THE CONSERVATIVE PARTY

CLINICIAL NEGLIGENCE

A RESPONSE BY THE ASSOCIATION OF PERSONAL INJURY LAWYERS

(APIL21/04)

OCTOBER 2004

The Association of Personal Injury Lawyers (APIL) was formed by claimant lawyers with a view to representing the interests of personal injury victims. APIL currently has around 5,000 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.

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

- To promote full and prompt compensation for all types of personal injury;
- To improve access to our legal system by all means including education, the exchange of information and enhancement of law reform;
- To alert the public to dangers in society such as harmful products and dangerous drugs;
- To provide a communication network exchanging views formally and informally;
- To promote health and safety.

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CLINICAL NELGLIGENCE

Introduction

1. APIL is disappointed with the Conservative Party's proposals and believes that they do not represent '*a better approach'* to dealing with clinical negligence litigation. Indeed any introduction of these proposals would ultimately lead to a lack of access to justice for many. In summary, APIL contends that the current system of funding for clinical negligence litigation is working effectively and efficiently. For example, there are an increasing number of legally-aided clinical negligence cases succeeding, with fewer public funds being lost in pursuing these cases. This clearly contradicts the Conservative Party's assertion that *"[t]he present system is associated with problems of expense, delay and modest success rate"*[1].

2. APIL suggests that the Conservatives' presumption that their proposals will reduce the *"rising cash burden being borne by the taxpayer*[2]*"* is ill-conceived, as the use of Conditional Fee Agreements (CFAs) will simply move the cash burden from the Legal Services Commission (LSC) to the National Health Service (NHS). In fact due to the recoverability of success fees and After-the-Event (ATE) insurance premiums, the cost burden to the Government will increase substantially.

3. While the proposals promise to resolve more cases *"informally"*[3] and *"out of court"*[4], APIL members report that this already happens within the current system with only a very small percentage of cases ever being contested at trial. APIL is more concerned, however, with the suggestion that use of the courts will be *"as a last resort"*[5]. We firmly believe that it is essential that an injured claimant's right to seek redress through the civil

[1] Conservative Party Press release – Friday 10th September 2004 – *"Clinical Negligence consultation launched"* (see http://www.conservatives.com/tile.do?def=news.story.page&obj_id=115507&speeches=1 for copy of press release)
[2] Ibid
[3] Clinical Negligence: Conservative Proposals – A Discussion Paper – page 4 (see http://www.conservatives.com/pdf/consultation-medicallitigation.pdf for copy of document)
[4] Ibid
[5] Ibid

justice system is not impeded in any way. APIL considers that any such restriction on a person's right to a fair trial would directly contravene Article 6 of the Human Rights Act 1998.

4. APIL feels that the use of CFAs within clinical negligence litigation would cause numerous difficulties. These difficulties include: an increase in the costs associated with clinical negligence litigation leading to a reluctance by insurers to enter the currently contracting After-the-Event (ATE) insurance market; the reluctance of solicitors to take on high risk cases due to the potential negative economic consequences; only the wealthiest people being able to undertake clinical negligence litigation due to the possible financial consequences of proceeding with a CFA without insurance; and the reduction of positive case outcomes as more non-specialised clinical negligence practitioners enter the market.

5. While APIL is encouraged to note that the Conservative Party recognises the need for an *"independent investigation of events*[6]*"* within any clinical negligence incident, it fails to appreciate that the NHS Redress scheme - as envisaged within the CMO's recommendations - was not intended solely to provide the *"factual basis of any proposed claim"*[7]*.*

6. Finally, APIL questions who will decide when a particular case is an *"appropriate case"*[8] for legal aid - as suggested within Phase 2 of the consultation's proposals. APIL would want any meritorious claim to be judged on the same basis as current legal aid cases.

The Problem?

7. APIL challenges the consultation paper's initial assumption that there is a problem within current clinical negligence practice, and that the present system is *"associated with problems of expense, delay and modest success rate, while there is a perception that access to justice is*

[6] Ibid, page 2
[7] Ibid, page 4

limited.[9]*"* In terms of expense, while the consultation quotes the figure of £446 million being spent on clinical negligence in 2002/03, this represents less than one per cent of the total NHS budget[10]. It should be noted that many businesses have to spend well in excess of one per cent of their budget on insurance alone. In addition, APIL contends that there is actually a need for more people to claim due to the fact that less than one per cent of adverse incidents eventually become actual claims[11].

8. Indeed figures from the Legal Services Commission (LSC) illustrate that there has been a steady decline in the number of legal aid certificates issued for clinical negligence cases, and this coincides with a decrease in the number of cases being closed; 7,337 cases were closed in 2003/04, an 11.6 per cent fall from 2002/03. In addition, the number of cases proceeding beyond initial investigation is falling - from a high of 49 per cent in 1996/97 to only 38 per cent in 2003/04 - while the success rate of cases proceeding beyond investigation has increased from 46 per cent in 1996/97 to 59 per cent in 2003/04.

9. The success of clinical negligence litigation can be seen by the fact that in 63 per cent of concluded cases claimants recovered damages, and in 78 per cent of contested trials claimants were also successful. The LSC states that these decreases are due to *"improved screening"* and *"it is likely that the overall success rate of new legal aid cases being funded will continue to improve steadily"*[12]*.* In fact, the LSC concludes that:

   "The combined effect of these various sources of outcome data suggests that it is no longer accurate to portray the existing clinical negligence litigation system as one which supports hopeless cases or which benefits

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[8] Ibid
[9] Conservative Party Press release – Friday 10th September 2004 – *"Clinical Negligence consultation launched"*
[10] Total NHS budget for 2002/03 - £55.752 billion – HM Treasury: Spending Review Report 2002, Chapter 7 (see http://www.hm-treasury.gov.uk./Spending_Review/spend_sr02/report/spend_sr02_repchap07.cfm for full details). The total amount of NHS funds spent clinical negligence represents 0.8 per cent of the total budget of the NHS in 2002/03.
[11] In NHS hospitals, an adverse event in which harm is caused to patients occurs in around 10 per cent of admissions – about 850,000 patients a year. (Department of Health: *'An organisation with a memory'* 2000). In comparison the Compensation Recovery Unit (CRU) report that in 2003/04 there were 7121 claims for clinical negligence. This represents 0.84 per cent of the supposed number of adverse incidents per year.

lawyers more than clients. Indeed net legal aid payments represent only five per cent of the total cost to public funds of clinical negligence"[13].

Conservative proposal: a better approach

10. In the press release accompanying the Conservative consultation, John Baron MP stated that *"the role of legal aid will be limited in medical negligence case, reducing the rising cash burden being borne by the taxpayer"*[14]. APIL suggests that any money the Government saves via reducing eligibility within legal aid will be offset against the increased cost of CFAs to the NHS – the main defendant in the majority of clinical negligence cases. Currently, under a legal aid certificate, the NHS has to pay the local guideline hourly rates for costs incurred by the claimant solicitor in any case which the NHS loses. With the introduction of CFAs, the NHS will have to pay, in addition to the claimant's base costs, the resultant success fee and ATE insurance premium. Due to the complex, and risky, nature of clinical negligence work it is highly likely that the success fee in such cases will be set at 100 per cent. This will effectively mean that the amount of legal costs which the NHS has to pay will double under Conservative Party proposals.

11. APIL contends that the Conservative Party's suggestion that its proposals will lead to disputes being resolved *"informally"* and "*out of court"*, and that the *"machinery of the court will be available as a last resort"* fails to appreciate the efficiency of the current clinical negligence system. According to the National Health Service Litigation Authority (NHSLA)[15] less than two per cent of cases it deals with (the majority being clinical negligence cases) go before a judge, and in only half of these cases is it in the form a of a contested trial; the majority of cases are otherwise settled outside of court either through round table

[12] Response of the Legal Services Commission (LSC): *Making Amends – Report of the Chief Medical Officer (CMO)* (October 2003), page 6 – paragraph 1.8 (see http://www.legalservices.gov.uk/docs/civil_consultations/cmo_report_lsc_response_oct03.pdf for copy of document)
[13] Ibid – page 7 – paragraph 1.10
[14] Conservative Party Press release – Friday 10th September 2004 – *"Clinical Negligence consultation launched"*
[15] NHSLA Annual Report 2004 – page 8

discussion or other settlement mechanisms. Indeed the NHSLA is now prepared, more than ever, to engage in mediation and actively promote the use of such techniques in settlement meetings and conferences.

12. APIL is also concerned with the suggestion that use of the courts will be *"as a last resort".* We believe that a person's right to be able to gain access to the courts should in noway be denied or restricted. This view has been echoed by the Chief Medical Officer who stated, in reference to his proposed NHS Redress Scheme, that it *"would not take away a person's right to sue through the Courts"*[16]*.* Indeed if the right to a fair trial were in any way impinged, APIL believes that it would be in direct conflict with Article 6 of the Human Rights Act 1998. Article 6 states that *"*[i]*n determination of his civil rights and obligations, … , everyone is entitled to a fair and public hearing within a reasonable time by an independent and impartial tribunal established by law".*

13. It would appear that the Conservative Party's specific proposals – the three phase model – primarily consists of elements suggested by two previous consultations into the clinical negligence system; the Chief Medical Officer's (CMO) report – *'Making Amends'* (June 2003); and the recent LSC consultation – *'A new focus for civil legal aid'* (July 2004). APIL has responded to each of these consultations separately – please see Appendix A and Appendix B, attached[17] – and therefore does not feel the need to reiterate these responses in their entirety. There are, however, several key points from APIL's previous responses which relate to specific elements of the current proposals by the Conservative Party.

14. APIL considers that the current system of clinical negligence funding works effectively and efficiently and the introduction of Conditional Fee Agreements (CFAs) - as an additional funding arrangement used to pursue litigation - will cause considerable difficulties to both claimants and defendants. In the first instance there are considerable practical

[16] Department of Health (DOH): Making Amends – A report by the Chief Medical Officer (CMO) (June 2003) – page 17

problems with using CFAs within the clinical negligence arena. At the moment CFAs are not used in such cases, and this has resulted in there being no active After-the-Event (ATE) insurance market supporting the use of CFAs. Indeed insurance companies are disincentivised from entering the ATE market due to them having no experience in the sector, as well as the high level of risk and cost associated with clinical negligence cases. In the rare instances where ATE cover is offered, the premiums are often prohibitively expensive – for example, it is not unusual for a five figure sum figure to be quoted for £100,000 of indemnity cover. This means that it is practically impossible to get ATE insurance on which to run a CFA-funded clinical negligence case.

15. In particular APIL would challenge the consultation paper's assumption that the proposed introduction of CFAs would mean that "[a]*ccess to justice will be available to anyone with a meritorious case"* and that "[w]*eak cases will be discouraged"* [18]. Due to the lack of insurance available for CFAs within clinical negligence litigation, the only other alternative is to pursue a case without the protection of an ATE policy. Without the protection of insurance, APIL believes that only the wealthiest individuals and/or law firms will be able to continue with a clinical negligence claim on a CFA basis. Due to the 'no-win, no-fee' nature of CFAs, solicitor firms will be more reluctant to consider cases on a CFA basis because of the potentially dire financial impact on the firm if the case is lost. While large solicitor firms are able to bear the burden of such cases – but even then only to certain limits – smaller firms will not have the financial resources to consider more difficult cases which may have a lower chance of success. This will lead to the 'cherry-picking' of clinical negligence cases, with only the most straightforward of claims being pursued. In real terms, this will lead to an erosion of claimants' access to justice.

[17] The documents can also be found at APIL's website at: http://www.apil.com under 'Press and Parliamentary' / 'Consultation responses'.
[18] Clinical Negligence: Conservative Proposals – A Discussion Paper – page 4

16. Furthermore, in the absence of ATE insurance, if a clinical negligence case was run and lost on a CFA then the claimant himself would be liable for the legal costs incurred. While a large insurance company may be able to bear the burden of such an adverse costs order, it is highly unlikely that an injured claimant would be able to bear such a cost. This potential financial burden would be enough to discourage the majority of injured claimants from undertaking litigation.

17. In addition, a CFA case may present a conflict of interests to the supervising lawyer as he would have to balance up the needs of the client with the economic needs of the firm. APIL believes the funding of a case should never result in the interests of the solicitor conflicting with those of the clients. Under a CFA funding regime, we feel that this conflict may well arise.

18. APIL views the introduction of franchising of specialist panels for legal aid work – for example clinical negligence – to have been a success. This success can be seen by the increased number of cases being won by specialist solicitors and, anecdotally, the NHSLA noting the rise in standards of claimant's legal representation. APIL envisages the introduction of CFA funding for clinical negligence potentially leading to decreasing, and poorer, outcomes as less specialised and competent practitioners enter, or re-enter, the field of clinical negligence. In contrast to the consultation document stated view, APIL contends a CFA system, rather than the current legal aid scheme, would produce *"low success rates"*[19] for medical litigation.

19. APIL is encouraged that the Conservative Party recognises the need for an *"independent investigation of events"* within a clinical negligence claims as proposed within the NHS Redress Scheme. We would, however, note that any such proposed scheme would still be part of the NHS system, and be inexplicably linked with the same organisation which would have caused harm to the injured claimant in the first place.

APIL would therefore question the Conservative Party's belief that the NHS Redress Scheme offers an independent investigation of events in the true sense of the word.

20. APIL is also puzzled by the Conservative Party's proposal to restrict the NHS Redress scheme to finding out *"what happened when things went wrong"*[20]. The CMO's recommendation was that the NHS Redress scheme was to act as a 'fast-track' system to deal with lower value clinical negligence claims; it was never intended to act solely as a vehicle to provide the *"factual basis of any proposed claim".* APIL feels that any investigation of the factual basis of a claim should either take place through an enhanced NHS complaints procedure or via a third-party external investigation. If the NHS Redress Scheme is to be retained under the Conservative Party proposals, it should be retained with its original purpose and not be compromised by a re-definition of its function.

21. In relation to Phase 2 of the proposals, APIL questions what is meant by *"legal aid in appropriate cases"*, in particular, who would decide when legal aid is *"appropriate"* for investigating liability? We believe that all meritorious cases should have full funding, if necessary, and this funding should be based on the needs of the claimant to effectively gain access to justice. APIL is concerned that *"appropriate"* funding will result in cases receiving support only where the chances of success are disproportionately high – i.e. 85 to 90 per cent. The current legal aid stipulation – once the applicant has met the stringent criteria for means-based eligibility – is that the case should be meritorious and have above a 50 per cent chance of success. APIL would want such full consideration to continue within the Conservative proposals.

[19] Ibid, page 1
[20] Ibid, page 5

Appendix A

APIL'S RESPONSE TO DEPARTMENT OF HEALTH

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

OCTOBER 2003

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:

David Marshall	President, APIL
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John Pickering	APIL Representative on Chief Medical Officer's Advisory Committee
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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[21], 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 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.

[21] APIL's response to the Department of Health consultation 'Clinical Negligence: What are the issues and options for reform?' (October 2001)

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[22]. 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

[22] Guidelines for the assessment of general damages in personal injuries cases (6th Edition), Judicial Studies Board, Oxford University Press,

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, 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 it 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 affect 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, distribution 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.[23]

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

[23] 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

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:

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'.*

Appendix B

APIL'S RESPONSE TO THE LEGAL SERVICES COMMISSION (LSC)

A NEW FOCUS FOR CIVIL LEGAL AID
(APIL20/04)

OCTOBER 2004

THE LEGAL SERVICES COMMISSION (LSC)

A NEW FOCUS FOR CIVIL LEGAL AID

A RESPONSE BY THE ASSOCIATION OF PERSONAL INJURY LAWYERS
(APIL20/04)

OCTOBER 2004

The Association of Personal Injury Lawyers (APIL) was formed by claimant lawyers with a view to representing the interests of personal injury victims. APIL currently has around 5,000 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.

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

- To promote full and prompt compensation for all types of personal injury;
- To improve access to our legal system by all means including education, the exchange of information and enhancement of law reform;
- To alert the public to dangers in society such as harmful products and dangerous drugs;
- To provide a communication network exchanging views formally and informally;
- To promote health and safety.

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

Colin Ettinger	President, APIL
Mark Harvey	Secretary, APIL
David Marshall	Immediate Past President, APIL
Frances Swaine	Executive committee member, APIL
Jane Williams	Executive committee member, APIL
Muiris Lyons	Executive committee member, APIL
Kevin Grealis	Clinical Negligence Special Interest Group (SIG) Co-ordinator, APIL
Richard Scorer	Child Abuse Special Interest Group (SIG) Co-ordinator, APIL
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A NEW FOCUS FOR CIVIL LEGAL AID

Executive Summary

- APIL believes that the current legal aid system meets the Legal Services Commission's (LSC) aims of *"encouraging early resolution"* and *"discouraging unnecessary litigation"*, and that the suggested reforms will simply restrict claimants' access to justice further.

- APIL considers that the LSC's proposal that a Conditional Fee Agreement (CFA) should be used instead of legal aid – *"whether or not insurance is in practice available"* - is in breach of the 'equality of arms' doctrine enshrined within Article 6 of the Human Rights Act.

- APIL proposes that the upper limits for eligibility for legal help and legal representation should be aligned to the higher of the two figures – that of legal representation – rather than downwards to the lower figure of legal help.

- The abolishment of the current £100,000 equity disregard, APIL contends, would effectively exclude the majority of home owners from legal aid eligibility. As such we feel this is a direct shackle on injured claimants' access to justice, and therefore the equity disregard should be retained and even increased.

- APIL considers that it is premature and unrealistic for the LSC to presume that all cases should initially go through a complaints system prior to public funding being considered and granted. For example, the NHS complaints system has recently been revamped, yet there has been no indication that this has made the system more effective or efficient. Until the complaints system can be seen to work well APIL believes it is too early for the LSC to base funding decisions on progress through it.

- APIL is encouraged by the LSC's acceptance of the formation of the NHS Redress scheme, but feel that it is still too early for there to be a presumption that all cases should initially progress through it. APIL feels that until we have seen the full details of the proposed NHS Redress Scheme it would be inappropriate to comment further at this time.

- APIL contends that the use of Conditional Fee Agreements (CFAs) within personal injury related actions - such as clinical negligence, group actions and child abuse litigation - will cause considerable difficulties for both claimants and defendants.

- These difficulties will include: whether or not the courts will accept the use of a CFA instead of legal aid; the lack of a properly functioning After-the-Event (ATE) insurance market, with the ATE policies that are available being prohibitively expensive; the increased level of success needed to qualify for CFA funding; the reluctance of solicitors to take on high risk cases due to the potential negative economic consequences; and the reduction of positive case outcomes as more non-specialised clinical negligence practitioners enter the market.

- While APIL is interested by the suggestion concerning the combination of public and private funding – typically a CFA – for the litigation of a case, we reiterate our opposition to the use of CFAs for currently legally-aided PI-related cases due to the difficulties detailed above.

- These above mentioned difficulties should therefore be explored in a provisional pilot scheme prior to the replacement of any legal aid funding with CFA funding.

- APIL considers that the use of Before-the-Event (BTE) insurance is unlikely to greatly affect any of the PI-related areas of litigation funded via legal aid due to the low-level of indemnity on such policies and the numerous case-type exemptions included within them.

- We are, however, opposed to the restriction of claimant choice in relation to legal representation that many BTE policies insist upon. APIL believes that the claimant should have freedom of choice to choose their own solicitor.

- APIL disagrees with the LSC's proposal for unsuccessful funded clients to pay the first £200 of any costs order. Legal aided clients represent the most vulnerable members of society, and it is doubtful whether they would be able to afford any part of a costs order.

- APIL considers that the LSC's proposal to raise the cost benefit ratios for clinical negligence – in line with other types of litigation – fails to fully appreciate the hugely complex nature of this type of work and would inevitably lead to further restrictions on eligibility. We feel that any such restriction would not be in the best interests of claimants' access to justice.

- APIL believes that the lack of take up of support funding is due to the difficulties involved with qualifying for eligibility. For example, the scheme is overly bureaucratic and uneconomic and few firms are willing to put their legal aid franchise at risk in attempting to use it.

- APIL is of the opinion that within clinical negligence litigation the further promotion of mediation is unnecessary as the majority of cases do not go before a judge and settle outside of court, either through roundtable discussion or another settlement mechanism.

- APIL considers that CFAs are not an appropriate funding mechanism for group actions. The potential consequence of running a group action on a CFA, without insurance, is that well-financed defendants may attempt to drive up the costs of a case, making it uneconomical for a firm to continue with the litigation; a war of attrition.

- Funding is already highly restrictive in granting legal aid to group actions, and any further tightening of the eligibility criteria will leave many injured claimants without the means to pursue meritorious litigation against well-financed defendants. APIL feels that this is in direct conflict with the 'equality of arms' doctrine within Article 6 of the Human Rights act.

- APIL suggests that cost savings could be achieved by allowing the court to decide, and rule, on generic issues. In addition, the current administrative framework surrounding group actions is highly inefficient. If this administration was made more efficient, there would be considerable cost savings.

- APIL feels that the recently introduced system of extending cost protection to generic work has not yet had the time and opportunity to develop to its fullest potential. We are therefore concerned that it is being abandoned prior to a full and proper evaluation

- APIL believes that the use of CFAs within child abuse litigation is simply not viable due to the complete lack of ATE insurance within this area of litigation. In addition, possible funding via BTE policies for these cases is unlikely as they will often include exemptions for child abuse litigation.

- Child abuse litigation is a continually developing area of law, and APIL considers that its further development will be severally hindered by further restrictions on accessing funding for such cases.

- APIL members report that informal mediation and Alternative Dispute Resolution (ADR) is already used within child abuse cases, and often leads to successful settlements.

Introduction

1. While APIL is sympathetic to the aims of the Legal Services Commission (LSC) consultation in *"encouraging early resolution"* and *"discouraging unnecessary litigation"*, we believe that these aims are already being met within the present legal aid system, in relation to clinical negligence work at least, and that the suggested reforms will simply restrict claimants' access to justice further.

2. APIL feels that access to justice is a basic human right. Yet in 2003-04 the civil legal aid system helped approximately 12 per cent fewer people then in the preceding year. It is clear that there is a *"significant unmet demand for legal aid … in certain … specific fields of law. The consequence is that, increasingly, the legal system is being restricted to those with very substantial wealth or no means at all. There is a substantial risk that many people of modest means but who are homeowners, for example, will fall out of the ambit of legal aid. This may amount to a serious denial of justice.*[24]*"*

3. APIL considers that the *"civil legal aid system was originally designed to support the most vulnerable in society"*[25]*.* Yet the current system *"falls far short"*[26] of that envisaged by the post-war Attlee Government where financial eligibility stood at 80 per cent of households being able to get legal aid, either free or on payment of a contribution. In 2001 that figure had decreased by almost half with only 47 per cent of households now being eligible. APIL contends that the real outcome of the current proposed reforms by the LSC is to place a further unnecessary restriction on the ability of injured claimants to gain access to legal aid.

[24] House of Commons: Constitutional Affairs Committee – Civil legal aid: adequacy of provision – Fourth Report of Session 2003-04 Volume 1 – paragraph 105, page 30
[25] *"Civil legal aid – in crisis"* Rt Hon Alan Beith MP, chair of the Constitutional Affairs Select Committee in the House of Commons - New Law Journal (NLJ) Volume 154 Number 7142 (3rd September 2004) page 1273
[26] House of Commons: Constitutional Affairs Committee – Civil legal aid: adequacy of provision – Fourth Report of Session 2003-04 Volume 1 – paragraph 102, page 30

4. Furthermore, APIL believes that the continuing constriction of the legal aid budget, in particular with reference to the current suggestion that Conditional Fee Agreements (CFAs) should be used without insurance, brings it into direct conflict with Article 6 of the Human Rights act[27]. Article 6 states that *"In determination of his civil rights and obligations, … , everyone is entitled to a fair and public hearing within a reasonable time by an independent and impartial tribunal established by law".* From various cases decided by the European Court, the right to a fair trial includes the necessity to comply with the principle of "equality of arms". The European Court of Human Rights has held that for there to be a fair trial an individual must have *"a reasonable opportunity of presenting his case to the Court under conditions which do not place him at a substantial disadvantage"*[28].

5. APIL considers that running a case on a CFA without the necessary After-the-Event (ATE) insurance places a claimant at a significant *"disadvantage"* due to the possible adverse costs order that may be levied against him. This possible threat is even more significant if, as APIL has recently learned, defendants intend to start using CFAs to defend claims. This will inevitably lead to defendants claiming a success fee, often in the region of 100 per cent if the case goes to trial. Such an uplift will ultimately result in the doubling of defendants' legal costs. As the losing party, the injured claimant will ultimately be liable for these costs. APIL believes that it is completely iniquitous that claimants should be in a position where they have no cost protection against large well financed defendants; APIL feels this represents inequality of arms and is therefore contrary to Article 6 of the Human Rights Act[29].

[27] Human Rights Act 1998 (Chapter 42)
[28] *Kaufman –v- Belgium 50DR98*
[29] APIL accepts that the LSC provides for legal aid to be granted by the Lord Chancellor in exceptional cases where *"without public funding for representation it would be practically impossible for the client to bring or defend the proceedings, or the lack of public funding would lead to obvious unfairness in the proceedings".* Yet by its very nature this funding in only available in exceptional circumstances, and even though APIL considers that the current funding arrangement mean that it is *"practically impossible"* to proceed with a meritorious case, such funding is unlikely to be granted in the majority of cases falling outside of the eligibility criteria.

6. APIL would contend that the real reasons for the LSC's proposed reforms are budgetary in nature. Admittedly APIL concedes that the legal aid budget is under considerable pressure, but we believe that the proposed reforms will not save the Government a considerable amount of money. Rather the costs burden will be relocated to the National Health Service Litigation Authority (NHSLA) – the defendant in the majority of clinical negligence actions – and subsequently the National Health Service (NHS) itself.

7. In addition, APIL firmly supports the belief that the use of legal aid in clinical negligence litigation – upon which APIL's response is predominantly centred – works efficiently and effectively. We would actually note that there is case for suggesting that more cases of clinical negligence should be encouraged due to the fact that less than one per cent of adverse incidents eventually become actual claims[30]. Regardless, the success of clinical negligence litigation can be seen to be illustrated by the fact that there has been no increase in the number of certificates issued in recent years. Indeed there has been a steady decrease in the volumes of certificates, with 6,064 certificates issued in 2003/04 down 3.9 per cent from 2002/03. In total there has been a 50 per cent decrease in the number of certificates from 1995/96. The long duration of many clinical negligence cases has meant it takes years for decreasing volumes of new cases to be reflected in the cost burden of closed cases both to the LSC and the NHS. Last year, however, even the number of cases closed showed a downturn of 11.6 per cent. In terms of case outcomes, the figures have steadily improved over the last few years. In cases where proceedings were issued only 16 per cent proceeded to a final hearing with the remaining 84 per cent being settled prior to issue. This indicates the level of "*early resolution"* that occurs within the current legal aid system. Furthermore, of these cases that proceeded to a final hearing, there was a 74 per cent success rate. Finally, in specific

[30] In NHS hospitals, an adverse event in which harm is caused to patients occurs in around 10 per cent of admissions – about 850,000 patients a year. (Department of Health: *'An organisation with a memory'* 2000). In comparison the Compensation Recovery Unit (CRU) report that in 2003/04 there were 7121 claims for clinical negligence. This represents 0.84 per cent of the supposed number of adverse incidents per year.

reference to high-cost clinical negligence litigation, in 84 per cent of cases the full amounts of claimants' costs are recovered. APIL feels this indicates the success with which clinical negligence is run using legal aid.

Financial Eligibility[31]

Income Limits

8. While APIL concedes that there is logic to aligning the upper limits of eligibility for legal help and legal representation, we are disappointed to note that the consultation has proposed that the lowest limit – that of legal help – be adopted. We believe that the criteria necessary for qualifying for legal aid is already significantly strict and only a small minority of the population is currently able to gain access to legal aid. Reducing the eligibility limit further would simply exclude a larger group of people from the scope of legal aid. APIL suggests that if there is to be an alignment between legal help and legal representation it should be upwards, towards the legal representation level.

Assessment of Capital – The £100,000 Equity Disregard

9. APIL disagrees with the LSC proposal to remove the £100,000 home equity disregard as this will virtually exclude all home-owners from being eligible for legal aid, and therefore deny some of the most vulnerable members of society access to justice. In addition, we feel that it patently unfair for injured claimants to have to rely on the vagaries of the housing market in order to fund their claims. APIL considers that the number of people who can effectively gain access to legal aid is already restricted – as evidenced by the above quote from the recent select committee report – and the removal of the equity disregard would simply narrow people's ability to gain access to appropriate legal advice further. With the current

[31] See Section 2 (page 13) of the consultation document

average house price being above £160,000[32], APIL envisages that the majority of homeowners will exceed the capital threshold for legal aid assistance making it extremely difficult to pursue a meritorious case without significant financial risk to themselves. Indeed APIL believes there is an argument for not only retaining the current equity disregard, but extending it to adequately reflect the current rise in house prices.

10. APIL feels that simply because someone is a homeowner it does not mean that they should put his home at risk in order to fund justified litigation against the person who injured him. Indeed APIL considers that there are considerable practical problems with such an assumption, with many people not having the ability to easily gain access to the capital within their homes. For example, people may have existing mortgage commitments which will not allow them to borrow further against the property. Also, particularly if there is a lack of income, lenders may be wary about lending money against a property.

11. Furthermore, APIL notes that there is a distinct lack of products available in relation to equity release; and the products that are available usually include prohibitive interest rates. There is also little sign that the market for this type of product is set to expand, with the Council of Mortgage Lenders (CML) stating that "[a]*ll indications are that lenders and intermediaries are taking a cautious … approach to opening up the equity release market"*[33].

Discouraging Unnecessary Publicly Funded Litigation[34]

Clinical Negligence Complaints

12. APIL feels that the LSC's suggestion that there should be a presumption in the funding code that *"all cases should pursue a complaint before*

[32] Halifax figures – 3 September 2004
[33] The Scotsman – *"Slowdown in equity release loans"* – 12 August 2004
[34] See Section 4 (page 31) of the consultation document

funding for litigation is considered"[35] is premature and unrealistic. While APIL accepts that a new, and supposedly improved, NHS complaints system is currently being introduced, the effectiveness of this system has yet been tested sufficiently to determine if it satisfies the needs of injured claimants. The Chief Medical Officer's (CMO) report – "Making Amends"[36] – readily identified that the NHS complaint process was viewed by patients and their representatives as lacking *"transparency, is insufficiently independent and too frequently fails to yield an apology or explanation for what went wrong"*[37]. APIL considers that any new complaints system needs to fulfil these patient needs fully before it is appropriate to consider whether all cases should progress through it.

13. While APIL disagrees with the LSC's proposal that there should be a *presumption* to proceed through the complaints procedure prior to litigation, we do recognise that there will be instances where, in the best interest of the injured claimant, it may be appropriate to proceed through the complaint system. This decision, however, should be left to experienced legal clinical negligence practitioners[38]. A possible advantage of using the complaints system is that evidence uncovered during the investigation may be of use in any ongoing litigation. APIL agrees that any findings, or evidence, produced via a complaint being pursued should be made available to the LSC for consideration.

14. APIL believes that the complaints process should work concurrently with the litigation process and that one should not be dependent on the other. This view is shared by the CMO who recognised that the NHS system should in no-way take precedence over the litigation process *"even in the larger value cases, if patients subsequently decide to pursue the litigation route, the complaints process should continue to provide the explanation*

[35] Consultation document – point 16, page 4
[36] Department of Health: Making Amends – A consultation paper setting out proposal for reforming the approach to clinical negligence in the NHS: A report by the Chief Medical Officer (June 2003) (can be found at: http://www.dh.gov.uk/assetRoot/04/06/09/45/04060945.pdf)
See http://www.apil.com/pdf/ConsultationDocuments/107.pdf for APIL's response to consultation.
[37] Ibid – paragraph 12, page 78
[38] For example, College of Personal Injury Law (CPIL) members - of 'litigator' level and above - will have over 5 years worth of specialist legal experience in personal injury cases and have completed over 30 hours of CPIL training over a 3 year period. (See http://www.cpil.ac/ for further information on the College of Personal Injury Law).

which patients and families seek"[39]*.* A significant criticism of the NHS complaints procedure has been the fact that there is a necessity for a complaint to cease once an injured person has indicated that he is going to litigate. Often this choice to litigate is as a result of injured claimants' *"frustration with the complaints system"*[40]*.* APIL is, therefore, disappointed to note that the newly proposed complaints procedure still retains this necessity. Difficulties arise – both for claimant solicitors and defendants' solicitors – when the patient consults a lawyer after his complaint has been dealt with unsatisfactorily. By this time any evidential trail has grown cold, and there may be issues of limitation concerning the case.

The NHS Redress Scheme

15. APIL is encouraged by the LSC's recognition that the creation of an NHS Redress scheme – as recommended in the CMO's Making Amends report – would significantly affect the provision of legal advice to clinical negligence claimants. At present there has been no official announcement about whether such a scheme will be introduced at all and, if it is to be introduced, when. Indeed there is still no indication of exactly which of the CMO recommendations will be implemented. It has been indicated to APIL, however, that various aspects of the CMO's recommendations are being considered and actively researched, with any eventual scheme being targeted for a 2007/08 start date.

16. APIL considers that the most important factor of any eventual scheme must be that the patient, or client, should continue to have the ability to gain full access to the litigation process. While the LSC implies that claims should in the first instance pass through the NHS Redress scheme, it does not detail the specific ramifications of doing so. For example, if your case progresses through the Redress scheme, but the eventual award is considered too low, will this adversely affect the

[39] Ibid – Recommendation 8 – page 124
[40] Ibid

claimant's ability to gain legal aid in order to proceed with litigation? APIL feels that, as with the complaints procedure, the information gained via the Redress investigation may be useful and any evidence found should be considered by the LSC if the claimant decides to proceed with litigation after unsuccessfully progressing through the scheme. APIL feels that it would be inappropriate and premature at this time to comment further on the Redress scheme until the exact details of it are known.

Conditional Fee Agreements

17. APIL believes there are considerable difficulties in attempting to use CFAs within previously legally aided areas such as clinical negligence. APIL considers that one of the primary problems within such a proposal is whether the courts are likely to accept the use of a CFA instead of legal aid. For example in a recent housing case[41] it was suggested that a claimant should have applied for legal aid instead of using a CFA to run the case; "[the claimant] *should have been told to seek legal aid, but there was no evidence that* [the claimant's solicitors] *had done so, and this had a materially adverse effect"*. This decision seems to suggest that legal aid should be used instead of CFAs due to the higher case costs incurred under the CFA agreement. As discussed elsewhere, CFA case costs will almost always exceed legal aid case costs due to recoupment of success fees and insurance premiums. APIL feels that it would be unjust if claimant solicitors were penalised for using a CFA when there was little chance of being granting legal aid due to the further eligibility restrictions.

18. APIL is more deeply concerned, however, with the LSC suggestion that legal aid could be refused for cases where there might be suitability for a Conditional Fee Agreement (CFA) *"whether or not insurance is in practice available".* We believe if CFAs are to be used in clinical negligence, either as a replacement for legal aid – which we would

strongly resist and which the LSC has reassured us is not the case – or as an additional funding mechanism, there needs to be a fully operating and buoyant after-the-event (ATE) insurance market to support it. It should be noted that the majority – approximately 90 per cent according to anecdotal evidence from APIL members – of clinical negligence work is conducted using legal aid funds. This leaves only ten per cent of clinical negligence work which is funded via CFAs and other means. The lack of clinical negligence actions involving CFAs means that the ATE market will have little, if no, experience within this area. This has led to a relative deficiency of supporting ATE products for clinical negligence. This lack of experience will also inevitably lead to reluctance by insurers to finance clinical negligence actions; and those actions which are financed will have to pay inflated premiums to compensate for the absence of reliable risk data available to the insurers.

19. A further disincentive for insurers to provide ATE products for clinical negligence actions is the high cost of such cases. In the event that a case was lost, the ATE insurer would have to pay the legal costs of both the claimants and defendants. While this is currently a considerable amount, it has been suggested to APIL that if the system were to change so that claimants use CFAs to run cases, defendants would follow suit. Therefore if a case was lost it is foreseeable that defendants would request a CFA success fee of 100 per cent, essentially doubling the amount that the insurer is liable for. This increased financial burden on the insurer would have a hugely detrimental effect, with either the amount of ATE premiums being driven up or the market further contracting. Furthermore, in absence of ATE insurance, if a clinical negligence case was run and lost on a CFA then the claimant themselves would be liable for the legal costs incurred. While a large insurance company may be able to bear the burden of such an adverse costs order, it is highly unlikely that an injured claimant would be able to bear such a cost. This potential financial burden would be enough to

[41] *Nicola Bowen & 10ORS v Bridgend County Borough Council* (SCCO – Master O'Hare – 25/03/2004)

discourage the majority of injured claimants from undertaking litigation and gaining their appropriate access to justice.

20. APIL contends that any money the Government saves via reducing eligibility within legal aid will be offset against the increased cost of CFAs to the NHS – the main defendant in the majority of clinical negligence cases. Currently, under a legal aid certificate, the NHS has to pay the local guideline hourly rates for costs incurred by the claimant solicitor in any case which the NHS loses. With the introduction of CFAs, the NHS will have to pay, in addition to the claimant's base costs, the resultant success fee and ATE insurance premium. Due to the complex, and risky, nature of clinical negligence work it is highly likely that the success fee in such cases will be set at 100 per cent. This will effectively mean that the amount of legal costs which the NHS has to pay will double from those under the current scheme. In respect of the amount of the ATE insurance, as mentioned earlier, clinical negligence cases usually attract extremely high premiums – it is not unusual for a five figure sum to be quoted for £100,000 of indemnity cover – due to the lack of products available, the complexity of clinical negligence and the uncertainty of success. Added to the high cost of recovering the ATE insurance premium would be a success fee which reflected the high rate of attrition and the high risk involved in clinical negligence litigation. It is frequently the case that for clinical negligence cases the success fee is stated as 100 per cent. Certainly if a clinical negligence case proceeded to trial a 100 per cent uplift would need to be recovered.

21. APIL believes that the use of CFAs would further restrict an injured claimant's access to justice as it would be more difficult to satisfy the requirements needed to justify funding a CFA – most insurers quoting a threshold of success at 60 per cent and often significantly more – than the current eligibility criteria required by the LSC – usually seen as a 'reasonable chance of success' or over the 50 per cent threshold. This difficulty will inevitably lead to fewer injured people being able to gain access to funding for meritorious claims.

22. In addition, due to the 'no-win, no-fee' nature of CFAs, solicitor firms will be more reluctant to consider cases on a CFA basis because of the potentially dire financial impact on the firm if the case is lost. While large solicitor firms are able to bear the burden of such cases – but even then only to certain limits – smaller firms will not have the financial resources to consider more difficult cases which may have a lower chance of success. This will lead to the 'cherry-picking' of clinical negligence cases, with only the most straightforward of claims being pursued. In real terms, this will lead to a further erosion of claimants' access to justice.

23. APIL views the introduction of franchising of specialist panels for legal aid work – for example clinical negligence – to have been a success for the LSC. This success can be seen by the increased number of cases being won by specialist solicitors and, anecdotally, the NHSLA noting the rise in standards of claimant's legal representation. APIL envisages the introduction of CFA funding for clinical negligence potentially leading to decreasing, and poorer, outcomes as less specialised and competent practitioners enter, or re-enter, the field of clinical negligence. This will ultimately lead to strong and meritorious cases being poorly run by practitioners within little, or no, experience in this highly specialised area.

CFAs in Clinical Negligence Cases

24. While APIL is interested by the suggestion concerning the use of public funding for the investigative stage of a case and then moving onto alternative funding – typically a CFA – for the litigation of a case, we feel that our above comments regarding CFAs are equally pertinent. APIL is also concerned that the introduction of CFA may introduce elements of conflict between a client and adviser. As already detailed, the use of a CFA places a significant financial burden on a legal practice. This pressure takes the form of balancing the best interests of the client with the best interests of the firm. This conflict could be seen to emerge where, for example, a legal adviser is in the position of considering an

offer from a defendant. If the offer, which is below what the adviser thinks is appropriate, is accepted then the firm recoups its expenses and does not incur further cost. If the offer is rejected in the best interests of the client, then there is the possibility that further expense will be incurred prior to potentially losing the case and being unable to retrieve any costs.

25. APIL suggests that the LSC should pilot a provisional scheme in which CFAs are included in the funding process for clinical negligence prior to any changes being made to the current legal aid scheme. Such a pilot scheme would help to determine exactly what the current state of the ATE market is, and whether it would be able to sustain the inclusion of clinical negligence litigation. APIL firmly believes that there needs to be sufficient support and capacity within the ATE market prior to any alteration to the current legal aid funding scheme.

Group Actions – Conditional Fee Agreements

26. APIL considers the implications of the LSC proposals and the use of CFAs in relation to group actions later in this response – please see paragraphs 37 - 47.

Before-the-Event Insurance (BTE)

27. APIL considers that the use of Before-the-Event (BTE) insurance is unlikely to greatly affect clinical negligence litigation as most policies include exclusions for both clinical negligence and group actions. In addition, the indemnity levels set within the policies are often too low to fully finance a case until court. For example, the limits of indemnity for many BTE policies are £15,000 - £50,000. APIL is more concerned that BTE insurers often do not have, or use, recognised clinical negligence panel members to conduct litigation. As already described, the use of specialist clinical negligence panels has ensured that waste and unmeritorious claims within the system have been significantly reduced. By allowing non-clinical negligence specialist solicitors to handle complex

and difficult litigation, APIL envisages incompetent advice being given and success rates dropping.

28. APIL also reiterates its opposition to the restriction of a claimant's ability to freely choose any solicitor which many BTE policies impose. We believe that freedom of choice to choose a solicitor is a vital component to achieving effective access to justice. For example, there have been occasions where BTE insurance panel solicitors have been appointed but their office is located no-where near the injured claimant. Naturally this makes it difficult for the injured claimant, who may have mobility problems to contend with, to see and communicate with his legal representative. It is therefore vital, in the best interests of the claimant, to ensure that freedom of choice is maintained in relation to receiving impartial legal advice.

Cost Protection

29. APIL disagrees with the LSC's proposal that there may be "*a case for reducing the full extent of cost protection by providing that unsuccessful funded clients should be liable for a certain part of any costs, say the first £200".* By the LSC's own admission there is not a 'compensation culture' prevalent within clinical negligence cases, or indeed elsewhere in personal injury litigation, therefore APIL does not understand the need to introduce such a measure in order to disincentive weaker claims. Within the current system of specialised clinical negligence practitioners, weaker or vexatious claims are removed from the litigation process early on. Any introduction of a cost penalty would simply penalise meritorious claims, many of whom come from the most vulnerable parts of society; £200 is a lot of money for someone who has qualified for legal aid.

30. APIL considers that by setting a precedent with the introduction of a £200 fee, it is unlikely that this figure will drop. In APIL's experience such figures inevitably rise as funding considerations become more stringent.

The General Cost Benefit Test

31. APIL considers that the LSC's proposal to raise the cost benefit ratios for clinical negligence – in line with other types of litigation – fails to fully appreciate the hugely complex nature of this type of work. In general terms, more work is required in order to pursue clinical negligence litigation than in other areas. Consequently the high level of costs required in clinical negligence cases will always mean that there will be a lower level of ratio in terms of the proportion of costs to damages. APIL contends that the current levels are already stringent. Further tightening of the cost benefit ratio would lead to more injured claimants falling outside the eligibility criteria. In order to illustrate the current difficulties, if it is assumed that pursuing a clinical negligence case to trial costs approximately £30,000 - £40,000, using the cost benefit ratio on a case which has a 79 per cent chance of success, the amount of damages which would be needed to justify initial and continued legal aid funding would £80,000. This is a considerable amount of money. Furthermore, if the chance of success on a case was 59 per cent – still considered a reasonable chance of success – the amount of damages which would need to be won is £180,000. It should be noted that APIL members report that, in general, the chance of success on a clinical negligence case is between 55–70 per cent, at best.

Other Changes[42]

Support Funding

32. APIL believes that the lack of take up of support funding – only 28 certificates in 2002/03 - is due to the difficulties involved with qualifying for eligibility. We feel that the necessary requirements to gain access to support funding are hugely restrictive, with a considerable amount of money needing to be spent on a case before it comes into the scope of

[42] See Section 5 (page 48) of the consultation document

support funding. By the stage this monetary requirement is met, application is considered redundant. The scheme is also overly bureaucratic and uneconomic, and due to the high number of compliance issues involved, most firms are reluctant to put their legal aid franchise at risk by using it.

Specific Issues

Non-family Mediation and other forms of ADR

33. APIL is supportive of any attempts to introduce meditation into the otherwise adversarial area of litigation, but feels that within clinical negligence such moves are unnecessary. According to the NHSLA less than two per cent of cases which they deal with – i.e. the majority of clinical negligence cases – go before a judge, and in only half of these cases is it in a contested trial; the majority of cases are otherwise settled outside of court either through round table discussion or other settlement mechanisms. Indeed the NHSLA is now prepared, more than ever, to engage in mediation and actively promote the use of such techniques in settlement meetings and conferences.

34. APIL questions whether the LSC is promoting mediation for budgetary interests, as the costs associated with mediation are not considerably less than that of litigation. Indeed APIL feels that within small low value clinical negligence cases, the use of meditation may well increase costs.

35. APIL's concern is that mediation is a consensual process where both parties need to agree. While the LSC currently requires claimants' solicitors to report offers of mediation to them, this information is not explored further. APIL proposes that the LSC should seek to find explanations from defendants about why offers of mediation have been declined.

36. APIL is also of the opinion that granting a legal aid certificate should not in any way be dependent on, or compel one to, engage in mediation. APIL believes that any restriction of a legal aid certificate to meditation would be an infringement of a person's access to justice.

Group Actions

37. In considering the effects of the LSC's proposals on personal injury group actions, APIL re-iterates its concern over the proposal that CFAs should be used instead of legal aid, *"whether or not insurance is in practice available".* APIL believes that such a presumption will severely restrict people's access to justice as, in common with clinical negligence cases, there is no active After-the-Event (ATE) insurance market and/or insurance products to support multi-party litigation. Furthermore, where insurance is available it tends to be hugely and prohibitively expensive. The lack of effective ATE insurance products for group actions therefore necessitates solicitor firms, and to lesser extent individual claimants, becoming liable for the costs incurred in the litigation process. APIL feels that this financial burden will result in fewer cases being accepted by solicitors and fewer claimants undertaking litigation.

38. APIL also believes that the huge costs risks involved in taking on a group action case on a non-insured CFA basis will place the solicitor under an inordinate amount of pressure – i.e. loss of all potential income, and the possible need to pay for the defendant's costs. In particular, we are concerned that there will be a conflict of interest between ensuring that the claimant receives a fair and just settlement, and the financial pressure of sustaining a business. Using a previous example, what happens when an offer is received from the defendant – does the solicitor accept the offer for the best interests of the client or the best interests of the business? APIL contends that within group actions this pressure is further exacerbated due to the high costs that such cases accrue.

39. APIL feels that this financial conflict may be further used by defendants to have litigation withdrawn via a 'war of attrition'. Indeed, a well-financed defendant could drive up the cost of the case in order to make it less and less viable for the opposing claimant solicitors to continue. In the case of group actions, which are ready one of the more expensive types of litigation, this may lead to claimants solicitors withdrawing from the litigation or more susceptible to accept a low settlement offer in order to restrict any further costs. For example, the recent tobacco litigation within the United States resulted in the cigarette companies engaging in such a tactic. This involved the claimant solicitor's costs being driven up to such a level that it was not financially viable for many of them to continue with the litigation. APIL is concerned that a similar tactic could be employed by large multi-national conglomerates within English group litigation. In particular, in relation to product liability, the defendant will often be a large pharmaceutical company.

40. APIL believes that there are already considerable difficulties in gaining access to legal advice within group actions, and that the new LSC proposals will cause further difficulties. For example, in the recent MMR/MR vaccine litigation, the Honourable Mr Justice Keith stated that he thought *"it would have made everyone's task easier if funding had been available to enable advice to be given to ensure that the litigation was brought to an orderly conclusion for many of the claimants who have decided that enough is enough.*[43]*"* He concludes that it is *"hardly an advertisement for access to justice that such advice as the claimants' parents have received has had to be given on a piecemeal and wholly unremunerated basis*[44]*".* These comments seem to indicate that problems already exist within the group action legal aid scheme and further restriction would simply aggravate them further.

41. APIL believes that by restricting people's access to litigation via essentially removing all viable means of funding, the basic tenet of

[43] *Sayers v Smithkline Beecham plc* ('MMR/MR vaccine litigation') [2004] EWHC 1899 (QB), paragraph 43
[44] Ibid

'equality of arms' as enshrined in Article 6 of the Human Rights act is undermined. Article 6 allows for a person to present their case to the court *"under conditions which do not place him at a substantial disadvantage"*[45]. APIL contends that most claimants would be unwilling, and many unable, to incur an adverse cost order if their litigation failed. This fact places them at a distinct disadvantage compared to well financed defendants. It should be noted that group actions, more so than other personal injury litigation, are conducted against large multi-national conglomerates where there is a huge disparity in the 'equality of arms' at each party's disposal. By allowing 'Goliaths' to undermine the ability of 'Davids' to pursue meritorious litigation, APIL considers that the LSC proposals to be in direct conflict with Article 6.

42. Within the consultation document the LSC state that for "[t]*he most expensive cases of all, typically major group litigation, funding should only be available in cases with exceptional public interest where clients stand to receive life changing levels of damages."* APIL believes these requirements place an overly restrictive burden on claimants applying for legal aid within group actions. The use of such exemptions – i.e. funding only provided for *"exceptional public interest"* cases and where there is *"life changing levels of damages"* - will result in the exclusion of hundreds, if not thousands, of people from being able to gain access to justice. APIL believes that such a situation is in direct opposition to the intention of numerous laws, such as the Consumer Protection act, intended to provide the public with protection against faulty products and goods.

43. APIL questions what is exactly meant by the *"most expensive cases"* within the above LSC quote. The LSC consultation details case cost figures of £100,000 to disposal or over £250,000 if they proceed to trial as being indicative of the *"most expensive litigation"*. Yet in APIL's members experience the majority of group actions will significantly exceed these cost levels. So by the LSC's definition virtually all group

[45] Kaufman v Belgium (50 DR 98)

actions will need to indicate that they meet the *"exceptional public interest"* test as well as illustrating that *"life changing levels of damages"* will be awarded.

44. Furthermore, in relation to the description of group litigation as being "[t]*he most expensive cases of all*", APIL members have suggested that this conclusion may be based on perceptions of the previous funding system. Within the previous system legal representatives were paid as per their normal hourly rates with a large proportion of costs being caused by the necessity to handle each case individually. This inevitably led to high case costs, often into the millions of pounds. The current system, however, allows for generic work to be dealt with as a single issue. Naturally this significantly reduces the amount of work, and invariably cost, needed for each case. This fact, combined with tight budgetary controls and the use of contracts and risk rates, means that many group action cases now run on a £70 legal aid charge rate. For example, in order for a case to cost more than £1 million within today's legal aid system, a solicitor would have to bill more than 14,000 hours, which is highly unlikely.

45. APIL also questions what is meant by *"life changing level of damages"* within the definition. Does "*life-changing"* refer only to claimants who have suffered catastrophic injuries? If so, this will unfairly discriminate against people who may have suffered injuries that are significant, but not catastrophic.

46. In relation to possible cost savings within group actions – although, as illustrated above, the cost of group actions are now tightly controlled – APIL believes that the courts should allow for generic issues to be decided and ruled upon. With the generic issue decided, the court would then be able to deal with the individual issues as it saw necessary, so reducing the cost associated with appearing in court – i.e. court charges, counsel fees, expert fees, etc. APIL believes a further cost saving could be made in the general administration of group actions as the case

management within this area of litigation is still inefficient. This lack of efficiently is further exacerbated by the difficulties within the CPR processes for handling multi-party actions.

47. APIL is concerned that the LSC are acting in haste in relation to group actions, especially as the recently introduced system of extending cost protection to generic work have yet to be fully used and evaluated. Indeed APIL believes that prior to any new mechanism be introduced, this system should be allowed to develop further. Group actions tend to be relatively rare, and as such few have had the opportunity to be run via this system. Introducing new systems, while previous systems have yet to be fully used and evaluated, will simply lead to further confusion and denial of access to justice for many.

Child Abuse cases

48. APIL members report that, similar to previous comments made about clinical negligence and group actions, After-the-Event (ATE) Insurance is simply not readily available for child abuse litigation, making the use of CFAs as a funding alternative unworkable. Insurance providers are deterred from insuring these cases because of limitation defences and high generic costs. In addition, the majority of Before-the-Event Insurance policies do not allow for child abuse or group actions. This has access to justice implications as a claimant is left with a choice of either litigating themselves with no insurance, at great personal expense and risk, or to take no action at all. Even in the event that the insurance market were to provide insurance for child abuse claims, and solicitors acted under a CFA, the costs savings that can be seen to be the primary driver behind the LSC proposals, would become a fallacy; solicitors would attempt to recover 100% success fees, so doubling their fees, and recover the cost of the insurance premium itself. Naturally the defendants would have to meet these increased costs, and where the defendant is a local authority or other public body, there will be no costs savings at all, but instead, a likely increase in Governmental costs.

49. APIL notes that child abuse litigation is a continually developing area of law. Without the support of public funding, APIL can envisage that the boundaries and scope of this litigation would not have developed as it has to date and its future development will be seriously curbed. There appears to be a failure by the LSC to recognise that the changes made by the Civil Procedure Rules (CPR), and the use of franchised and audited specialist lawyers experienced in this field, have made a huge difference to how claims are run and the attitude of solicitors themselves. Indeed, this is reflected in the decrease of cases.

50. APIL is fully supportive of the LSC's aim to discourage unnecessary litigation, but in relation to the argument for excluding weaker cases from group actions in practice this is often harder said than done. Some claimants are suffering from severe psychiatric illnesses, and it is only after disclosure that it becomes clear that the worse abuse suffered was either pre-care or elsewhere and not within the Group Litigation Order. Weak cases often appear strong at the outset and vice versa. By the very nature of these cases and our typical claimants, the whole truth is not apparent at the outset. These types of cases involve a very vulnerable client group.

51. APIL members within child abuse litigation report that they do tend to use informal mediation and Alternative Dispute Resolution (ADR) to achieve settlement in their cases. The use of mediation helps to quantify the case and to investigate the limitation discount. To negotiate successfully, however, takes time and money. Nor does attending mediation rule out the need to prepare the case. APIL members are still expected to act in the client's best interests and this means it still necessary to enter the mediation properly prepared.