Response of the Personal Injuries and Clinical Negligence Teams at Guildhall Chambers, Bristol, to the invitation from Sir Rupert Jackson to provide views before the fixed recoverable costs review commences, January 2017.

1. We are grateful for the invitation to respond before the consultation commences and will respond more fully to the consultation at the appropriate time and once the proposals are formulated.

2. We note that our attention is drawn to specific questions which effectively ask *how* not *whether* fixed recoverable costs (FRC) should be extended. With respect, in the fields of injury litigation, we do not accept the assumptions which underlie the proposals for *any* extension of the current FRC. We explain why below and urge Sir Rupert Jackson to *broaden* the scope of the proposed consultation to include the anterior question of *whether* to extend the scope of FRC and to *postpone* it until the publication of:
    - A full assessment of the effects of & evidence from post LASPO costs budgeting;
    - The National Audit Office investigation in to the NHSLA's effect on costs (announced December 2016);
    - The awaited DOH consultation on FRC in Clinical Negligence cases.

3. **The Assumptions underlying the case for FRC [1]**:
    - Current litigation costs restrict access to justice[2].
    - England & Wales have higher litigation costs than other comparable jurisdictions[3].

[1] Sir Rupert Jackson's lectures *Fixed Costs - the time has come* January 2016 & *The future for Civil Litigation & The Fixed Costs regime* May 2016

[2] Paragraph 2.1 January 2016 lecture - "The Problem"

[3] Paragraphs 2.2 and 3 of the January 2016 lecture

- Lawyers are currently rewarded for inefficiency[4]/ the LASPO reforms have not achieved their aims.
- Claims worth £250,000 can fairly be treated as low value claims.
- Recoverable costs can be fairly fixed at significantly lower rates than are currently incurred.

4. We question those underlying assumptions in the context of clinical negligence and personal injury cases and make suggestions for a future consultation to consider alternative ways of improving the management of costs.

5. Do Current Litigation Costs restrict Access to Justice?

5.1 The case for moving to fixed costs identified one problem: "*high litigation costs inhibit access to justice".* We can all agree that if high costs prevent access to justice, this undermines the rule of law and is a bad thing. But *are* the current costs of litigation inhibiting access to justice for personal injury and clinical negligence claimants?

5.2 It is right to remind ourselves that the overwhelming majority of clinical negligence and personal injury cases are brought under conditional fee arrangements so that the lawyers receive no fees if the claim is unsuccessful and the Claimants are rarely exposed to any/ more than minimal costs risk.

5.3 Where is the evidence that injured people are not bringing their claims? There is perhaps a false note here where the complaints come not from those seeking to bring claims but from the Defendants. This is perhaps particularly so in relation to clinical negligence claims where the Department of Health announced its desire to bring in fixed costs as part of a raft of measures to reduce the NHS bill (by £80m per annum). An increase in claims even on the proposed fixed costs is likely to increase the NHS bill. If the real aim is to reduce not increase claims, this should be acknowledged by those who propose it.

5.4 In any event: the answer to this question is only relevant if it can also be said that FRC will extend access to justice. Yet that is not a claim made by those in favour of the scheme: the benefits are set out in paragraphs 2.13 of the

[4] Paragraph 2.2 January

January lecture and 2.09 of the May lecture. They are limited to lower costs, certainty, predictability, ease of explanation and no cost of budgeting /assessment.

5.5 Budgets are easy to explain to clients and provide them with reasonable certainty and predictability. The costs of budgeting are modest (capped at 3% of overall costs). Costs of budgeting and assessment are a reasonable price to pay for fairness. FRC will not in fact reduce Claimant's costs liabilities in the vast majority of cases where there is QOCS (qualified one way costs shifting). FRC will normally have the reverse effect and *increase* the Claimant's liability for irrecoverable costs.

5.6 If the only substantial aim and only real difference is to reduce *Defendants*' costs liabilities, this should be acknowledged by those who propose it.

5.7 So, would FRC extend access to justice? And if so for whom?

5.8 Looking at Claimants first: It is no secret that FRC are intended to be lower than current costs. So, either the Claimants will not recover their full costs (and so are not put back in to the position they would have been in but for the injury) or their lawyers are required to fight their case with less ammunition. It must be right to say that *irrecoverable costs are worse for a Claimant than recoverable costs* - whatever level. In injuries litigation where QOCS applies Claimants would very rarely benefit from the fact the Defendant's costs are fixed.

5.9 Do the current costs reduce Defendants' access to justice?

5.10 It is not clear that Defendants to personal injuries and/or clinical negligence claims are making a substantiated case to this effect. Certainly the DOH have previously argued that C's lawyers charge unreasonable fees which are disproportionate but they have accepted this was said without assessment; without taking account of the existing powers of courts to address this and without taking account of the effect of Defendant NHSLA's behaviour on costs [5]. It is a difficult argument to sustain in light of costs budgeting and CPR 44.3

[5] See AvMA Department of Health Fixed Recoverable costs proposals for clinical negligence : implications for patient's access to justice and for patient safety October 2015

where no budgets are sanctioned unless the parties and/or a Judge agrees that the fees are both reasonable and proportionate[6].

5.11 We understand the DOH's delayed investigation in to the question of fixed costs was originally going to be for clinical negligence cases up to £250,000 but has now been reduced to those up to £25,000 (July 2016 CPRC notes) which may indicate a revised position.

5.12 We also understand that the National Audit Office announced in December 2016 that it would undertake an investigation in to the operations and efficiencies of the NHSLA and its effect on costs and that this is intended to be completed in the summer of 2017.

5.13 If FRC would not demonstrably increase parties' access to justice, and may hinder it, what is the purpose of the reforms? If the concerns are in fact about lingering abuses and overcharging, let's identify and address that.

6. Are we an expensive jurisdiction?

6.1 The case for FRC relies on an assertion that in other jurisdictions, which have complex laws and procedural rules, litigation costs are lower than in ours[7]. But *is that right*?

6.2 The only two examples cited (and presumably any could have been) are Germany and New Zealand. In the fields of clinical negligence and personal injuries litigation, these countries have wholly different jurisprudential (NZ) and procedural (Germany) systems.

6.3 In NZ there is no fault compensation for injury compensation so that, as a rule, neither breach of duty nor causation is litigated nor requires expert evidence.

6.4 In Germany, some 85% of clinical negligence cases are settled at mediations funded by the healthcare providers/ insurers and provided with independent lawyers and medical experts. In the remaining 15% cases which go to court,

[6] As Jackson LJ said at the Harbour lecture in May 2016, if some judges are not policing this adequately, the solution is judicial training.

[7] Paragraphs 2.2 and 3 of the January 2016 lecture

the process is not adversarial as we know it but inquisitorial with court appointed experts significantly limiting the role (and cost) of party experts. [8]

6.5 In both countries the injured parties' damages are limited to those above and beyond the losses provided for by the state and so involve considerably fewer heads of loss/ issues than in our jurisdiction. All this comes, presumably, with a concomitant reduction in work for the lawyers and medico legal experts.

6.6 There may of course be good arguments for moving towards either system but - as NZ acknowledged - theirs requires "*a kind of social charter largely replacing the common law*". Until or unless that is achieved, or a change of our adversarial system, questions of funding litigation have to relate to the common law adversarial system we have and the quantum of costs in these countries is simply irrelevant[9].

6.7 Any proposed solution which prevents the Claimant from recovering the reasonable and necessary costs of establishing liability at common law but does not at the same time prevent the Defendants from using and funding common law defences is unjust on a most basic level.

6.8 Are we comparatively expensive? We are not provided with true comparators by reference to Germany and NZ. No other comparisons are made - others may know the answer. Someone needs to look at this - if so, what can we learn from truly comparable jurisdictions?

7. Are lawyers currently rewarded for inefficiency? Have LASPO reforms achieved their aims?

7.1 As a result of costs budgeting and proportionality, we now have the emerging evidence of what Judges and parties in this jurisdiction consider to be reasonable and proportionate costs in the form of agreed and adjudicated costs budgets.

7.2 Why consult without the benefit of that rigorous, detailed and specialist evidence? A full and proper evaluation of this should be readily easy to undertake (e.g. courts could record all/ sufficient samples of basic costs

[8] http://scholarship.kentlaw.iit.edu/cgi/viewcontent.cgi?article=3814&context=cklawreview

[9] And in our view inadequately met by "modification" as proposed at 3.7 of the January paper.

budget information over a year which could be anonymised and analysed to answer specific questions).

7.3 If abuses persist with over charging, or if inefficiency is rewarded, that will be evident from a proper analysis of existing budgets. If that is the problem, we need to recognise it and say so in terms because the solutions are quite likely to be different according to the problem. Let's identify the abuses and inefficiencies: Who is overcharging? When? Is it duplication of work? Failure to comply with the protocols and court timetables? Excessive hourly rates for straightforward tasks? Is work increased by unnecessarily late admissions? By failures to negotiate?

7.4 If these are the problems, are they not better met by training and guidance for costs judges; procedural expectations in the practice directions and rules and by proper regulation of the lawyer's market place than by low fixed costs which are likely to force the better quality solicitors out of the market and reduce the involvement of the bar?

7.5 If the purpose of ignoring the emerging evidence is in fact to fix Claimants' recoverable costs at an artificially low amount which is lower than can properly be sanctioned as a reasonable and proportionate necessity of proving his case, that undermines the common law's requirement that the tortfeasor puts the Claimant back in to the position he would have been in but for the injury. We have to be honest about this.

7.6 Is it appropriate for the state to impose this in order to reduce its own costs liability where it is the Defendant which negligently injured the Claimant? [10]. Has the pendulum has swung too far to the benefit of insurance companies? Is it right that their financial interests should be guarded as a matter of public policy beyond the arguments on each individual case?

8. Are claims of up to £250,000 low value?

8.1 Many injury cases are serious, important and complex whilst attracting damages of £250,000 and significantly under. A family breadwinner who, through injury, loses his/her earnings at the national living wage loses c. £13,500 p.a. Even loss of such earnings for a short period will cause

[10] We echo AvMA's concern that the DOH is driving these reforms as a costs saving measure in its own interests and that it is inappropriate for the MOJ to allow the DOH to develop its policy for it.

significant financial pressure. It may be instructive for those not involved in this work routinely to look at the quantum cases collected in Kemp or Lawtel (Lawtel includes compromised as well as judicially approved cases).

By way of examples from our own recent experience:

8.2 **0 - £25,000 clinical negligence cases**: Psychiatric injuries as a consequence of a still birth; death of newborn children; death of a child during surgery; serious neonatal injuries with suspected brain injury which could not be excluded until age 16; provisional damages for child with skull fracture caused by forceps from which he recovered save for the risk of epilepsy; suicide of a mentally ill patient; psychiatric injury of a non working parent; death of a prisoner as a consequence of inadequate healthcare; knee injury as a consequence of abusive treatment by healthcare staff in a psychiatric hospital.

8.3 **£25,000 - £50,000** Death of an infant's father with underlying health issues involving 4 experts re liability; loss of kidney; delayed diagnosis of HIV causing onward infection.

8.4 **£50,000 - £100,000** Many serious RTA and employers' liability injuries fall in to this category causing death within a relatively short period of time so reducing damages; or life altering disabilities in non working/ low income people or where claimants manage to continue in some work; significant injuries without expensive care implications e.g. loss of hearing in one ear in child requiring cochlear implants; delay in cancer diagnosis causing mastectomy, chemotherapy, psychiatric injuries and reduction in life expectancy but C able to work; delayed appendicitis diagnosis; multiple operations and out of work for 2 years.

8.5 **£100,000 - £175,000** Claims for asbestos related injuries and care until their untimely deaths including mesothelioma; surgical errors causing total loss of fertility in men and women; bowel or bladder incontinence; orthopaedic injuries which limit return to work and /or injuries causing care needs; delayed diagnosis of cancer.

8.6 **£175,000 - £250,000** All or any of the above injuries in cases where there is a longer period of loss of earnings or higher care needs; amputation in older person. Cauda equina injury where the claimant has suffered bowel and bladder dysfunction and loss of sexual sensation but no loss of mobility and is

able to return to work. Generally expert evidence is needed in 4 disciplines on breach and causation: GP, emergency department, spinal surgery and urology. These are expensive and complicated cases to litigate despite sometimes having a value less then £250,000.

9. <u>Can recoverable costs be fairly fixed at significantly lower rates than are currently budgeted?</u>

9.1 <u>Take only the first (under £25k) bracket:</u> Absent very early admissions, each of the type of case referred to at paragraph 8.2 above, above requires significant experts' involvement in turn requiring conferences, questions, agendas etc; frequently inquests (sometimes with a jury) where multiple doctors gave evidence and the coroner called expert evidence so requiring representation before issue; sometimes contested disclosure applications for documents underlying serious incident reviews. The timing of settlement is dependent on Defendant engagement - delays before the letters of response; routine denials not based on independent expert evidence; refusal to give full disclosure and very late admissions by the Defendants is the norm (sometimes despite criticism in internal reviews before the litigation began).

9.2 All of these factors apply to equivalent cases at the higher brackets too.

9.3 It is, of course, true that some low value claims could be litigated more cheaply, but the current proposals would make the more complex ones effectively impossible to bring. If the rationale is that the kinds of cases set out at 8.2 above are too minor to justify litigating if complex, then that should be stated explicitly, rather by imposing a regime that effectively prevents Claimant's having access to the Courts without explicitly stating so.

9.4 <u>The more complex cases with multiple experts</u>**:** We note the suggestion that there should be an uplift in fixed costs where the case involves more than 2 experts. We are confused by the amount suggested (10% per expert over 2). Each additional expert does not cause just 10% more work. There is significantly more work required with each additional expert being matched by one from the other side and all requiring conferences, agendas, questions to other sides' experts, longer trials etc and further, the need for more than 2 experts is often a reflection of the increased complexity inherent in the case. This is already recognised in legal aid funding of clinical negligence cases

where a 5 expert case attracts possible fees up to the end of the liability trial of 350% more than a 2 expert case, not 30% more.[11]

9.5 Costs vary hugely in the larger cases according to complexity. A full review is needed but it is our current view based primarily on our experiences and also on a limited review of budgets available in our own cases that wherever liability is (a) in issue and (b) a matter of expert evidence, it is highly unlikely the claims could be litigated with anything approaching equality of arms against the NHSLA or insurance companies for the proposed fixed sums.

9.6 In the time provided, we have not been able to obtain a large or representative sample of cases particularly because Counsel do not routinely have possession of the costs budgets in clinical negligence cases or those cases falling within the higher bands. However, the data such that we currently have is provided at annexe 1 and these observations can be made:

9.6.1 The figures demonstrate that the value of the claim is not a reliable indicator of the reasonable and proportionate costs. There are obviously other factors that affect proportionality e.g. complexity.

9.6.2 The reasonable and proportionate costs in a lower value claims may exceed the costs in a higher value, depending on the issues.

9.6.3 The cases reasonable and proportionate costs vary significantly within each band.

9.6.4 The figures suggested in the table from Sir Rupert Jackson are significantly lower than the sums currently allowed.

9.6.5 It should be recalled that the bands within which the budgeted figures fall relate to *pleaded* value whereas the FRC proposals relate to the *judgment* figure which is usually lower (and often very significantly lower) than the pleaded figure for many good reasons.

10. <u>Barristers:</u>

[11] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/468725/legal-aid-clin-neg-funding-checklist.pdf legal fees for 2 expert case = up to £29,750 (on legal aid hourly rates) / 5 expert case = up to £103,000 to the end of the liability trial (with further allowance of up to £75,000 for quantum assessment and trials involving multiple quantum experts). If 10% were added per expert on this model, the 5 expert case would attract £38,675.

10.1 We have not sought to separate the Bar's interests from our solicitor colleagues' interests in this response. In part this is because we consider that the way in which we are used in complex injury cases is so integral to every stage, from pre-issue to trial and also so variable that it cannot readily be hived off in an FRC regime. We also consider that we remain excellent value for solicitors to use and that in most complex cases they will continue to do so.

10.2 However, we share concerns expressed by others for the loss to clients and the loss of specialism at the Bar if the lower value or cases perceived to be simple are increasingly kept in house by solicitors struggling to make ends meet. We do not think Judges underestimate the particular set of skills traditionally practised by the Bar required to plead cases, to undertake legal and forensic analysis and to ask questions of experts and advise at certain key points nor the usefulness of having a second set of eyes to see the wood for the trees at times. That second opinion frequently results in the reduction of costs, allowing a realistic view to be taken of cases, abandoning the hopeless ones and settling the meritorious. This is the reason why counsel are routinely instructed at joint settlement meetings, resulting in huge savings of both costs and court time. Any FRC scheme should recognise the importance of those factors at each stage of the litigation.

10.3 Moreover, we consider it likely that a full analysis of costs budgets will demonstrate few if any cases of overcharging for these aspects of the work. Counsels' fees are, in our experience, usually the least contentious part of any budgeting hearing. We believe that it is important to identify any areas of overcharging so as to ensure that it is those areas and not the necessary and efficient work which is affected by any changes to the current scheme.

11. ***Further concerns about the proposed scheme***:

11.1 The proposed scheme wrongly assumes that:

(a) a single set of fixed costs is workable across a diverse range of cases where costs will be markedly divergent;

(b) that for cases over £25,000 there is sufficient volume to make the principle of "swings and roundabouts" effective. In fact, cases worth nearer £250,000 are low in number and the scope for injustice rises sharply.

11.2 There is a risk that FRC leads to unintended and unwanted changes in behaviours. For example, Claimant solicitors acting in cases that fall within the FRC face a potential conflict of interest as the solicitor can potentially benefit from undervaluing the case and making a low Part 36 offer. This increases the chance of the Claimant subsequently beating the offer and thereby obtaining indemnity costs over and above the limited FRC regime. This is something that is difficult to clearly identify but has been noted by members of chambers working in fast track personal injury cases since the case of *Broadhurst v Tan* [2016] EWCA Civ 94.

11.3 The proposed scheme as currently advanced makes no distinction between those cases where liability is admitted and those where it is denied - the fixed costs recoverable are the same in either case. Two points arise:

(a) This is in contrast to the existing fixed costs regime in portal cases: if liability is in issue the case drops out of the portal - in recognition of it being more expensive to litigate and therefore inappropriate for portal fixed costs (although the case would then move to the higher fast track fixed costs regime).

(b) If no distinction is to be made by the proposed scheme for cases where liability is in issue there will be a strong incentive of defendants *never* to admit liability (or at least only to do so once quantum can be agreed). Defendants will put claimants to the trouble of dealing with liability, disclosure and gathering evidence in order to apply costs pressure to settle. There will be no sanction for such behaviour because the scheme wishes to avoid "Balkanisation".

12. **Timing of the consultation**:

We urge Sir Rupert Jackson to postpone the consultation at least until after the publication of:

- A full assessment of the effects of post LAPSO costs budgeting;
- The National Audit Office investigation in to the NHSLA's effect on costs (announced December 2016);

- The awaited DOH consultation on FRC in Clinical Negligence cases.

13. <u>Breadth of the consultation</u>:

We consider that any future consultation should***:***

13.1 Take full account of and consult upon whether costs budgeting is working and/or how it can be improved;

13.2 Identify over charging and its causes;

13.3 Consult fully on how parties' behaviour is considered to be driving up costs on either side and how this could be managed;

13.4 Consider alternative routes to litigation such as mediation schemes (here we could perhaps learn from Germany);

13.5 Consider the reintroduction of legal aid in clinical negligence or the use of CLAFs;

13.6 Consider the restriction of specialist work to specialist lawyers on accredited panels;

13.7 Consult on how best to recognise and allow for the specialist work traditionally undertaken by the bar at each stage of the litigation;

13.8 Ask whether FRC should be extended and if so in what circumstances e.g. might it work in cases where liability is not in issue (and so more similar to NZ no fault compensation)?

13.9 Consider the likely unintended consequences of introducing FRC on access to justice and the conduct of litigation.

Appendix 1:

Sample of Approved/Agreed Costs Budgets

Band 1 - £25,001 - £50,000

Sir Rupert Jackson's grid total figure: **£18,750**

Nature of case	Industrial Disease	PI – RTA	PI – non RTA	PI – non RTA	PI – non RTA	**Average**
Profit Costs	41,029	28,266	26,476	24,061	40,754	**32,118**
Counsel's fees	14,335	10,325	9,850	13,435	21,120	**13,813**
Total profit costs and Counsel's fees	55,364	38,591	36,326	37,496	61,754	**45,931**
Comments	Asbestos (pleural thickening). Liability and quantum in issue.	Liability in dispute. Secondary victim. 1 expert psychiatrist for C; none for D	Liability admitted. Settled for £30,500	Trip while working. Liability in dispute. 1 medical expert	PL claim. Primary liability admitted. Con neg in issue. 2 medical experts for C. None for D.	

Band 2 - £50,001 - £100,000

Sir Rupert Jackson's grid total figure: **£30,000**

Nature of case	Clin Neg	Clin Neg	Clin Neg	PI – non RTA	RTA	**Average**
Profit Costs	126,689	42,121	26,753	45,483	45,007	**57,211**
Counsel's fees	44,480	17,395	14,850	4,000	19,660	**20,077**
Total profit costs and Counsel's fees	171,169	59,516	41,603.20	49,483	£64,660	**77,288**
Comments	Delayed diagnosis of HIV. Fought by D until month before trial. Budget approved by Circuit Judge.	Delayed diagnosis of appendicitis. Breach admitted. Causation in issue. One expert on each side.	Breach admitted. Dispute over cause of hearing loss in 1 ear. Only special damages cochlear implants	Liability admitted. Con Neg alleged. Straightforward. 1 day trial.	Liability admitted. 3 medical experts for C. 1 for D.	

Band 3 - £100,001 - £175,000

Sir Rupert Jackson's grid total figure: **£47,500**

Nature of case	Disease	PI – RTA	PI – non RTA	**Average**
Profit Costs	52,520	58,742.60	45,451.20	**52,238**
Counsel's fees	22,625	21,400	20,298.75	**21,441**
Total profit costs and Counsel's fees	75,125	79,742.60	65,749.95	**73,679**
Comments	Stress claim. Liability, causation and quantum disputed. 1 psychiatrist each side. Full value in this bracket but settled for £20,000 without admission.	Liability admitted. 2 medical experts for C. None for D. Self-employed. Issue loss of earnings. Accountants on each side.	PL. Liability admitted. Broken wrist causing CRPS. Expert evidence agreed.	

Band 4 - £175,001 - £250,000

Sir Rupert Jackson's grid total figure: **£70,250**

Nature of case	PI – non RTA	PI – Non RTA	PI – Non RTA	Clin Neg	**Average**
Profit Costs	35,184.40	53,921.00	60,377.70	91,095.00	**60,145**
Counsel's fees	25,600.00	27,248.42	31,745.50	30,250.00	**28,711**
Total profit costs and Counsel's fees	60,784.40	81,169.42	92,132.20	121,345.00	**88,858**
	Fatal claim. Workplace accident. No expert evidence. Settled for £200,000	EL claim. Primary liability admitted. Con neg in issue. Medical experts in 4 fields. 2 non-medical experts: OT and employment	EL claim. Liability admitted. Medical experts in 2 fields. 2 non- medical experts: OT and motorcycle adaptations	Clin neg, injury, reducing mobility of already disabled patient	