

**DEPARTMENT OF HEALTH**

**MAKING AMENDS**

**A CONSULTATION PAPER SETTING OUT PROPOSALS FOR REFORMING  
THE APPROACH TO CLINICAL NEGLIGENCE IN THE NHS**

**A RESPONSE BY THE ASSOCIATION OF PERSONAL INJURY LAWYERS**

**OCTOBER 2003**

The Association of Personal Injury Lawyers (APIL) was formed in 1990 by claimant lawyers with a view to representing the interests of personal injury victims. APIL currently has over 4,900 members in the UK and abroad. Membership comprises solicitors, barristers, legal executives and academics whose interest in personal injury work is predominantly on behalf of injured claimants. APIL does not generate business on behalf of its members.

APIL's executive committee would like to acknowledge the assistance of the following in preparing this response:

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## **Department of Health: Making Amends**

### **Introduction**

1. APIL is committed to the review of the clinical negligence system and welcomes this opportunity to comment on the Chief Medical Officer's (CMO) proposals for reform. In responding to the 'Call for Ideas' in September 2001, APIL stated that any reforms should be based on detailed and impartial information, as it was concerned about the influence of media reporting of the alleged 'compensation culture' at the time. It is encouraging that a substantial part of 'Making Amends' provides an invaluable insight into the current system.

### **The Reforming Principles**

2. APIL agrees that it is important to define the reforming principles. These are stated in the consultation paper as:
  - Risks of care are steadily reduced and patient safety improves because medical errors and near misses are readily reported, successfully analysed and effective corrective action takes place and is sustained.
  - Harm and injuries arising from healthcare are fairly and efficiently compensated.
  - Payment of compensation acts as an incentive on healthcare organisations and their staff to improve quality and patient safety.
  - The process of compensation does not undermine the strength of the relationship between patient and healthcare professional.

- Different entry points to expressing complaints and concerns about standards of care are well co-ordinated and well understood by the public and healthcare professionals.
  - The system of compensation is affordable and reasonably predictable in the way it operates.
3. APIL broadly supports these reforming principles. The primary focus within any reforms must be driven by the need to reduce adverse incidents in the longer term. Indeed the report seems to promote the reduction of risks of care, rather than tackling just the administrative and legal costs; tackling the root causes of the problem not just the symptoms. Yet while the proposals indicate wide ranging and extensive reforms, the report says the system of compensation needs to be 'affordable'. APIL recognises that there will need to be an increase in budget provision to provide the proposed changes, but we fully support this need for additional funding if it delivers appropriate redress and reduces adverse incidents. The proposals should not be compromised by an undue emphasis on making the scheme affordable.
4. APIL is also concerned with the aim that *'harm and injuries from healthcare are fairly and efficiently compensated'* rather than fully compensated. All claimants should have the right to full and fair compensation i.e. compensation that puts them in the same position that they were in prior to the adverse incident.

## **Proposals for Reforms**

5. APIL is attracted to many aspects of the proposed composite package of reforms. The package certainly appears to be patient-focused and to address many of the concerns APIL and other interested parties have raised. On a general level, we welcome the fact that the CMO has considered the clinical negligence system in the context of the general procedures in place for dealing with patients regardless of whether or not they suspect that something has gone wrong with their treatment. To reform only the compensation mechanism of the system would be to tackle only part of the problem.
6. We particularly welcome the fact that the Chief Medical Officer has rejected the concepts of no-fault compensation and a tariff-based compensation scheme. Both schemes were strongly opposed by APIL in our previous response. Costs aside, we believe both of these systems would have been inequitable to injured patients and the bereaved.
7. Whilst we are attracted by many of the reforms, however, we are extremely concerned that the consultation document offers little detail about how the reforms will work. As such APIL will detail the precise questions we believe need answering in each of the appropriate sections.
8. Finally, APIL intends any remarks made in this paper to be constructive and aid with the development of the scheme as a whole. APIL would like to offer to assist in any implementation consultation that is necessary.

**Recommendation 1:**

**An NHS Redress Scheme should be introduced to provide investigations when things go wrong; remedial treatment, rehabilitation and care where needed; explanations and apologies; and financial compensation in certain circumstances.**

9. The stipulation that all adverse incidents, or complaints, would be investigated is fully supported by APIL. The combination of a local investigation and self reporting should enable the vast majority of incidents to be identified and investigated. These moves will help increase patients' confidence in the NHS as they would feel that their problem is being taken seriously and that something is being done. Also, as detailed in our previous response<sup>1</sup>, the provision of an explanation following the investigation would provide some of the answers that injured patients or the bereaved are seeking. Indeed many patients do not just want financial compensation but a wider range of remedies.
  
10. APIL is, however, uneasy about the time-limits involved in the investigation of adverse incidents and the pursuant redress scheme claim. The current limitation period for a personal injury claim is three years. If, for example, a patient decides not to accept an offer via the proposed redress scheme, his ability to pursue a claim through litigation will have been adversely affected in respect of this limitation period. This can be seen to be particularly problematic in reference to clinical negligence claims which involve complex causation and legal issues. This concern is partially mitigated by the assertion in the report that a time-limit of six months will be imposed for decisions to be made within the redress scheme. To make the process meet the needs of the patients, however, any investigation should have this time-limit of six months rigidly adhered

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<sup>1</sup> APIL's response to the Department of Health consultation 'Clinical Negligence: What are the issues and options for reform?' (October 2001)

to. Without the time-limit being strictly adhered to, APIL feels that investigations could drift on, leaving the patient without answers and with potential limitation period problems.

11. Whilst APIL welcomes the investigating of all adverse incidents, we have questions over the operation of the scheme in practice. Indeed, the MORI information in the report states there could be as many as 800,000 preventable adverse events per year. As a claimant organisation APIL feels that the cost in time and money that this would require would be worthwhile, helping to reduce adverse incidents in the long term. In addition APIL would be willing to help formulate policy in this area.

12. After investigation and explanation, APIL welcomes the assertion that the NHS will develop and deliver packages of care providing remedial treatment, therapy and continuing care to injured patients via the redress scheme. As an organisation that deals with injured plaintiffs and claimants, we have always strongly promoted the need for prompt and efficient treatment, as well as rehabilitation. In theory, provided an injured person receives the care he needs, we are fully supportive of the suggestion. We are concerned, however, that the NHS does not have the capacity to develop and deliver a suitable package of care and is unlikely to be able to do so in the near future. Indeed in the consultation paper itself these limitations are discussed:

*“In the short term, the capacity of the NHS to provide packages of care may be limited and financial recompense may be offered as an alternative.”*

- Q: Who will decide when the NHS does have sufficient capacity and on what basis? Patients should not have to ‘make do’ with what is available.

- Q: How much flexibility would there be in the system – will the NHS be able to take into account the fact that a patient may have lost confidence in his local hospital?
- Q: If the patient accepts a package of care, what would happen if it subsequently became inadequate?

13. How the financial elements of the compensation package are delivered to the patient concerns APIL. Indeed it is noted that the financial element of the compensation could include *“the notional cost of the episode of care or other amount as appropriate, at the discretion of the local NHS Trust”*. We are concerned about the use of the term ‘notional’, and its lack of definition within the document. If the required care is not available from the NHS, the injured patient will have to purchase it privately. The injured patient should, therefore, receive the actual, rather than the notional, cost of care. We appreciate that this is linked to the debate surrounding s.2 (4) of the Law Reform (Personal Injuries) Act and our views on this appear later.

- Q: What is meant by ‘notional cost’ in relation to the financial element of the compensation?

14. APIL feels the suggested £30,000 limit on the financial element of the compensation package as proposed within the NHS redress scheme is too high. The reason for this is that the NHS redress scheme is attempting to simplify, or ‘fast-track’, the compensation process thus making it more applicable to cases that are straightforward and less complex. The concern is that legally complex and medically difficult cases would inadvertently be included in this ‘fast-track’ redress scheme. For example, a case involving damage to a female patient’s reproductive organs depends on a variety of factors including: whether or not the affected woman already has children and/or whether the intended family was complete; scarring; depression or psychological scarring; and whether a



foetus was aborted. Dependant on these factors a compensation award for pain, suffering and loss of amenity (PSLA) can range from £5,000 to £87,500<sup>2</sup>. The difficulty lies in the fact that it is the determination of these relevant factors that defines the award. It would thus be unlikely that the exact amount, or quantum, of the compensation award could be determined at the outset of a case, leading to the case being mistakenly included in the redress scheme.

15. APIL feels a more appropriate threshold level for the financial element of the compensation package would be £15,000. Indeed a threshold of £15,000 is currently used for determining fast-track cases in civil litigation as well as being used in the recent 'Speedy Resolution Scheme' within NHS trusts in Wales. The working party dealing with the Welsh scheme has recommended that "claims be accepted into the scheme worth £5,000 - £15,000... The scheme will apply to relatively straightforward claims". It should be noted, however, that if a claim becomes more complex once entered into the NHS redress scheme, there should be the option to opt out and pursue the case via the traditional litigation.
16. Any financial limit for the scheme should apply to the cash only element of the compensation, and should not apply to the whole package of care and cash. It would be highly impractical to seek to value the notional cost of care. In addition this difficulty in assessment would lead to a great deal of uncertainty for patients entering the scheme.
17. APIL is opposed to the suggestion in the consultation document that '*it would not be necessary for lawyers to be routinely involved*'. We believe that independent legal advice and funding should be made available to the injured patient from the outset once an adverse incident has occurred,

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<sup>2</sup> Guidelines for the assessment of general damages in personal injuries cases (6<sup>th</sup> Edition), Judicial Studies Board, Oxford University Press,

regardless of monetary threshold. The need for independent legal representation is essential for maintaining the rights of the vulnerable patient dealing with the same organisation which provided them with sub-standard treatment. While APIL is fully supportive of the principles underlying the proposed scheme, it should be remembered that there is an inherent lack of independence within the scheme; the state investigates an incident, and decides how much the state should pay to a patient which the state injured. Thus the presence of an independent legal representative will allow for the patient's interest to be dealt with by someone other than the defendant. APIL is, however, keen to be constructive and would appreciate the opportunity to work with the NHS to examine how the lawyer can more efficiently interact with the process of the NHS redress scheme.

18. APIL agrees with the consultation document that a claimant should use an independent legal expert to ascertain whether the compensation offer that the NHS Redress Scheme finally proposes is appropriate. We feel, however, that provision for legal advice should be available at all times during the redress scheme (as detailed above). Without the protection that legal representation provides, how will the patient be able to make an informed decision as to whether he should use the redress system or seek a remedy through the normal tort system?

- Q: How will the NHS Redress Scheme work alongside normal civil litigation?
- Q: With the initial retention of the Bolam standard, it is debatable that the redress scheme has the same level of duty of care as normal tort litigation. Thus is the NHS redress scheme attempting to replace tort litigation within clinical negligence?

19. We do not believe that there should be a minimum qualifying level in terms of the extent of the disability. Under the law of tort, it is only necessary to establish a personal injury – no threshold of injury applies. The NHS redress scheme should reflect this legally established principle.

20. APIL feels that the NHS Redress Scheme should be applicable to all categories of care, such as primary care, from the outset.

21. In summary, therefore, whilst we welcome many aspects of the scheme, we have several concerns about how various aspects of it will work, and there are several areas where significantly more detail is needed.

**Recommendation 2:**

**The NHS Redress Scheme should encompass care and compensation for severely neurologically impaired babies, including those with severe cerebral palsy.**

22. APIL welcomes the intention behind the proposed redress scheme as it applies to babies who are severely neurologically impaired. As noted in the consultation paper, many injured babies do not receive compensation due to technical and legal problems. It is not equitable, however, to create specialist compensation for a particular group of people. Severely neurologically impaired babies should be considered as any other entrant to the redress scheme. In addition it would appear that the proposals confuse ‘compensation’ for negligent treatment, with the appropriate care for children suffering from brain damage where no element of negligence was involved. APIL firmly believes that the NHS is under a duty to provide appropriate care for all children who suffer from brain damage, regardless of fault, and that this has nothing to do with the issue of compensation which should be awarded to children who have been injured as a result of

negligence. It would seem that the redress scheme, as part of the compensation package, is offering health care to parents of brain damaged children that they should be entitled to regardless. This would also create a state of inequality; children who are negligently injured outside the NHS should not be treated any differently from those children injured within the NHS.

23. APIL questions the practical application of the redress scheme in relation to severely neurologically impaired babies, and what checks will be built into the system so that it retains its integrity. In particular, are there any time limits for acceptance of an offer made through the NHS redress scheme? There is also a concern that if it is decided that the compensation package awarded by the redress scheme is not sufficient and the case is taken through normal tort litigation, the refusal of the redress scheme package will effect on the amount of the final award. Under the current civil procedure rules (CPR), part 36 deals with offers to settle. In the case of normal civil litigation, either defendant or claimant can make an offer to settle (known as a part 36 offer) to the other side. If this offer is turned down and the final award is either equal to, or less than, this offer, costs are awarded to the other side. Naturally this will effect on the amount of compensation that is actually collected. APIL is concerned that the redress scheme would adversely influence compensation awards in a similar way.

24. APIL would also like some clarification on whether the awards of compensation as proposed by the redress scheme will be scrutinised by an independent review body. Currently compensation awards are protected via part 21 of the CPR where any award is signed off by an independent court official. APIL feels that there should be a clearly defined mechanism where any award is approved via an independent welfare check.

- Q: Within the eligibility criteria section please define the scope of the phrase 'related to'? Will it be defined in less stringent terms than 'caused by'?

25. APIL feels in such a complex area as severely neurologically damaged babies the right to litigate must be rigorously protected. If parents choose to litigate after accepting a compensation package under the redress scheme the balance of any difference between the resulting awards should be credited back to the court. This will prevent any accusations of double compensation. A similar scheme operates within criminal injuries compensation; there is a right to litigate after an award has been issued, but any monies received through litigation have to be paid back.

26. APIL is also uneasy that the provisions for providing for neurologically impaired babies are extraordinarily vague. We would like clarification on whether the following examples fall within the remit of the scheme :

- Placental abruption (prior to labour), which is not dealt with adequately i.e. caesarean section not performed quickly enough
- Interurine foetal growth reduction – identified but not acted upon.
- Baby is compromised in utero – poor neonatal techniques and care provided.

27. APIL feels additional clarification is needed in respect of the exact definition of NHS Trust care. As such APIL feels that any NHS redress scheme, pilot scheme included, should encompass all areas of healthcare, such as GPs and mid-wives.

28. As previously stated APIL is strongly in favour of independent legal advice being available to all patients who have been affected by an adverse

incident. Naturally this applies to parents of children with birth-related severe neurological impairment. Such is the serious nature of this type of adverse incident that legal advice is particularly important and should be available instantly. The provision of legal advice should, however, not be restricted by the lack of adequate legal funds.

29. APIL believes that any claimant should have the right to be dealt with by the court if there is a belief that negligence can be proved. We also believe that the right to go to court should not be replaced by a tribunal system and any deliberations which are made by an expert panel should be available in any court proceedings.

**Recommendation 3:**

**A national body building on the work of the NHS Litigation Authority (NHSLA) should oversee the NHS Redress Scheme and manage the financial compensation element at national level.**

30. APIL's over-riding concern, regardless of the format, in relation to the redress scheme, is that it should inspire public confidence and be built upon transparency and demonstratable objectivity in its operation and functions. As such we are anxious that a modified NHSLA would, fundamentally, be tied to the same agency that caused the initial harm. Thus APIL proposes that an independent and impartial agency should oversee the redress scheme.

31. In addition to an independent agency overseeing the functioning of the scheme, the most efficient way of ensuring that the patient's rights are being protected is through the continuing use of independent legal representation at all stages within the process. The presence of

independent legal representation, however, must be adequately funded so as to give real access to justice.

- Q: In noting the functions of the body, it is stated that it would levy insurance payments from NHS service providers to fund the new schemes. We would like clarification on this point. It is difficult to see how the schemes can be cost-neutral, and it would helpful to know to what extent the levy will contribute to costs.

**Recommendation 4:**

**Subject to evaluation after a reasonable period consideration should be given to extending the scheme to a higher monetary threshold and to primary care settings.**

32. APIL has grave reservations about any extension of the monetary threshold as we currently consider the monetary threshold too high at £30,000. APIL proposes the threshold should be lowered to £15,000. The lowering of the threshold will ensure that cases are not dealt with in a superficial and unfair manner, and that normal tort proceedings will be applicable.

33. APIL advocates that the scheme should be applicable to all care settings including general practitioners and other primary care professionals. This assertion is subject to APIL's comments on the detailed operation of the scheme.

**Recommendation 5:**

**The right to pursue litigation would not be removed for patients or families who chose not to apply for packages of care and payment under the NHS**

**Redress Scheme. However, patients accepting a package under the Scheme would not subsequently be able to litigate for the same injury through the courts.**

34. APIL welcomes the fact that the injured and bereaved would still be entitled to litigate their claim, if that is what they would prefer to do and indeed we could not support a redress scheme without this. Whilst we accept additional schemes aimed specifically at injured patients may be advantageous, patients must continue to have the same rights as other personal injury victims. The choice to litigate, however, must be a genuine choice not restricted via provisos or cost considerations.

35. APIL is thus wary of removing the right to litigate completely in any circumstance, regardless if a claim has been settled previously through the redress scheme. As discussed in paragraph 25, in relation to parents of brain damaged children, we feel that if a patient chooses to litigate after accepting a compensation package under the redress scheme the balance of any difference between the resulting awards should be credited back to the court. This will prevent any accusations of double compensation.

36. APIL feels that some clarity is needed in the recommendations with regard to the circumstance in which claimants are able to pursue action through NHS Redress Scheme. For example, if a claimant pursued an action through the courts because it was above the threshold for the redress scheme claims, yet failed due to a technicality, APIL feels it would be unjust not to allow the claim to be heard under the NHS Redress Scheme.

37. APIL is concerned that the report implies that there will be a restriction to legal funding and that only '*a small amount of money*' will be available for independent legal advice. Access to appropriate funding for legal



representation is essential in order to allow people to pursue negligent claims and gain access to justice. It should be remembered that a compensation award is a significant amount of money, and may often be more than a year's salary for many patients. While not life changing, this compensatory award will help them hopefully regain and enjoy their previous standard of life prior to the accident; the importance of the effect of any award highlights the need for independent legal advice to say whether such an award is appropriate or not. Indeed research by Hazel Genn has shown, within the context of criminal injuries compensation, the presence of legal representation positively affects that amount of compensation awarded. Sufficient funding must be available to patients to assess whether they should pursue litigation or accept what is being offered through the redress scheme (See also paragraph 17 and 18).

- Q: If a patient does use the redress scheme but subsequently decides to litigate his claim, could that patient experience difficulties in securing public funding from the Legal Services Commission?
- Q: Would the Commission, for example, examine the patients' reasons for rejecting the redress scheme?

**Recommendation 6:**

**A new standard of care should be set for after-event/after-complaint management by local NHS providers.**

38. APIL fully supports after-event/after-complaint management by local NHS providers as long as it effectively addresses the needs of the patients. Whilst we support the principle, however, we are concerned that it may be economically difficult to deliver.

39. We feel that while the use of a local investigation into an adverse incident is appropriate in respect of economical and time considerations, the investigation should be conducted by an objective investigator outside of the medical team being scrutinised and a statement to this effect should be made within the written report.

40. APIL concedes that for practical reasons investigations will be handled proportionally with regard to the 'severity' of adverse incident being investigated. We also believe it would be beneficial to have time limits on the investigations. An adverse incident, however, resulting in the death of the patient naturally should be fully investigated regardless of time and financial constraints.

- Q: If investigations are to be proportionate to the severity of the injury, who would decide this and how?

41. APIL strongly supports the immediate provision of rehabilitation to injured patients (discussed further in paragraphs 46 - 50). Rehabilitation will help to counteract the harm suffered and aid the quick recovery of the patient.

#### **Recommendation 7:**

**Within each NHS Trust, an individual at Board level should be identified to take overall responsibility for the investigation of and learning from adverse events, complaints and claims.**

42. APIL considers that in order for an NHS trust to effectively develop a culture of responsibility, trust and candour (as discussed throughout the recommendations) the issue of risk management needs to be firmly put on the agenda at a senior level. In addition these responsibilities should have appropriate sanctions and punishments attached.

43. APIL has already addressed the issue of senior management responsibility in respect of negligence in the workplace, and feels that this policy is equally applicable here. APIL feels that there should be a clearly identifiable member of the NHS trust board who is entrusted with health and safety issues, as well as issue of clinical negligence. Such a provision should be a pre-requisite for all NHS boards. This will allow a 'top-down' approach to be instigated when there are issue of severe clinical negligence. Thus any investigation will start at the board room and work down through the trust.

**Recommendation 8:**

**The role in the current NHS Complaints Procedures requiring a complaint to be halted pending resolution of a claim should be removed as part of the reform of the complaints procedure.**

44. APIL strongly welcomes the recognition that injured patients and families still require explanations and, where appropriate, apologies, even if they have decided to pursue a legal claim for personal injury compensation. This should certainly help to reduce the dissatisfaction and confusion claimants and complainants often feel.

**Recommendation 9:**

**Training should be provided for NHS staff in communication in the context of complaints, from the initial response to the complaint through to conciliation and providing explanations to patients and families.**

45. APIL fully supports the proposed training of all staff in dealing with complaints and adverse events. This should help to ensure that injured

patients who suspect something has gone wrong with their treatment receive a satisfactory response. This approach enables a more patient focused method of dealing with complaints. Training would also encourage a consistent approach within the NHS.

**Recommendation 10:**

**Effective rehabilitation services for personal injury, including that caused by medical accidents, should be developed.**

46. APIL continues to fully support the provision of timely rehabilitation as it allows victims to achieve a better ultimate recovery, adapt to their family and social environment and achieve employability as far as possible.

47. We are committed to increasing and encouraging the use of rehabilitation within the context of litigation. APIL played an integral part in the development of the Code of Best Practice on Rehabilitation, Early Intervention and Medical treatment which calls for both claimant and defendant representatives to work together in the context of litigation and focus on the early release of adequate funds to enable claimants to access rehabilitation at an early stage when it will be of most benefit.

48. APIL recognises that the number of rehabilitation facilities needs to significantly increase and that such an increase will be expensive. This expense, however, should be viewed as essential in achieving the aims of the redress scheme. This will allow rehabilitation to be available to all who need it. We feel, however, that it would be inappropriate that patients injured whilst in the care of the NHS should be given preference in gaining access to rehabilitation, 'leap-frogging' those who have not been injured in the care of the NHS. As detailed previously with reference to neurologically injured babies, it is not equitable to provide different

standards of treatment for particular sub-sets of individuals who are differentiated by whether they have been injured by the NHS or not.

49. We also feel that it may be inappropriate for a patient who has suffered an injury due to the negligence of their local NHS provider to be treated by them again in respect of rehabilitation. Once a patient has lost the trust of a particular healthcare provider it is unreasonable to expect that person to go back to that provider.

50. As detailed in the CMO report *'dedicated rehabilitation services are not widely available for those injured as a result of treatment or otherwise'*. Thus until the necessary rehabilitation services become available on the NHS they would need to be purchased from private sources.

**Recommendation 11:**

**The Department of Health together with other relevant agencies should consider the scope for providing more accessible high quality but lower cost facilities for severely neurologically impaired and physically disabled children, regardless of cause.**

51. APIL always welcomes more accessible high quality facilities for severely neurologically impaired and physically disabled children 'regardless of cause'.

**Recommendation 12:**

**A duty of candour should be introduced together with exemption from disciplinary action when reporting incidents with a view to improving safety.**

52. APIL agrees that a statutory duty of candour should be introduced to require all healthcare professionals and managers to inform patients when they become aware of a possible negligent act or omission. This duty, however, should be a two-way process for all concerned; senior managers should be candid with doctors, as well as vice versa. It is hoped that a culture of openness will also lead to patients being more candid with their doctors. At the moment NHS staff medical staff operate under a duty of candour as laid down by their respective governing bodies (General Medical Council, Nursing and Mid-Wifery Council, etc.), while NHS managers have a contractual obligation that is analogous with a duty of candour. A statutory duty of candour would simply provide a defined set of standards for the entire NHS, which would in turn promote candour in the wider cultural setting. A statutory duty of candour would compel NHS workers to openly discuss any, and all, acts of negligence with both patients and other professionals. The duty of candour will allow the system to be transparent and allow health professionals to be clear about the action that should be taken when an adverse clinical outcome occurs.

53. In order for the duty of candour to be fully effective there is a need for sanctions to be introduced to enforce it; just as there are criminal sanctions for not reporting accidents at work within health and safety legislation, similar sanctions should be available for failure to respect the duty of candour. The exact sanctions and necessary determining factors needs to be given careful analysis and further thought.

**Recommendation 13:**

**Documents and information collected for identifying adverse events should be protected from disclosure in court.**

54. APIL believes that it would be illogical to promote a duty of candour without a similar duty extending to all pertinent documents involved. In addition the current legal process provides for the court to request the necessary documents at the prerogative of the judge, and APIL sees little reason why this doctrine should not be replicated within the current discussions.

**Recommendation 14:**

**Where a claimant was seeking Legal Aid to pursue a claim of clinical negligence, the Legal Services Commission should take into account whether or not the case had already been pursued through the NHS Redress Scheme.**

55. APIL considers that all legal aid applications should be judged on their own merits, with the fullest of information available, and the fact that the claim has been pursued through the redress scheme should not be solely a determining factor. There should always be redress through the civil litigation system, and funding is vital in maintaining the patient's access to this system. In order for the scheme to be independent there needs to be the proper provision for legal advice and genuine access to the court system. Any restriction in legal funding is fundamentally affecting a patient's access to justice and compensation. APIL is concerned that this may be attempt to remove legal aid from funding clinical negligence cases via the 'backdoor'. Naturally APIL would strongly object to any such possibility.

**Recommendation 15:**

**Mediation should be seriously considered before litigation for the majority of claims which do not fall within the NHS Redress Scheme.**

56. APIL agrees that NHS representatives should be required to consider every case for mediation and to offer mediation where appropriate. As we outlined in our previous response, mediation has many advantages, as it can be constructive and less adversarial than litigation thereby reducing the alienation of the parties and restoring relationships; address the real causes of the dispute; and allow injured patients to feel that they have some control over their claim.

57. Views on the kinds of claim for which mediation is suitable, however, differ considerably. It is clear that mediation can only work if the parties have sufficient information available to them and provided there is no point of legal principle at stake. The extent to which mediation can save costs is unclear.

**Recommendation 16:**

**The expectation in paying damages for future care costs and losses in clinical negligence cases not covered by the new NHS Redress Scheme should be that periodical payments will be used.**

58. APIL supports the use of periodical payments provided the claimants' wishes are taken into account. The appropriate method of compensation should be dictated by the claimant, who is the best 'judge' of their own needs.

**Recommendation 17:**

**The costs of future care included in any award for clinical negligence made by the courts should no longer reflect the cost of private treatment.**



59. APIL does not believe that s.2 (4) Law Reform (Personal Injuries) Act 1948 should be repealed or modified. At the moment a victim can recover damages for the reasonable expense of private health care rather than be required to obtain that future health care on the NHS under s.2 (4). It is suggested within the consultation document that this provision should be removed in clinical negligence cases. This stems from concerns about the cost of private health care and the perception that claimants whose compensation includes the cost of private healthcare receives that healthcare free from the NHS in any event. There is no evidence to support this perception. In fact, it is acknowledged within the consultation document itself that many of the services that would need to be provided by the NHS to meet their care package obligations *'may be similar to providing a sum of money to purchase private care as the NHS would have to fund elements of the care package privately and from a variety of sources'*.

60. We strongly believe that s.2 (4) should remain. There are important reasons why a claimant should be able to recover for private health care. Claimants may not wish to obtain treatment from an NHS Trust which has already let them down – they may have no confidence in the treatment provided, relationships with key NHS staff may have been damaged. The CMO report recognises that *'the effects of a serious adverse and unexpected outcome of care go beyond the impact of the physical injury itself. The psychological and social impact can include anxiety, depression, fear of future treatment, disruption to work and family life'*. In addition claimants may fear or know that the NHS will be unable to meet their needs.

61. Professor Hazel Genn conducted a survey of claimants following the conclusion of their claims on behalf of the Law Commission. She found that a significant proportion opted for some private medical treatment,

often using physiotherapy or osteopathy to assist in the rehabilitative process. The choice of private care was based on perceptions of its speed and quality as well as the fact that the type of service might not have been available on the NHS.<sup>3</sup>

62. When the Law Commission looked at this issue in Damages for Personal Injury: Medical, Nursing and Other Expenses (LC144)(December 1996), it concluded that s.2 (4) should be retained for all claims on the following grounds:

*“As we have indicated, private treatment offers advantages which are more than merely ‘medical’ in nature, and of which claimants ought to be entitled to take advantage...Section 2(4) as it stands, does not entitle a claimant to unlimited private treatment: the costs claimed must still be reasonable. This limitation is in line with the general principles of recovery in claims for expenses (in particular, the duty to mitigate), and we see no reason why medical or nursing expenses should be treated differently in this respect.*

63. If the use of NHS services is to be introduced to replace the cost of private medical care, then APIL proposes that the specified care programme should be guaranteed. In turn this guarantee should be backed by an indemnity for private care should the provisions promised by the NHS not be satisfactory or cannot be delivered. This will mean that claimants will have the peace of mind to accept the NHS Redress Scheme rather than use the traditional tort system.

### **Recommendation 18:**

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<sup>3</sup> Personal Injury Compensation: How Much is Enough? A study of the compensation experiences of victims of personal injury, Law Com No. 225 (1994), paragraph 3.13

**Special training should be provided for Judges hearing clinical negligence cases.**

64. APIL continues to wholeheartedly support the training of judges in specialist areas of personal injury law, including clinical negligence. The complexity of clinical negligence cases is such that specialist lawyers are used to deal with the case. It is logical, therefore, that specialisation should be required of judges.

65. APIL, via the College of Personal Injury Law (CPIL), offers this specialist knowledge to all of its members. It is suggested that this knowledge base could be used to train and enrich judges dealing with personal injury cases.

**Recommendation 19:**

**The Department of Constitutional Affairs (DCA) and the Legal Services Commission should consider further ways to control claimants' costs in clinical negligence cases which are publicly funded and the DCA and the Civil Justice Council should consider what further initiative could be taken to control legal costs generally.**

66. APIL feels that the procedures and reforms introduced by the Law Services Commission (LSC) and the Woolf reforms are still taking effect. It would be inappropriate to introduce a further level of cost cutting measures until the full extent of these reforms have been allowed to take hold. Indeed the recent Lord Chancellors Department (LCD) report 'Further Findings' into the Civil Justice Reforms (August 2002) stated *'[i]t is still too early to provide a definitive view on costs. The picture remains relatively unclear with statistics difficult to obtain and conflicting anecdotal evidence'*.