph 1.1. It will not be necessary very often to instruct an expert outside of this scope but in cases valued up to £25,000 injuries may not just be soft tissue in nature and may require a report from an expert who is not on the list and not subject to a fixed fee.

Question 5

APIL has drafted an accreditation model on which this process could be based. This has been provided to the MoJ core whiplash reform group, and is being used in that context as a detailed starting point for discussion. The document is attached.

[1] 13 August 201, Mold District Registry, case number 3YK08470

Data sharing

APIL is committed to sharing fraud data with the insurance industry. A recent survey of APIL members indicated that nearly 90 per cent of respondents (87%) would support the introduction of a data sharing scheme. Nearly eighty per cent (79%) said that having a potential client's personal injury claims history for the last five years *would* help them identify possible fraud. It is important to note, however, that a number of them did highlight that a client's claims history would not be the only factor used when deciding to take-on a case and that it was important for the results of the search not to be misinterpreted. The respondents were split over whether it should be compulsory.

The actual cost is still unknown. Just over half of the APIL members responding to the survey (52%) wanted to pay for the data sharing facility via an annual license fee - similar to 'askMID' - with only about one in five of the remaining respondents (20%) choosing to 'pay per click'. Only about 20 per cent of members said they wouldn't be prepared to pay for such a facility at all. A copy of the APIL survey is attached.
It is essential in APIL's view that all claims, whether they are settled following legal representation or not, are subject to the mandatory search otherwise any data will be incomplete.

APIL members want to see the Portal, CUE PI and MedCo software 'joined up'. All IT systems need to talk to each other and populate automatically. Without this there is no streamlining, with extra steps and further cost burdens from claimant solicitors point of view. The key is simplicity, and accuracy in use of software.

As previously mentioned, governance where everything comes under one roof through subcommittees of Portal Co is also the most desirable option as this is the most collegiate approach (see further comments above).

Question 6
APIL agrees that this search must be mandatory.
Stakeholders have been in discussion regarding suggested wording which has been sent to the MoJ.

SUGGESTED ACCREDITATION MODEL

ASSOCIATION OF PERSONAL INJURY LAWYERS
Standard of competence for
Accredited Medico Legal Expert in Soft Tissue Injury

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INTRODUCTION

The Accredited Medico Legal Expert in Soft Tissue Injury

Accredited status is essential for medical experts who wish to carry out examinations of claimants with soft tissue injuries resulting from road traffic accidents where a claim is being pursued via the claims portal.

Accredited Medico Legal expert (AMLE) in soft tissue injury is a personal accreditation status awarded to doctors, consultants, physiotherapists by their Governing Body, overseen by MedCo. Medical Experts must be registered either with the General Medical Council, or, in the case of a physiotherapist, the Health Professions Council, and hold the relevant licence or certificate.

An AMLE is likely to have reported on a wide range of soft tissue injuries, and indeed some, but not all, may specialise solely in this area. Whilst it is likely that an AMLE will devote some of their time to medico-legal work, it is recognised that it is often only part of a medics role, with most medics concentrating their practice on treatment.

The scope of the Standard

The Standard assumes possession of the medical knowledge, understanding skills and experience required by the expert to undertake a best practice examination, diagnosis and prognosis, along with an understanding of the legal process of medical reporting and the medical experts' obligations to the court. The Standard deals with the medico-legal reporting aspect of the role only. It does not accredit the wider role of the doctor, consultant or physiotherapist.

The Standard reflects the law, regulations, Civil Procedure Rules and Pre-Action Protocols in England and Wales (as at September 2014).

Accreditation

Peer review

Peer review is an important part of accreditation and reaccreditation**.** Peer review is essentially an audit of the medico-legal work of the expert by a suitably qualified assessor, plus the provision of references by industry peers which will provide evidence that the candidate is competent. A referee must be a person with substantial personal knowledge of the professional work of the medical expert and must be competent to make judgements about the professional skills, knowledge and behaviour of the expert.

The medical expert is required to produce two references, from

- A solicitor or barrister with which he /she works with regularly in providing evidence in personal injury cases
  or
- An insurer with which he / she works with regularly in providing evidence in personal injury cases
-
  And

- Another medical professional who has close working knowledge of the expert

Referees will be required to comment on specific competences in the form attached in Appendix A. It may be the case that a referee cannot comment on all competences, in which case the two references need be complementary and cover all competences between them.

The medical expert seeking accreditation will need to complete the form in appendix B

Initially, an assessor will look at a written submission by the medical expert, the references, and will examine a number of medical reports selected at random. There will also be a short interview conducted with the medic to establish their knowledge of best practice. Evidence of competent practice comes from the day to day work of the medic. Accredited medics are expected to be able to work unsupervised.

The assessor needs to be satisfied that the medical expert will be able to carry out the examination and reporting to the specified standard.

Sanctions

Experts who do not meet the standard will not be accredited and will not be able to report on or give evidence in soft tissue injury cases dealt with by the RTA protocol.

Where there are concerns over quality of reporting, accredited medics then fail re-accreditation, initially accreditation will be suspended pending further training and /or further audit, but then no improvement will result in removal of accreditation status completely.

Where there are concerns over competence, accreditation will be suspended and referrals will be made to their governing body.

Where there are concerns over fraud, accreditation will be suspended and referrals will be made to their governing body.

Any removal of licence to practice by the appropriate governing body will result in an automatic loss of accreditation status.

Appeals

Any appeal will be considered by MedCo under their appeals procedure.

Cost of Accreditation

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A fee of £x is payable upon initial accreditation and a lower fee of £x for re-accreditation. This fee is non-profit making and will cover the costs of running the system.

Re - accreditation

Medical experts will be reaccredited every year. Reaccreditation will include examination of sample medical records plus an overview of data on all records submitted in comparison to the norm. Medics will also be required to show that they have kept up to date with latest best practice – short update training will be provided each year. If a medic undertakes only low levels of work, they may be required to repeat the full training as a refresher. Re-accreditation will be quicker and simpler than the initial accreditation.

Where a medical experts' reports do not conform with the normal distribution of data, it may be necessary to carry out a more in depth process, selecting more reports, conducting a further interview, or observing examinations. It may be, for example, that consultants tend to see the more serious cases and as such their prognosis tends to be worse.

It is important that re-accreditation is robust so as to weed out low quality reports.

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THE STANDARD

An AMLE acts on the instructions of a solicitor to examine and report on soft tissue injuries resulting from a road traffic accident claim being dealt with via the Claims Portal. The AMLE must take an independent view of the injuries – their duty is to the court, not the instructing solicitor. There must be no financial link between medical experts and other interested parties in the claim. If necessary, the medico legal expert will give evidence to the Court. The range of required competences covers:

- Accepting instructions
- Examination
- Diagnosis
- Prognosis
- Obtaining medical records
- Report writing
- Giving evidence in Court

A person will be regarded as competent if they have the knowledge, understanding, know-how and skill to demonstrate the outcomes of effective performance listed below, whilst displaying the behaviours which underpin effective performance.

KNOWLEDGE AND UNDERSTANDING

To meet the Standard, you need to have knowledge and understanding of:

1. The legal role of a medic in a personal injury case

- The core knowledge and understanding of the role of an independent medic in a personal injury case, the status of a medical report, and the duty of the medic to the Court.
- An overview of the law relating to liability, causation and damages.

2. Examination of the injured party

- Depending on your field of practice, you will have knowledge and understanding of best practice examination of soft tissue injury.
- When to seek medical records
- When to recommend a further experts report
- When to recommend rehabilitation
- What to do if fraud is suspected

3. Rules of procedure, etc.

- Civil Procedure Rules and Practice Directions
- Pre-Action Protocols for Road Traffic Claims
- The 2007 Rehabilitation Code
- UK Rehabilitation Council standards
- Civil Justice Council Protocol for the Instruction of Experts

4. Guidance

- Best practice guidance as agreed by the Department of Health, NHS England and the General Medical Council

5. Professional conduct

- Code of Conduct of the General Medical Council
- Code of Conduct of the Health Professionals Council (for physiotherapists)

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TRAINING

To meet the Standard, you need to undertake accredited medico legal training for experts in soft tissue injuries. This training will cover:

- the role of an expert witness,
- confidentiality and conflicts of interest,
- examination,
- diagnosis,
- prognosis, including the proportion of people who recover fully over periods of time, and the deterioration rate of those who do not recover
- dealing with children and protected parties,
- rules on disclosure and privilege,
- dealing with questions,
- spotting fraud,
- report writing,
- latest research and developments,
- presenting sufficient evidence for a court to make an appropriate award.

Training will be available on-line. Subsequent to this training, medics will make appropriate use of seminars, networking and knowledge sharing activities to keep up to date with the latest research to achieve the outcome of undertaking a competent medico legal examination.

Medics are also expected to meet the wider CPD requirements of their regulator.

THE OUTCOMES OF EFFECTIVE PERFORMANCE

The outcomes of effective performance are grouped in to five units, each made up of a number of elements, each of which in turn reflects a specific function, or a group of related functions.

1. **Accepting Instructions**

When considering whether to accept instructions, you must be able to:

a) conduct an initial assessment based on the accident report (claimants version) and the accident report (defendant version) if different accompanied by signed statements of truth;
b) exercise vigilance in satisfying yourself that the claim the client is pursuing is not fraudulent;
c) check whether the client has had any recent injury claims and determine whether medical records will be required to assist in the examination.

2. **Examination – General**
   - Arrange to conduct the examination as soon as reasonably practicable
   - The examination should occur in a place geographically close to the claimant
   - The examination must take place face to face
   - The examination must take place in consulting rooms suitable to conduct a medical examination
   - The examination should include inspection of photo ID

3. **Examination - Specific**

To the extent required by instructions from your instructing solicitor, you must be able to report in writing on the balance of probabilities:

a) your analysis of the injuries including extent and location, and an understanding as to whether injuries to other parts of the anatomy may overlap or be connected

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b) analysis of medical records to determine pre-accident health and to see any post-accident examination and /or treatment to corroborate symptoms and determine any relevant degeneration
c) consideration of previous accident history if appropriate, to see if the accident is compounding previous injuries
d) The examination must include inspection, palpation, and assessment of the range of movement made during conversation, distraction, and formal examination of walking, bending, raising legs, stretching and rotation.
e) Observation of Wadell signs such as tenderness, pain in the back on axial loading, simulated rotation, distraction, gross regional weakness, and overreaction to the examination
f) All potential diagnoses should be considered including no injury, soft tissue injury, musculo ligamentous sprain, disc facet joint or bony lesion
g) The probable effect of those abilities on the claimants ability to function both in and out of work and an explanation to the reasons why;
h) The likely period of recovery, including best and worst case scenarios, and a clear indication as to the likely symptoms the injured person will suffer from and the likely impact on mobility and health during the recovery period. An indication as to whether the symptoms will remain constant, or will change, and if so when.
i) If the injury is likely to result in a chronic condition, an indication of the likely impact on day to day activities
j) Consideration as to whether the injured person would benefit from rehabilitation
k) Identifying nuisance symptoms and distinguishing them from more serious ones;
l) Identifying any red flag symptoms such as malingering and exaggeration
m) If two versions of events are provided, to consider 'What difference would it make to your prognosis if either the claimants or the defendants version of events is found to be true?
n) Deliver an informed prognosis based upon objective evidence whereby the conclusion fits and is compatible with the medical examination.

4. **Reporting**

To the extent required by instructions from your instructing solicitor, you must complete the mandatory medical report online to show full details of the experts examination and findings, and full details of how the injury has affected the claimants life and for how long; in a way that is:

- succinct but comprehensive and are written in good English
- are properly completed in the mandatory format and style
- give an independent view of claimants injuries
- understands that factual issues must be left to the court
- fulfil the legal requirements of a medico legal report and conform to court rules
- are produced in an efficient and timely manner
- provides early disclosure of report to all interested parties

To be properly completed, reports must include:

a) patients name, age and address
b) confirmation that the client's identity has been checked
c) the date of the accident
d) the date and place of the examination
e) details of other persons present at the examination, and why they were present
f) the time taken for examination and interview
g) the medical records obtained and relied upon
h) any other non- privileged documents read and relied upon

Pre – accident history

a) the injured persons account / and or medical records account of relevant pre accident medical history
b) any conditions affecting their earning capacity
c) a description of the injured persons pre accident work
d) a description of the injured persons pre accident hobbies and sports

The accident

a) the claimants version of events
b) the defendants version of events if different
c) the expert should not take a view as to fault

Injuries and Treatment

a) the injured persons injuries should be listed
b) any post- accident treatment detailed
c) current complaints with reference to pain, suffering, loss of amenity, loss of sporting activity, loss of other capacity etc

Examination

a) an accurate record of all aspects of the physical examination
b) comment on malingering or functional overlay if appropriate
c) percentages given for restrictions on movement

Opinion and prognosis

a) summarise injuries
b) give a concise diagnosis detailing which tissues are damaged
c) refer to pre-existing conditions if appropriate
d) overall restrictions on work, social and sporting activities
e) a concise prognosis including timescale
f) any future treatment or rehabilitation required
g) if a further report is required by a different medic

And finally

A singed statement that 'the contents of this report are true to the best of my knowledge and belief'

5. **<u>Giving evidence in Court</u>**

(i) You must be able to prepare for and give evidence in fast track court proceedings

BEHAVIOURS WHICH UNDERPIN EFFECTIVE PERFORMANCE

1. At all times you act in a manner which reflects your duty to act in the best interests of the injured person, and your duty to the court.
2. You conduct all of your work to a proper professional standard and safeguard your independence and integrity as a suitably qualified and accredited medical practitioner .
3. You have an awareness of the limits of your own knowledge and competence, you will refer to other medics if necessary, on matters which are outside your field of expertise.
4. You present information clearly, concisely, accurately and in ways which promote understanding.
5. You use communication styles which are appropriate to different people and situations, and display empathy with the injured claimant.
6. You are active in keeping up to date with developments in clinical best practice, through reading journals and participation in conferences and training.

A medical expert who is competent in the above areas and displays appropriate behaviours will qualify for the award of accredited medico legal expert.

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Appendix A

ACCREDITED MEDICO LEGAL EXPERT - REFERENCE FORM

Details of candidate

Name: ____

Address: ____

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Qualification & Date:____

Details of referee

Name: ____

Address: ____

____

____

____

Professional qualification held: _________________________________

For how long have you known the candidate, in your professional capacity?

____

In that period, on how many occasions have you had the opportunity to observe his/her professional work? ______________________________

What has been the nature of the opportunities you have had to observe his/her professional work?

____

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____

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____

Having regard for the AMLE Standard, please provide your overall assessment of the candidate's suitability for AMLE status.

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On the basis of your observation of the candidate’s professional work, please use the tables below to indicate which of the individual elements of competence you are able to say that the candidate has met. Please note that it is not expected that every referee will be able to attest to competence against all of the components; you should sign only against those where you feel able to certify competence from your personal knowledge.

Function **1. Accepting Instructions** When considering whether to accept instructions, the medico-legal expert must be able to:	**Signature of referee certifying competence**
a) conduct an initial assessment based on the accident report (claimants version) and the accident report (defendant version) if different accompanied by signed statements of truth;	
b) exercise vigilance in satisfying yourself that the claim the client is pursuing is not fraudulent;	
c) check whether the client has had any recent injury claims and determine whether medical records will be required to assist in the examination.	

2. Examination - general The expert arranges to conduct the examination as soon as reasonably practicable The examination should include inspection of photo ID	**Signature of referee certifying competence**

The examination should occur in a place geographically close to the claimant	
The examination must take place face to face	
The examination takes place in consulting rooms suitable to conduct a medical examination	

3. **Examination - specifc**	**Signature of referee certifying competence**
a) The medico legal expert undertakes examinations covering the following: b) Analysis of the injuries including extent and location, and an understanding as to whether injuries to other parts of the anatomy may overlap or be connected c) Analysis of medical records to determine pre-accident health and to see any post-accident examination and /or treatment to corroborate symptoms and determine any relevant degeneration d) Consideration of previous accident history if appropriate, to see if the accident is compounding previous injuries e) The examination must include inspection, palpation, and assessment of the range of movement made during conversation, distraction, and formal examination of walking, bending, raising legs, stretching and rotation. f) Observation of Wadell signs such as tenderness, pain in the back on axial loading, simulated rotation, distraction, gross regional weakness, and overreaction to the examination g) All potential diagnoses should be considered including no injury, soft tissue injury, musculo ligamentous sprain, disc facet joint or bony lesion h) The probable effect of those abilities on the claimants ability to function both in and out of work and an explanation to the reasons why; i) The likely period of recovery, including best and worst case scenarios, and a clear indication as to the likely symptoms the injured person will suffer from and the likely impact on mobility and health during the recovery period. An indication as to whether the symptoms will remain constant, or will change, and if so when. j) If the injury is likely to result in a chronic condition, an indication of the likely impact on day to day activities k) Consideration as to whether the injured person would benefit from rehabilitation l) Identifying nuisance symptoms and distinguishing them	

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from more serious ones; m) Identifying any red flag symptoms such as malingering and exaggeration n) If two versions of events are provided, to consider 'What difference would it make to your prognosis if either the claimants or the defendants version of events is found to be true? o) Deliver an informed prognosis based upon objective evidence whereby the conclusion fits and is compatible with the medical examination. :	
4. REPORTING The expert produces reports that are: • succinct but comprehensive and are written in good English • are properly completed in the mandatory format and style • give an independent view of claimants injuries • understands that factual issues must be left to the court • fulfil the legal requirements of a medico legal report and conform to court rules • are produced in an efficient and timely manner • provides early disclosure of report to all interested parties	

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BEHAVIOURS WHICH UNDERPIN EFFECTIVE PERFORMANCE	**Signature of referee certifying that the behaviour is displayed consistently**
They act in a manner which reflects their duty to act in the best interests of the injured person, and their duty to the court.	
They have an awareness of the limits of their own knowledge and competence, they will refer to other medics if necessary, on matters which are outside their field of expertise.	
They conduct all of their work to a proper professional standard and safeguard your independence and integrity as a suitably qualified and accredited medical practitioner .	
They present information clearly, concisely, accurately and in ways which promote understanding.	
They use communication styles which are appropriate to different people and situations, and display empathy with the injured claimant	
They are active in keeping up to date with developments in clinical best practice, through reading journals and participation in conferences and training.	
. They act independently at all times	

Certificate

I certify that the assessments I have provided in this reference are accurate to the best of my knowledge and belief.

Signature of referee ____

Date ____

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Appendix B

ACCREDITED MEDICO LEGAL EXPERT - Application Form

Please provide three medical reports that evidence the requirements below and indicate in each case how it meets the requirements:

5. Accepting Instructions When considering whether to accept instructions, you must:	Report 1	Report 2	Report 3
d) conduct an initial assessment based on the accident report (claimants version) and the accident report (defendant version) if different accompanied by signed statements of truth;			
e) exercise vigilance in satisfying yourself that the claim the client is pursuing is not fraudulent;			
f) check whether the client has had any recent injury claims and determine whether medical records will be required to assist in the examination.			

6. Examination - general You arrange to conduct the examination as soon as reasonably practicable The examination should include inspection of photo ID			
The examination should occur in a place geographically close to the claimant			
The examination must take place face to face			
The examination takes place in consulting rooms suitable to conduct a medical examination			

7. Examination - specifc You undertakes examinations covering the following: p) Analysis of the injuries including extent and location, and an understanding as to whether injuries to other parts of the anatomy may overlap or be connected q) Analysis of medical records to determine pre-accident health and to see any post-accident examination and /or treatment to corroborate symptoms and determine any			

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relevant degeneration r) Consideration of previous accident history if appropriate, to see if the accident is compounding previous injuries s) The examination must include inspection, palpation, and assessment of the range of movement made during conversation, distraction, and formal examination of walking, bending, raising legs, stretching and rotation. t) Observation of Wadell signs such as tenderness, pain in the back on axial loading, simulated rotation, distraction, gross regional weakness, and overreaction to the examination u) All potential diagnoses should be considered including no injury, soft tissue injury, musculo ligamentous sprain, disc facet joint or bony lesion v) The probable effect of those abilities on the claimants ability to function both in and out of work and an explanation to the reasons why; w) The likely period of recovery, including best and worst case scenarios, and a clear indication as to the likely symptoms the injured person will suffer from and the likely impact on mobility and health during the recovery period. An indication as to whether the symptoms will remain constant, or will change, and if so when. x) If the injury is likely to result in a chronic condition, an indication of the likely impact on day to day activities y) Consideration as to whether the injured person would benefit from rehabilitation z) Identifying nuisance symptoms and distinguishing them from more serious ones; aa) Identifying any red flag symptoms such as malingering and exaggeration bb) If two versions of events are provided, to consider 'What difference would it make to your prognosis if either the claimants or the defendants version of events is found to be true? cc) Deliver an informed prognosis based upon objective evidence whereby the conclusion fits and is compatible with the medical examination. :			
8. REPORTING You produces reports that are: • succinct but comprehensive and are written in good English			

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• are properly completed in the mandatory format and style • give an independent view of claimants injuries • understands that factual issues must be left to the court • fulfil the legal requirements of a medico legal report and conform to court rules • are produced in an efficient and timely manner • provides early disclosure of report to all interested parties			

BEHAVIOURS WHICH UNDERPIN EFFECTIVE PERFORMANCE			
You act in a manner which reflects their duty to act in the best interests of the injured person, and their duty to the court.			
You have an awareness of the limits of their own knowledge and competence, they will refer to other medics if necessary, on matters which are outside their field of expertise.			
You conduct all of their work to a proper professional standard and safeguard your independence and integrity as a suitably qualified and accredited medical practitioner .			
You present information clearly, concisely, accurately and in ways which promote understanding.			
You use communication styles which are appropriate to different people and situations, and display empathy with the injured claimant			
You are active in keeping up to date with developments in clinical best practice, through reading journals and participation in conferences and training.			
. You act independently at all times			

Certificate

I certify that the assessments I have provided in this reference are accurate to the best of my knowledge and belief.

Signature of referee ____

Date ____

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DATA SHARING SURVEY RESULTS

APIL Data Sharing survey

Summary of results

A research report by the Association of Personal Injury Lawyers

September 2014

EXECUTIVE SUMMARY

Brief details about you

- Nearly a third of respondents (31%) to the survey indicated that they mostly handle road traffic accident (RTA) cases, while a further quarter (26%) indicated that they primarily handled employment liability (EL) accident cases. Finally, just over one in five respondents (21%) handled public liability (PL) cases in the main (Q2).

Data sharing proposal

- Nearly eighty per cent (79%) of respondents said that having a potential client's personal injury claims history for the last five years *would* help them identify possible fraud (with nearly half of them answering 'yes, definitely' [43%]) (Q3), with the information being used principally to inform a case's risk assessment (Q4). A number of respondents did, however, highlight that a client's claims history would not be the only factor used when deciding to take-on a case and that it was important for the results of the search not to be misinterpreted (Q4).

- Just over half of people responding to the survey (52%) wanted to pay for the data-sharing facility via an annual license fee - similar to 'askMID' - with only about one in five of the remaining respondents (20%) choosing to 'pay per click'. Only about 20 per cent of people wouldn't be prepared to pay for such a data-sharing facility at all. A number of people felt that a fee for claimants was only acceptable if it could be claimed as a disbursement (Q5).

- For those indicating that they would be prepared to pay for the data-sharing facility annually, over a third (36%) indicated that the fee should be between £51 and £100. A further one in five of the responses (18%) suggested that the annual fee should be between £101 and £200 (Q6).

- Of those people indicating that they preferred a 'pay-per-click' fee, nearly a third (29%) suggested that it should be less than £1 with a further third (38%) suggesting it should be between £1.01 and £2 (Q7).

- Respondents were undecided about whether the data-sharing scheme should be mandatory with 40 per cent indicating that it *should* be and 37 per cent indicating that it *shouldn't* be (Q8).

- Overall nearly 90 per cent of respondents (87%) indicated that they would support the introduction of a data-sharing scheme (with well-over half [56%] indicating that they would 'definitely' support such a scheme) (Q9). Of those people who did not support the scheme or were unsure about it, a number were concerned with the presumption of fraud by claimants, misuse of the data by insurers and the fact that it was only really pertinent to RTA claims (Q10 & Q11).

General questions about fraud

- Based on their own personal experiences, over three-quarters of people (77%) felt that the number of fraudulent personal injury claims had stayed largely the same over the last five years, with one in five (17%) suggesting that the number had actually dropped (Q12).

- Well-over half of respondents (59%) indicated that they reject about one to ten per cent of cases due to suspicions of fraud, with a further third of people (38%) saying that they don't reject any claims due to a suspicion of fraud (Q13).

- Two-thirds of people (65%) said that in the last two years no claims they have handled have been found to be fraudulent, while a further third (31%) say that it is only in about one to ten per cent of cases (Q14).

Allegation of fraud by defendants

- Over half of those people who responded (56%) indicated that the number of allegations of fraud had increased over the last five years, with about a quarter of these suggesting that the increase has been substantial (24%) (Q15).

- Half of respondents (50%) said that in the last two years defendants have made allegations of fraud in about one to ten per cent of cases, with about one in five (16%) saying that it happens in 11 to 20 per cent of cases (Q16).

- While allegations of fraud are made, respondents indicate that in nearly three-quarters of cases (71%) these allegations are found not to be true in any cases (Q17).

Additional comments

- The main comments provided by respondents highlighted their concerns over the data being misused or misinterpreted, and the actions of defendants in response to providing the data. In addition, people suggested that there are actually low levels of fraud, but high levels of fraud *allegations*. Finally, the suggestion that the claims search should be mandatory was queried (Q18).

Background

As part of the industry's moves to tackle fraud, the Association of Personal Injury Lawyers (APIL) along with the Motors Accident Solicitors Society (MASS) and the Law Society has been in discussions for some time with the Association of British Insurers (ABI) about sharing claims data. Insurers have historically been very resistant to the idea of sharing data with the claimant community. Following pressure from the Transport Select Committee and Ministry of Justice (MOJ) the ABI has now proposed that claimant firms will be able to ask the Claims Underwriting Exchange Personal Injury (CUEPI) database a validation question. By inputting a client's name, address, date of birth and National Insurance number the database will confirm how many claims they have made in the last five years.

There is a suggestion that each search request generates a unique reference number that is then inserted into a mandatory field in the claims notification form (CNF) used within the Claims Portal. This will provide confirmation that the claimant lawyer has completed a search of the database. This could also then be a mandatory step within the protocol. An insurer could reject the form as incomplete if that unique reference number was absent. In addition, the data 'captured' by the database could then be interrogated by the Insurance Fraud Bureau (IFB) in order to help to detect organised fraud rings.

In terms of the cost of the data sharing proposal, it is suggested that the costs are shared with claimant law firms potentially paying an annual license fee (similar to 'askMID') of about £180. For smaller or niche firms, with a lower volume of cases, it may be more sensible to pay on a case-by-case basis ('pay per click') with the suggested fee being approximately £2 per check.

APIL members were subsequently surveyed to gauge their views on the data-sharing proposals being put forward.

Methodology

The survey was hosted on SurveyMonkey[1] (an online survey tool), with a web-link included in an e-mail sent by Deborah Evans (APIL's Chief Executive) to all English and Welsh practitioner APIL members (3,193 in total) on Tuesday 12th August 2014 from the 'datasharing' APIL mailbox. The deadline for the survey was originally 5pm on Wednesday 27th August 2014, but was later extended by a week to 5pm on Wednesday 3rd September 2014 (an item indicating this extension was included in APIL Weekly News dated 29/08/14).

In total, 117 APIL members responded, either fully or partially - a response rate of 3.7 per cent. This is relatively low response rate considering that online surveys traditionally aim to achieve a 10 to 15 per cent response rate

A copy of the questionnaire can be found at Appendix A.

[1] https://www.surveymonkey.com/

Results

Brief details about you

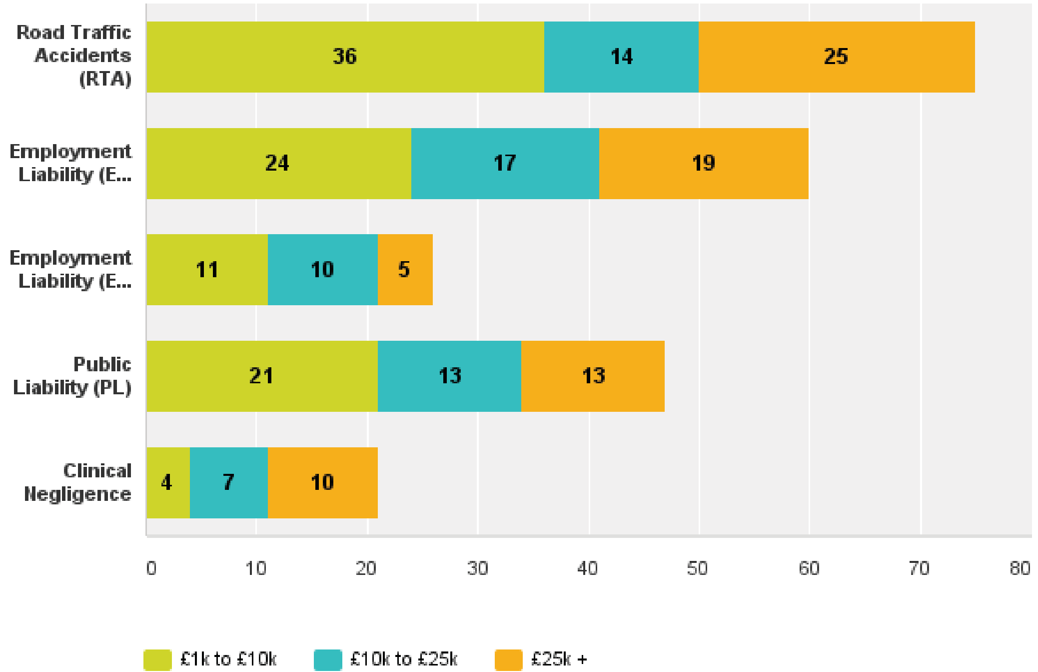
Q2. What types of personal injury claims do you MOSTLY handle (please tick only ONE)?

While the survey question asked for respondents to specify only one type of personal injury claim they handle, it is obvious from the results that a number of respondents indicated more (116 people responded to this question, identifying 229 types of personal injury claim). The reason for this could be that those respondents who primarily handle cases within the Claims Portal may have ticked both *'£1k to £10k'* and *'£10k to £25k'* when answering in respect of road traffic accidents (RTA), employment liability (EL) (both accident and disease) and public liability (PL) cases.

Regardless, this is not a huge issue as the question was intended to identify any particular areas of PI litigation which may be over, or under, represented within the sample; thankfully, respondents appear to have a broad range of specialisms in terms of liability type and value. Unsurprisingly, reflecting the general trend in terms of personal injury liability types, the majority of respondents to the survey handle RTA cases (31%), followed by EL (accident) (26%) and PL (21%) cases.

Q2 What types of personal injury claims do you MOSTLY handle (please tick only ONE):

Answered: 116 Skipped: 1

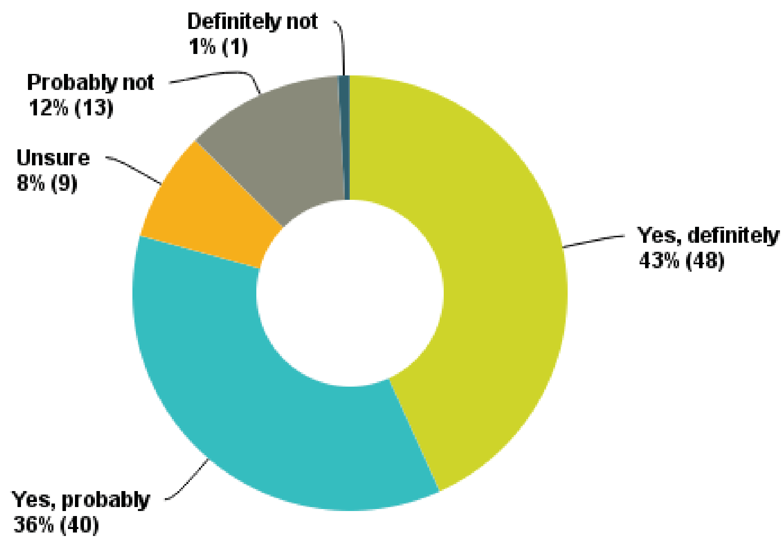


–	£1k to £10k	£10k to £25k	£25k +	Total
Road Traffic Accidents (RTA)	48.00% 36	18.67% 14	33.33% 25	75
Employment Liability (EL) - Accident	40.00% 24	28.33% 17	31.67% 19	60
Employment Liability (EL) - Disease	42.31% 11	38.46% 10	19.23% 5	26
Public Liability (PL)	44.68% 21	27.66% 13	27.66% 13	47
Clinical Negligence	19.05% 4	33.33% 7	47.62% 10	21

Data sharing proposal

Q3. Would having a potential clients personal injury claims history for the last 5 years help you identify claims where there is fraud or potential fraud?

An overwhelming majority of respondents indicated that having a potential client's personal injury claims history for the last five years would help them identify possible fraud, with nearly eighty per cent (79%) answering *'yes, definitely'* (43%) or *'yes, probably'* (36%) to the question. In contrast, only about one in ten (13%) indicated that the data would help them identify fraudulent cases.



Answer Choices–	Responses–
Yes, definitely	43% 48
Yes, probably	36% 40
Unsure	8% 9
Probably not	12%

Answer Choices–	Responses–
	13
Definitely not	**1%** 1
Total	111

Q4. If you were supplied with a potential clients PI claims details for the last 5 years, can you briefly describe how you would use this information (e.g. 'it would be one of the primary factors in the initial claims risk assessment')?

About 109 respondents provided further details about how they would use the information about a client's number of personal injury (PI) claims in the last five years in their internal processes. As suggested in the example within the questions itself, the majority of respondents said that it would inform the initial risk assessment:

> *"When taking an initial statement from a client I would ask whether they had been involved in any previous accidents. If they were to tell me that they had not, but I subsequently obtained information which suggested otherwise, this would to some extent tell me whether my client was being honest with me. If they were not, then this would allow me to decide whether or not I wanted to continue with their case…"*

> *"It would assist risk assessment for the case, particularly if the information given was at odds with the client's instructions."*

> "[K]*ey to establishing risk in the claim and veracity of instructions avoiding future costs and complications in cases that end up as discontinued or with the claimant as a litigant in person after we remove ourselves from the court record. The saving in costs and time to Defendants and the courts is immense putting aside any self interest in protecting our time, costs and reputation."*

In addition, however, a number of respondents indicated that it would not be the only piece of information used in assessing claims:

"It would be used as risk factor but also used as with medical records to see a client's history and discuss the same with them."

"It would be a useful tool by which to question the Claimant regarding any discrepancies in their reported Claims history & assist with the risk assessment but it would not be the defining factor as to whether to take the case or not; this would depend on the number of claims identified and the explanation provided as to any discrepancies on a case by case basis."

"[T]*he information would be used in addition to checking the claimants medical records."*

The potential misinterpretation of the results is another factor respondents identified:

"… [I]*t would be one of the factors in initial risk assessment but it may well be that that particular client has just been unlucky. I myself was involved in two rear end shunt accidents in the space of 6 months about 6 years ago but yet have never had any accidents since. Just because someone has been unlucky to be involved in more than one accident within the last 5 years does not mean that any claim is fraudulent. Likewise it could be a claimant's first RTA claim and yet it could be fraudulent. An indication of how many RTAs someone has been involved in within the last 5 years does not necessarily help us in identifying fraudulent claims and in fact may have the opposite affect* [sic] *of innocent parties having difficulty in getting a solicitor to take on their claim."*

"It would be helpful to enable us to obtain full details of the other claims and copy medical reports/records etc at an early stage to assess any issues at that stage, however simply having a list of previous claims would not, in my view, identify fraud in itself, regardless of what Defendants may think."

"It would be part of the initial risk assessment which we carry out at a weekly departmental meeting. However, I think we need to take care not to assume that more that 1 claim in 5 years equals fraud. I suspect this is what the insurance industry will want to suggest."

Finally, the value of the data-sharing scheme outside of low-value road traffic accident (RTA) was questioned by a number of respondents:

"In Trade Union funded EL work, the number of previous claims is not very relevant factor when assessing potential fraud, as the claims are often encouraged by Trade Union Safety reps to highlight problems within the workplace."

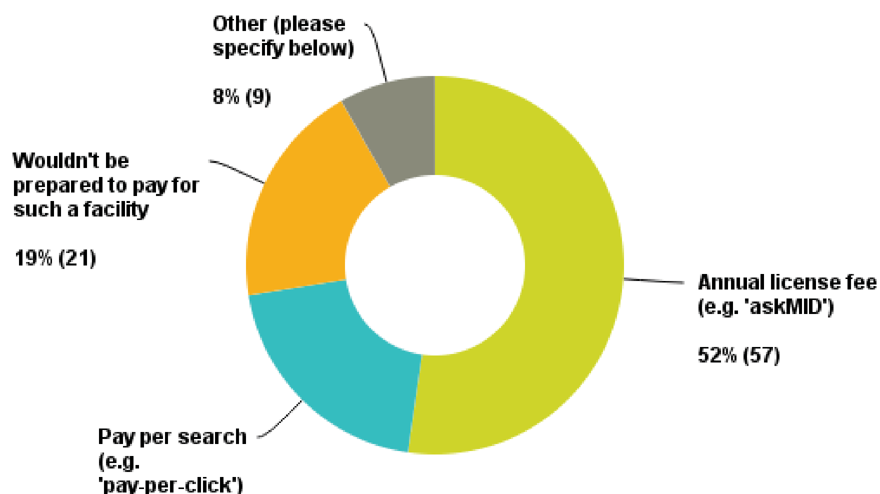
"Uncertain of it's use other than in RTA claims where it would certainly be factor to consider in the risk assessement [sic].*"*

Q5. In terms of paying for such a search facility, what method would you prefer?

It appears that over half of respondents (52%) would like to pay for a data-sharing facility via an annual license fee. This may reflect the fact that the proposed scheme broadly reflects 'askMID', a system many respondents will already be familiar with. Of the remaining respondents, about one in five would either like a 'pay per click' system (20%) or not to have to pay for search facility at all (19%).

Q5 In terms of paying for such a search facility, what method would you prefer?

Answered: 109 Skipped: 8



Answer Choices	Responses
Annual license fee (e.g. 'askMID')	52% 57
Pay per search (e.g. 'pay-per-click')	20% 22
Wouldn't be prepared to pay for such a facility	19% 21
Other (please specify below)	8% 9
Total	109

In terms of the final eight per cent who answered *'Other'* (above), a number highlighted the fact that the insurance industry already has this data (i.e. it does not have to be collected specially for the scheme) and it is directly beneficial to them to have less fraudulent claims:

> *"This data already exists. Surely it is in the insurers interests to prevent fraud."*

"The facility should only have a token charge as the insurers already have the information."

"If this service is readily available to insurers, why should we be expected to pay for it?"

Several responses also indicated that they saw the fee as acceptable if it was claimable from defendants as a disbursement:

"… If there is to be a fee then it MUST be recoverable as a disbursement."

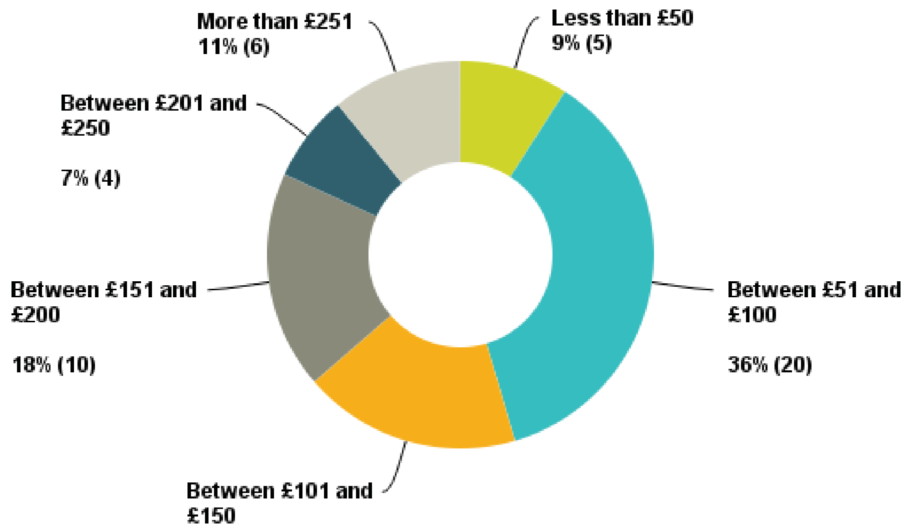
"I would only be willing to pay for such a search if it was recoverable from the Defendant."

"I am only prepared to pay if I can reclaim the cost as a disbursement."

Q6. How much would you be prepared to pay for an annual licence?

The respondents who indicated that they favoured an annual license fee were subsequently asked how much such a license fee should be. While there was relatively wide spread of responses, over a third of people (36%) indicated an annual fee between £51 and £100. A further one in five responses (18%) suggested a slightly higher fee between £101 and £150 and £151 and £200, respectively.

It should be noted that the current 'askMID' system - which is being as a comparator system to the new data-sharing proposal - charges about £180 per year. As such a fee between £51 and £100 would represent a significantly lower fee than 'askMID'.

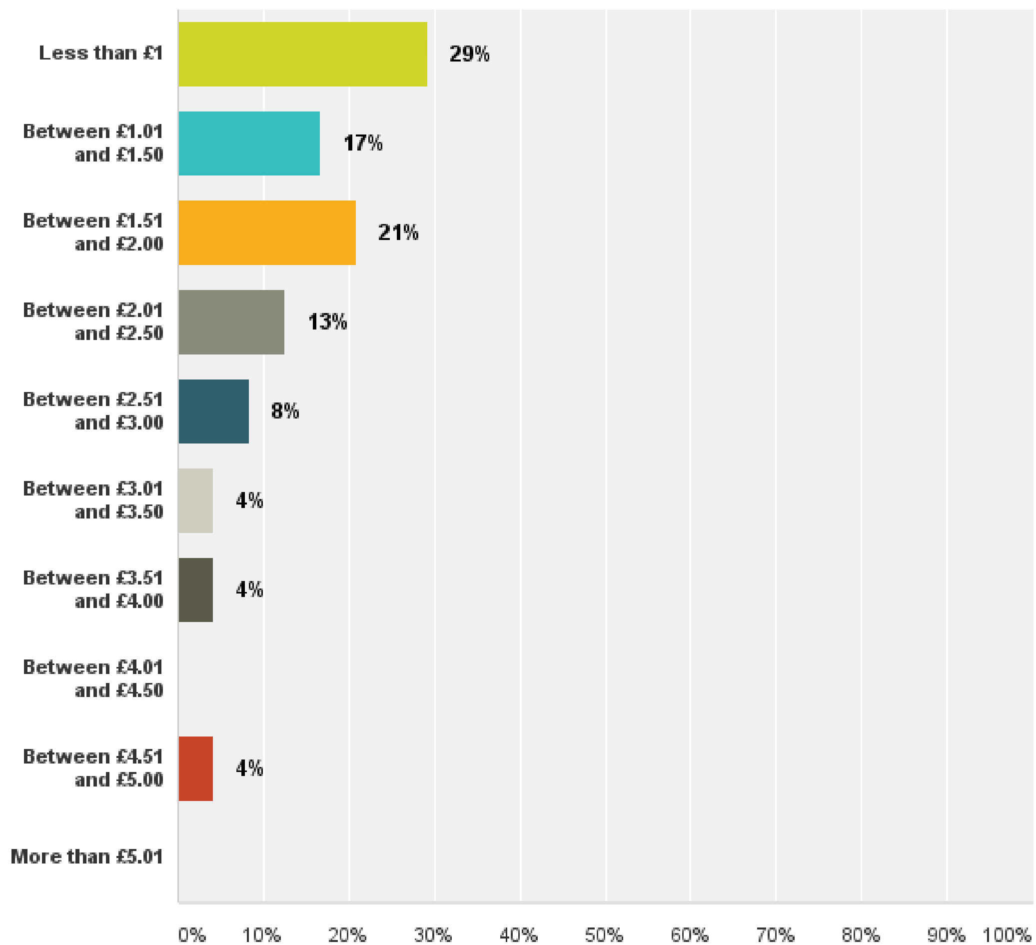


Answer Choices	Responses
Less than £50	9% 5
Between £51 and £100	36% 20
Between £101 and £150	18% 10
Between £151 and £200	18% 10
Between £201 and £250	7% 4
More than £251	11% 6
Total	55

Q7. How much would you be prepared to pay per search?

For those respondents who indicated that they would prefer a 'pay-for-search' charging method, there was a huge variety of figures in terms of *exactly* how much should be charged. About a third (29%) thought that it should be less than £1 per search, while about a fifth thought it should be between £1.01 and £1.50 (17%) and

between £1.51 and £2 (21%), respectively. Similar to the preferred level of annual fee (above), these figures are below the recommended level initially suggested by the scheme (namely £2 per search).



Answer Choices	Responses
Less than £1	29% 7
Between £1.01 and £1.50	17% 4
Between £1.51 and £2.00	21% 5

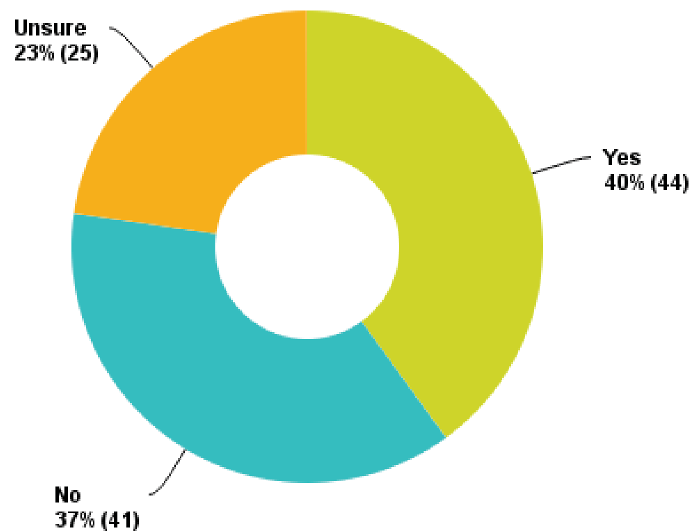
Answer Choices	Responses
Between £2.01 and £2.50	**13%** 3
Between £2.51 and £3.00	**8%** 2
Between £3.01 and £3.50	**4%** 1
Between £3.51 and £4.00	**4%** 1
Between £4.01 and £4.50	**0%** 0
Between £4.51 and £5.00	**4%** 1
More than £5.01	**0%** 0
Total	24

Q8. If a data sharing scheme was introduced, should it be made mandatory for all Portal claims (i.e. you would have to undertake a check before submitting a claims notification form [CNF])?

While there appears to be overall support for the data-sharing scheme (see responses above), the suggestion that it should be mandatory for all Portal Claims is less conclusive. Indeed it is almost split equally split down the middle, with 40 per cent of respondents indicating that it should be mandatory with a further 37 per cent indicating that it shouldn't be mandatory; the remaining quarter (23%) are sitting on the fence.

Q8 If a data sharing scheme was introduced, should it be made mandatory for all Portal claims (i.e. you would have to undertake a check before submitting a claims notification form [CNF])?

Answered: 110   Skipped: 7

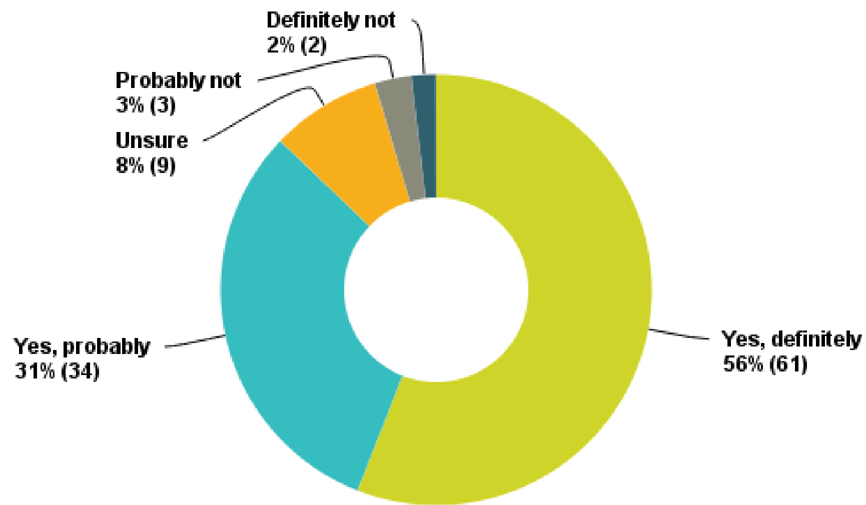


Answer Choices	Responses
Yes	40% 44
No	37% 41
Unsure	23% 25
Total	110

Q9. Can you please indicate whether you would support the introduction of a data sharing scheme (as described)?

While it appears that aspects of the scheme still need work (e.g. how the scheme is paid for, how much it should cost and whether it should be mandatory or not), overall nearly 90 per cent of respondents (87%) indicated that they would support the

introduction of such a data-sharing scheme. Indeed well-over half of respondents (56%) indicated that they would 'definitely' support a scheme.



Answer Choices	Responses
Yes, definitely	**56%** 61
Yes, probably	**31%** 34
Unsure	**8%** 9
Probably not	**3%** 3
Definitely not	**2%** 2
Total	109

Q10. Please briefly indicate why you wouldn't support such a data-sharing scheme?

Only 6 respondents provided further details about why they wouldn't support a data sharing scheme, with the comments falling into three camps, namely: that the presence of previous claims does not automatically signal a fraudulent claim; that the process should be independent of the insurance industry; and, finally, that the scheme is only really pertinent to RTA claims:

> *"If a client has suffered an injury historically and received compensation for that, that should not mean the client is a high risk/ potentially fraudulent. It is a matter of discussing previous accidents with the client and forming an opinion on a case by case basis."*

> *"History has shown that the ABI cannot be trusted any … data held by them will be used for whatever purpose they believe is necessary. If such data is to be collected then it needs to be independent of the ABI."*

> *"This is aimed entirely at RTA fraud, and it should not be introduced in the EL portal as it does not fit. I am not aware of any reliable data that fraud is serious problem in EL claims."*

Q11. Please indicate what aspects of the scheme you are unsure about?

Of the 7 respondents who provided comments to this question, the overwhelming concern was about the misuse of data and the presumption of fraud:

> *"Confidentiality; potential to misuse information; danger that genuine claimants would be tarred with a fraud brush."*

> *"The presumption of innocence until proven guilty will be lost forever and will give Insurers grounds for fiercely defending even the weakest of cases."*

"What are we to do with the data when one finds previous accidents but no evidence of fraud? This is an abuse of the Claimant's data. It is for insurers to raise a defence of fraud, not us, and the bar should be set very high. If insurers fail in such a defence they should face similar consequences as befall a Claimant for inflating his claim. At present there are none. Fraud needs to be identified with those actually perpetrating it; not all claimants as appears to be the present position of the ABI".

"… [A]*n automatic "fraud search" raises a presumption of fraud. Also, having had more than one accident could be a result of an employers' unsafe working practice rather than fraudulent claims."*

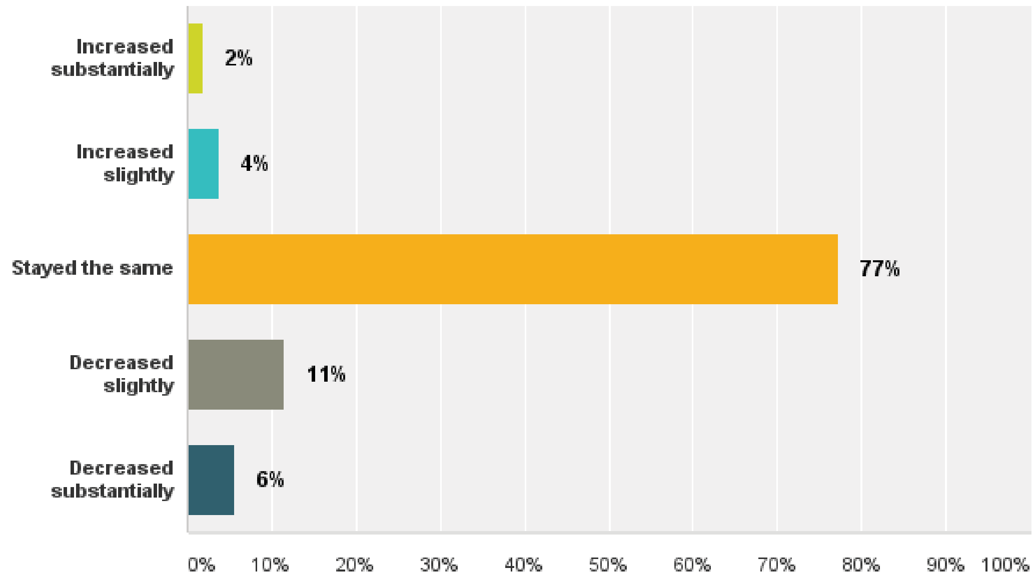
General questions about fraud

Q12. In terms of the number of personal injury claims you handle, has the number of fraudulent claims increased or decreased over the last 5 years?

The primary policy driver behind the data-sharing scheme is the reduction of fraudulent personal injury insurance claims. As such, the survey asked respondents, based on their own personal experience, to comment on the whether the number of fraudulent claims had gone up or gone down in recent years. In terms of the number of such claims over the last five years, three-quarters of respondents (77%) indicated that it had largely stayed the same. If anything, nearly one in five respondents (17%) seemed to think that the number of fraudulent claims had actually gone *down* in the timeframe.

Q12 In terms of the number of personal injury claims you handle, has the number of fraudulent claims increased or decreased over the last 5 years?

Answered: 105 Skipped: 12



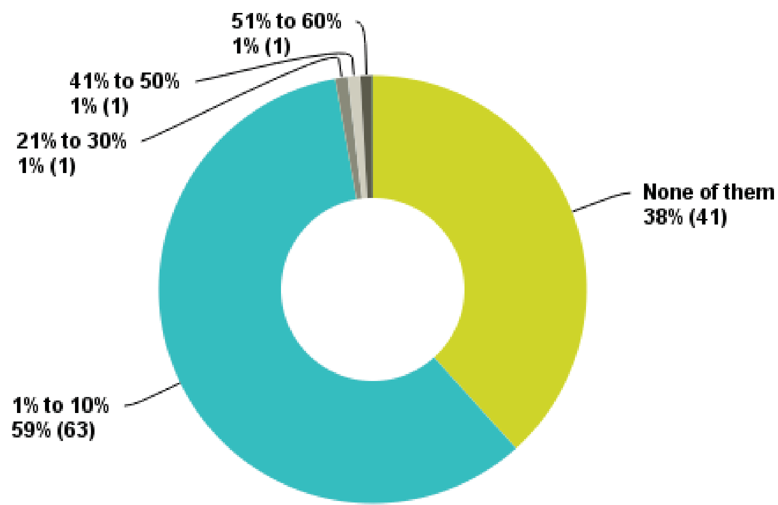
Answer Choices	Responses
Increased substantially	2% 2
Increased slightly	4% 4
Stayed the same	77% 81
Decreased slightly	11% 12
Decreased substantially	6% 6
Total	105

Q13. Prior to taking on a claim (i.e. before a letter of claim or claims notification form [CNF] is sent), approximately what percentage of personal injury claims do you reject due to a suspicion of fraud?

With nearly 60 per cent of respondents (59%) indicating that only about one to ten per cent of cases are rejected due to fraud, it seems that the vast majority of potential cases are rejected due to other issues. In fact a further 40 per cent of respondents (38%) haven't rejected a potential case due to a suspicion of fraud. These results can be seen to be due to a number of different possible reasons - for example, one possible explanation is that there simply isn't enough information at a pre-CNF/letter of claim stage to be able to effectively assess whether the claim is potentially fraudulent; it is only once the case has been taken on and more investigation has taken place that fraud can be more readily detected. Alternatively, it could be that more prosaic legal reasons - such as liability, causation, contributory negligence, limitation periods, etc. - actually lead to cases being rejected at the initial assessment stage.

Q13 Prior to taking on a claim (i.e. before a letter of claim or claims notification form [CNF] is sent), approximately what percentage of personal injury claims do you reject due to a suspicion of fraud?

Answered: 107 Skipped: 10



Answer Choices–	Responses–
None of them	38% 41
1% to 10%	59% 63
11% to 20%	0% 0
21% to 30%	1% 1
31% to 40%	0% 0
41% to 50%	1% 1
51% to 60%	1% 1
61% to 70%	0% 0

Answer Choices–	Responses–
71% to 80%	**0%** 0
81% to 90%	**0%** 0
91% to 99%	**0%** 0
All of them	**0%** 0
Total	107

Q14. In the last 2 years, out of ALL the personal injury cases you have handled, how many have subsequently been found to be fraudulent?

It is interesting to note that the suggestion above (Q13) that *"it is only once the case has been taken on and more investigation has taken place that fraud can be more readily detected"* would seem to be partially confirmed with the results from this question. While nearly two-thirds of respondents (65%) indicate that in the last two years they haven't had any cases which were subsequently found to be fraudulent, a further third (31%) indicate that between one and ten per cent of their cases *have* been found to be fraudulent. This suggests cases are taken on beyond the initial CNF/letter of claim stage and only then found to be fraudulent.

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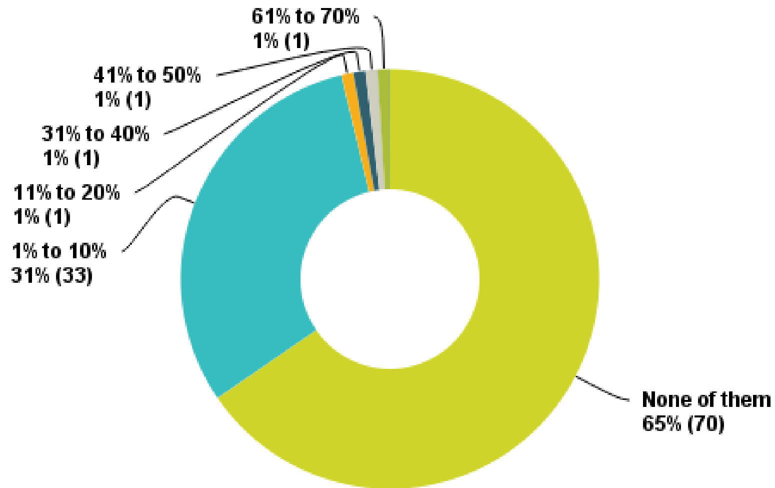
Q14 In the last 2 years, out of ALL the personal injury cases you have handled, how many have subsequently been found to be fraudulent?

Answered: 107   Skipped: 10



Answer Choices	Responses
None of them	65% 70
1% to 10%	31% 33
11% to 20%	1% 1
21% to 30%	0% 0
31% to 40%	1% 1
41% to 50%	1% 1
51% to 60%	0% 0
61% to 70%	1% 1
71% to 80%	0% 0
81% to 90%	0%

Answer Choices	Responses
	0
91% to 99%	**0%** 0
All of them	**0%** 0
Total	107

Allegation of fraud by defendants

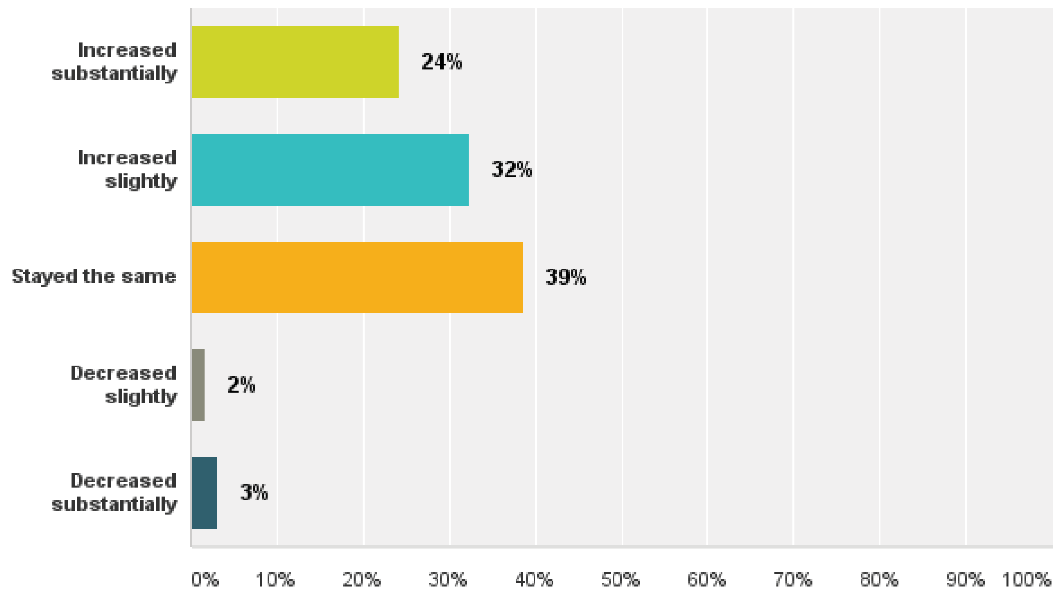
The previous section (questions 12, 13 and 14) asked about respondents' experience of actual fraudulent claims. In response to these questions, a number of early respondents indicated that it was allegations of fraud by defendants which were more problematic than actual fraudulent claims (which were few and far between). As such, the following questions (Q15 to Q17) were added on Friday 15th August - approximately three days after the launch of the original survey. All respondents who had already completed the survey were re-contacted and asked to re-enter the survey and complete the new questions. The drop in response numbers (from approximately 100 in the previous questions to about 60) is due to the addition of these new questions.

Q15. In terms of the number of personal injury claims you handle, has the number of claims were the defendant alleges fraud increased or decreased over the last 5 years?

In responding to question 12, over three-quarters of respondents (77%) indicated that the number of *actual* fraudulent claims has stayed the same in the last five years (i.e. no increase or decrease). In contrast, over half of the respondents (56%) who responded to question 15 indicated that the number of *allegations* of fraud has increased during the same time period, with nearly a quarter of respondents (24%) indicating the increase has been substantial.

Q15 In terms of the number of personal injury claims you handle, has the number of claims were the defendant alleges fraud increased or decreased over the last 5 years?

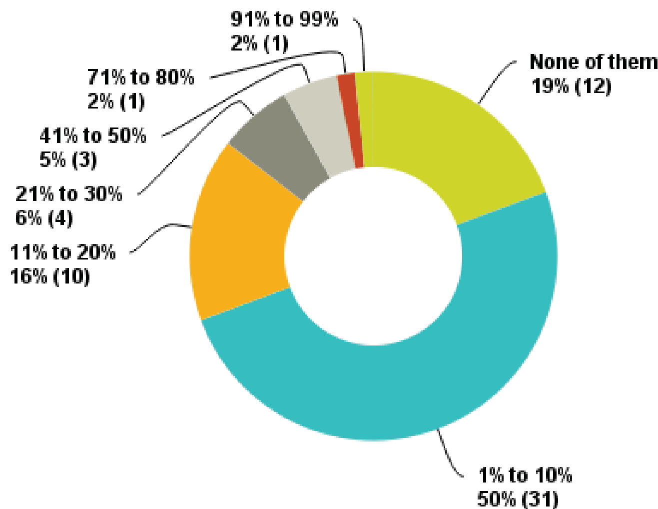
Answered: 62 Skipped: 55



Answer Choices	Responses
Increased substantially	24% 15
Increased slightly	32% 20
Stayed the same	39% 24
Decreased slightly	2% 1
Decreased substantially	3% 2
Total	62

Q16. In the last 2 years, in approximately what percentage of ALL the personal injury cases you have handled has the defendant made an allegation of fraud?

While question 15 suggests that there has been an increase in the number of allegations of fraud by defendants, responses to question 16 provides details about how often it happens. Half of the respondents (50%) to this question indicated that an allegation of fraud is made in made in about one to ten per cent of cases, with just less than one in five respondents (16%) suggesting that it happens in between 11 and 20 per cent of cases. More worryingly, six per cent of respondents (6%) suggest that in approximately a quarter of cases (21% to 30%) fraud allegations are made.



Answer Choices	Responses
None of them	19% 12
1% to 10%	50% 31
11% to 20%	16% 10

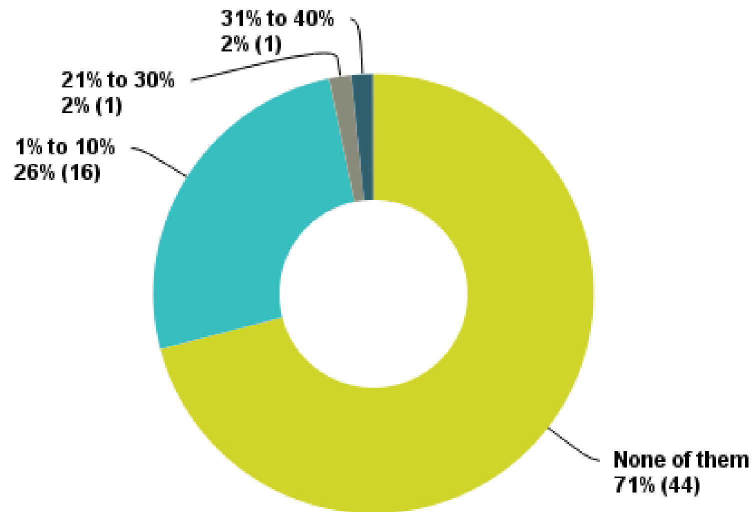
Answer Choices	Responses
21% to 30%	6% 4
31% to 40%	0% 0
41% to 50%	5% 3
51% to 60%	0% 0
61% to 70%	0% 0
71% to 80%	2% 1
81% to 90%	0% 0
91% to 99%	2% 1
All of them	0% 0
Total	62

Q17. And in what percentage of cases has the defendant's allegation of fraud been found to be true (i.e. proven with evidence and/or pleaded in the case)?

Yet although defendants make various allegations of fraud, nearly three-quarters of respondents (71%) indicate that these allegations are never found to be true. In a small minority of cases - one to ten per cent - a quarter of respondents (26%) indicate that fraud is found to be true (or at least it is pleaded in the case). There is still, however, a sharp discrepancy between the numbers of cases where fraud is alleged and the number of cases where fraud is proved.

Q17 And in what percentage of cases has the defendant's allegation of fraud been found to be true (i.e. proven with evidence and/or pleaded in the case)?

Answered: 62 Skipped: 55



Answer Choices	Responses
None of them	71% 44
1% to 10%	26% 16
11% to 20%	0% 0
21% to 30%	2% 1
31% to 40%	2% 1
41% to 50%	0% 0
51% to 60%	0% 0
61% to 70%	0% 0

Answer Choices	Responses
71% to 80%	**0%** 0
81% to 90%	**0%** 0
91% to 99%	**0%** 0
All of them	**0%** 0
Total	62

Additional comments

Q18. If you have any additional comments, please add these below?

In total 39 respondents provided further comments about the data-sharing proposal. Similar to responses received to questions 4, 10 and 11 a number of people highlighted their concerns about the data being potentially misused or misinterpreted by insurers / defendants and the approach insurers will take to the provision of this information:

> *"It is clearly important that the insurer's provide and share correct information and not convoluted data which could be open to misinterpretation and misuse."*

> *"…It should also be the case that the Def insurer should disclose at a very early stage any concerns they have."*

> *"Insurers have been closing fraud departments as have their solicitors. They have raised fraud in the public domain without any evidence being published let alone open to cross examination. They should defend all cases where there is suspicion of fraud at their own expense. The proposed scheme further enables them to put the cost on others for their inefficiencies.. If they were properly staffed with competent people this fraud theme could have been nipped in the bud before it escalated out of all proportion."*

"The Defendants often infer fraud rather than formaly [sic] *plead because they wish to have the protection of any ATE policy. I suspect that will now change following 1/4/13."*

"I would be interested to know if the Defendant insurers' records of allegedly fraudulent claims include cases where: a) they have raised an allegation of fraud that was unproven; and b) where a head of claim was dropped or was unsuccessful at trial for whatever reason, as given my experience, which is mirrored firmwide and amongst all my claimant PI solicitor friends the percentages cited by ABI representatives for fraudulent claims must be either made up or include items such as a) and b) ante where there is no proof of fraud at all."

A number of respondents also questioned the idea of previous searches being compulsory:

"…RTA claims fail but rarely due to fraud in my experience. I see most of my clients therefore the anti-fraud measures (though potentially useful) may be less important for me than for firms receiving written instructions or taking instructions by telephone. I would like the option to use it, but do not think it is necessary for most of my clients."

"I do not believe the search should be compulsory prior to submitting a CNF. I would carry out a search for those clients who we do not know or have concerns about. it may be that having seen the medical records we would want to do a search later in the claim…"

Reflecting the additional questions which were added to the survey (Q15 to Q17), a number of respondents reported low levels of actual fraud but high levels of allegations of fraud:

"…I have not had one single fraudulent claim in 30 years of practice…"

"Speaking from my own personal experience, fraudulant [sic] *claims are a rarity…"*

"[W]*hilst none have been held to be fraudulent a third have had allegations made"*

"From my experiance [sic] *most of the fraud is found in the low value RTA cases and with a simple check list these can be weeded out. Any additional advances on the fight against fraud is never going to be a bad thing although I would suggest that perhaps 95% of firms would identify the cases without this service and it is the other 5% that need looking at."*

"In my experience as a personal injury solicitor over the last 25 years I can only think of one definite fraudulent claim which we discontinued as soon as we discovered it and then sued the client full refund of the costs. I think the idea that claimants are fraudsters is massively overstated and in my practice where we get to meet most of our clients we very quickly identify any cases where fraud is suspected."

"I do not consider that there has been an increase in the number of fraudulent claims. There has been an increase in the number of fraud allegations raised by insurers, which are in my experience never proven or properly pleaded and routinely dropped during the course of proceedings."

Finally, a couple of respondents question how accurate the data provided will be and whether it actually provides a full enough picture:

"The data provided needs to bear more accuracy than has been shown in the past from CUE and PI Cache reports seen in disclosure from Insurer Defendants. Who is responsible for the accuracy of information provided and what processes exist to correct errors/mistakes? DPA alone should suffice

but a process similar to that with Credit Reference Agencies should exists so an individual can obtain a copy of the Register entry in their name to check it is correct."

"There are several reasons why an insurers my allege fraud; the fraud flags they use target ethnic minorities, vehicle age, post code area etc. not just claims history. Sharing of claims data would be useful but I do not believe it offers any great assistance in reducing the number of allegations of LVI, & occupancy disputes which in my experience are the majority of fraud allegations in the current climate raised by insurers. It is important to be mindul [sic] *that an allegation of fraud can be used as a tool to deter innocent claimants."*

Miles Burger

Head of Research

10 September 2014

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- Ends -

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Appendices

APIL data sharing survey

Background

As part of APIL's on-going work in tackling fraud, it has been in discussions with MASS, the ABI, the Law Society and the Ministry of Justice (MoJ) about the possibly of greater data sharing between claimants and insurers. As APIL has previously stated "data can be essential in the fight against fraud" and we have called "upon insurers to share data with lawyers so that potential fraudsters can be spotted right at the start of a claim" (http://tinyurl.com/ktuf6w6).

To this end, a potential new data-sharing scheme has been developed and is currently being consulted on. The scheme would operate along broadly the same lines as the current 'askMID' database (http://www.askmid.com/), but would reference the Claim and Underwriting Exchange Personal Injury (CUEPI) database instead. Once basic client details are entered, the CUEPI database indicates how many personal injury claims the potential client has made in the last five years (and the dates of these claims). This information can then be used by you to risk assess the particular case. Another suggestion is that CUEPI searches could be made compulsory prior to the submission of a claims notification form (CNF) into the Portal (a unique reference number would have to be entered on the submitted CNF).

In terms of cost, it is suggested that the claimant law firm could pay a annual license fee (similar to 'askMID') of about £180. For smaller or niche firms, with a lower volume of cases, it may be more sensible to pay on a case-by-case basis ('pay per click') with the suggested fee being approximately £2 per check.

The potential benefits of the scheme are that it could save you, and your firm, a significant amount of time (and money) by alerting you to possible fraudulent claims. In addition it would show the wider world that the personal injury community is taking pro-active steps to combat fraud.

As to the exact details of any scheme, these are still very much up for discussion. To this end, APIL would like to know your views about the proposed scheme - can you please spare 5 to 10 minutes to quickly complete the following short questionnaire.

While you may not be able to supply all the requested information, we still want ANY information you may have; some data really is better than no data!

The deadline for the survey is 5pm on WEDNESDAY 3rd SEPTEMBER 2014.

Please note, as with all of APIL's research, your responses will be treated as anonymous and will only be used in an aggregated form i.e. no individual or firm will be identifiable.

If you have any questions, please contact Miles Burger, head of research, by email at miles.burger@apil.org.uk or telephone 0115 943 5423.

Thank you very much in anticipation of your help.

Brief details about you

*** 1. Please provide the following details:**

Name:

Firm:

E-mail address:

2. What types of personal injury claims do you MOSTLY handle (please tick only ONE):

	£1k to £10k	£10k to £25k	£25k +
Road Traffic Accidents (RTA)	○	○	○
Employment Liability (EL) - Accident	○	○	○
Employment Liability (EL) - Disease	○	○	○
Public Liability (PL)	○	○	○
Clinical Negligence	○	○	○

Data sharing proposal

3. Would having a potential clients personal injury claims history for the last 5 years help you identify claims where there is fraud or potential fraud?

- ◯ Yes, definitely
- ◯ Yes, probably
- ◯ Unsure
- ◯ Probably not
- ◯ Definitely not

4. If you were supplied with a potential clients PI claims details for the last 5 years, can you briefly describe how you would use this information (e.g. 'it would be one of the primary factors in the initial claims risk assessment'):

5. In terms of paying for such a search facility, what method would you prefer?

- ◯ Annual license fee (e.g. 'askMID')
- ◯ Pay per search (e.g. 'pay-per-click')
- ◯ Wouldn't be prepared to pay for such a facility
- ◯ Other (please specify below)

Please specify here:

6. How much would you be prepared to pay for an annual licence?

- Less than £50
- Between £51 and £100
- Between £101 and £150
- Between £151 and £200
- Between £201 and £250
- More than £251

7. How much would you be prepared to pay per search?

- ◯ Less than £1
- ◯ Between £1.01 and £1.50
- ◯ Between £1.51 and £2.00
- ◯ Between £2.01 and £2.50
- ◯ Between £2.51 and £3.00
- ◯ Between £3.01 and £3.50
- ◯ Between £3.51 and £4.00
- ◯ Between £4.01 and £4.50
- ◯ Between £4.51 and £5.00
- ◯ More than £5.01

8. If a data sharing scheme was introduced, should it be made mandatory for all Portal claims (i.e. you would have to undertake a check before submitting a claims notification form [CNF])?

- ◯ Yes
- ◯ No
- ◯ Unsure

9. Can you please indicate whether you would support the introduction of a data sharing scheme (as described)?

- ◯ Yes, definitely
- ◯ Yes, probably
- ◯ Unsure
- ◯ Probably not
- ◯ Definitely not

10. Please briefly indicate why you wouldn't support such a data-sharing scheme:

11. Please indicate what aspects of the scheme you are unsure about:

General questions about fraud

12. In terms of the number of personal injury claims you handle, has the number of fraudulent claims increased or decreased over the last 5 years?

- ◯ Increased substantially
- ◯ Increased slightly
- ◯ Stayed the same
- ◯ Decreased slightly
- ◯ Decreased substantially

13. Prior to taking on a claim (i.e. before a letter of claim or claims notification form [CNF] is sent), approximately what percentage of personal injury claims do you reject due to a suspicion of fraud?

- ◯ None of them
- ◯ 1% to 10%
- ◯ 11% to 20%
- ◯ 21% to 30%
- ◯ 31% to 40%
- ◯ 41% to 50%
- ◯ 51% to 60%
- ◯ 61% to 70%
- ◯ 71% to 80%
- ◯ 81% to 90%
- ◯ 91% to 99%
- ◯ All of them

14. In the last 2 years, out of ALL the personal injury cases you have handled, how many have subsequently been found to be fraudulent?

- ◯ None of them
- ◯ 1% to 10%
- ◯ 11% to 20%
- ◯ 21% to 30%
- ◯ 31% to 40%
- ◯ 41% to 50%
- ◯ 51% to 60%
- ◯ 61% to 70%
- ◯ 71% to 80%
- ◯ 81% to 90%
- ◯ 91% to 99%
- ◯ All of them

Allegation of fraud by defendants

15. In terms of the number of personal injury claims you handle, has the number of claims were the defendant alleges fraud increased or decreased over the last 5 years?

- ◯ Increased substantially
- ◯ Increased slightly
- ◯ Stayed the same
- ◯ Decreased slightly
- ◯ Decreased substantially

16. In the last 2 years, in approximately what percentage of ALL the personal injury cases you have handled has the defendant made an allegation of fraud?

- ◯ None of them
- ◯ 1% to 10%
- ◯ 11% to 20%
- ◯ 21% to 30%
- ◯ 31% to 40%
- ◯ 41% to 50%
- ◯ 51% to 60%
- ◯ 61% to 70%
- ◯ 71% to 80%
- ◯ 81% to 90%
- ◯ 91% to 99%
- ◯ All of them

17. And in what percentage of cases has the defendant's allegation of fraud been found to be true (i.e. proven with evidence and/or pleaded in the case)?

- ◯ None of them
- ◯ 1% to 10%
- ◯ 11% to 20%
- ◯ 21% to 30%
- ◯ 31% to 40%
- ◯ 41% to 50%
- ◯ 51% to 60%
- ◯ 61% to 70%
- ◯ 71% to 80%
- ◯ 81% to 90%
- ◯ 91% to 99%
- ◯ All of them

Additional comments

18. If you have any additional comments, please add these below: