Ministry of Justice: Reducing the number and costs of whiplash claims

Response by Thompsons Solicitors

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Introduction

Insurers have been pressing for an increase in the small claims limit for many years. The debate has been ongoing since the Woolf Review in the 1990's. Insurers know any increase will limit access to legal representation for vast numbers of injury victims. Every increase, however small, leaves more people having to claim and negotiate alone against the might of the insurance industry.

For insurers, increasing the small claims limit and claims capture (third party capture) are two routes to the same destination – weak unrepresented claimants having to negotiate and litigate against strong, well financed and expertly represented insurers. This is a fundamental inequality of arms.

This is why Thompsons and other claimant stakeholders are opposed to any increase in the small claims limit, whether it is for whiplash, other RTA personal injury claims or all PI claims.

It is significant that:

- Sir Justice Jackson rejected an increase in his review of the civil justice system.
- The Law Society opposed an increase.
- The Civil Justice Council opposed an increase.
- The Ministry of Justice decided against an increase in their response to the claims process review.
- Lord Woolf decided against an increase in his Review.

Damage to current balanced model

The vast majority of PI cases are above the current £1,000 limit. This means that, notwithstanding the forthcoming civil justice reforms, block providers such as BTE insurers and trade unions can deliver representation to those with small claims by requiring their law firms to provide representation to them as part of the overall package.

That model is premised on the many paying for the few and would collapse should the balance shift (as it will) if the limit rises. The few cannot pay for the many and neither can half pay for the other half. The losers would not only be those with claims below the new general damages limit but also those with claims below £1,000 who are currently represented.

Defendants would continue to be legally represented

Insurers have continued to instruct solicitors and counsel in PI cases whether they are above or below the small claims limit. This has been the position since the limit was increased to £1,000 in 1991 and continued to be after it was increased again in 1999 when the £1,000 was specified to apply to general damages only.

The practice of most insurers in PI cases is to conduct negotiation in house or through loss adjusters until proceedings are commenced and thereafter instruct solicitors and counsel. This applies irrespective of value and there is no reason to suggest that this would change if the limit rose. It remained the case after 1991 and has been the case since 1999.

This emphasises the inequality of arms - insurers can afford to pay for legal representation in order to protect

their interests, irrespective of recovery of costs (as insurers rarely recover costs). PI claimants, on the other hand, are reliant on recovery of costs such that an increase in small claims would discourage them from instructing lawyers unless they are prepared to have a reduction in their compensation to allow them to do so.

This means the unrepresented injury victim would not only have to deal with experienced insurers but will also be confronted with experienced solicitors and counsel.

Complex injuries

Jackson LJ's interim report confirmed that *"by increasing the small claims limit to £5,000 many relatively severe and complex injuries would be brought within the scope of the small claims track"*. In fact, that would be the case even if the small claims limit were at levels lower than £5,000.

The following examples from the current Judicial Studies Board Guidelines illustrate the extent to which even a modest increase of the current small claims limit would bring within its ambit many cases of significance and importance to those injured and also injuries of some complexity.

- In relation to psychiatric damage, minor psychiatric damage starts at £1,000 (category 3 *(A) (d)*). These are cases serious enough for people to have had difficulties with daily activities and effects on their sleep, albeit temporary.
- In the case of minor cases of post traumatic stress disorder, resulting from "a psychologically distressing event which causes intense fear, helplessness and horror", affecting *"basic functions such as breathing, pulse rate and bowel and/or bladder control"… persistent re-experience of the relevant, difficulty in controlling temper, in concentrating in sleeping and exaggerated startle response"* are given a bracket of £2,500 to £5,250 where there has been a virtually full recovery made within 1 to 2 years. (category 3 *(B) (d)*)
- Cases of *"minor eye injuries, including cases where there has been temporary interference with vision"* are given a bracket of between £2,500 and £5,600. (category 4 (A) (h))
- A chest injury leading to collapsed lungs but with a full recovery has a bracket of £1,400 to £3,450. (category 5 *(A) (f)*)
- Minor shoulder injuries with considerable pain for up to a year but almost complete recovery are given a bracket of "up to £2,750". Even an injury of this sort which causes 2 years of considerable pain has a bracket of between £2,750 and £5,000, (category 6 *(C) (d)*)
- Undisplaced fractures of the nose have a bracket of £1,100 to £1,600, only very slightly above the current small claims limit (category 7 *(A) (c)(iv)*)
- Even fractures of the nose which are displaced and require manipulation but no more than this have a bracket of £1,600 to £2,000, which is not much further above the current small claims limit (category 7 *(A) (c)(iii)*)
- Displaced fractures of the nose requiring surgery to ensure a complete recovery have a bracket of £2,500 to £3,250, (category 7 *(A) (c)(ii)*)

These show that many injuries with very substantial immediate effects are categorised as attracting only low level damages - if the effects are not permanent. Awards are made with the benefit of hindsight, once it is known that no permanent damage has been done. The injured person on their own is time poor and our experience is that these sort of temporary injuries are often accompanied by worries about the long term effects in the immediate aftermath of the injury.

Controlling the market

Increasing the small claims limit has the potential to lead to the growth of a huge and unregulated industry. Insurers will see the opportunity to set up limited companies to do small claims linked to BTE or at a low fixed fee which will allow them to effectively control the market including which medical expert the claimant can go to.

The outcome, putting it bluntly, will be a market that is stitched up to the advantage of insurers. Claimants will have the Hobsons choice of fighting the insurers on their own, having to pay out of their compensation, or opting for a representative owned and run by insurers, who will be compromised by their lack of independence from those insurers.

The proposals in this consultation will reduce the numbers of genuine whiplash and RTA PI claims as people injured through no fault of their own choose not to represent themselves, or decide they will lose such a significant proportion of their damages as to make pursuing a claim not worth while.

Fraudulent claims – not hitting the target

There is little prospect that an increase in the small claims limit will reduce the number of fraudulent claims. A claimant intent on pursuing a fraudulent claim will not be put off by having to use the small claims track. Quite the opposite – they will have a further incentive to pursue the claim because they will be running a lesser risk in that they won't have to pay costs if they fail to satisfy the court of the claim. Whereas, outside of the small claims track, under the new QOCS regime from April, those pursuing dishonest claims will be liable to pay the insurer's costs.

What this proposal does is provide insurers with an incentive to allege fraud without foundation in order to stop genuine claims – they will be able to do so with impunity against unrepresented claimants. Deciding if there has been fraud should be for the courts based on the evidence provided by insurers, not for the insurers to allege without evidence.

The small claims court was never designed to deal with fraud. Quite the opposite. District Judges will, understandably, routinely transfer a case out of the small claims track where fraud is alleged. We do not therefore follow the logic that it will somehow be more effective to challenge a fraudulent claim in the small claims track than anywhere else. It will simply mean that the genuine cases, which are the vast majority, will be forced into the small claims track. The only cases not in that track will be those with an allegation of fraud as they will be transferred to the multi-track.

Like any crime, the primary action against fraudsters should be criminal proceedings. Insurers have not provided evidence that they are working with the police to ensure that known offenders, including claims firms, are routinely challenged.

Insurers are not helpless to tackle fraud and some are taking a more robust approach than in the past. It is right that they are. The courts will and do support them when they deal with fraud correctly, as a case of ours demonstrates.

We initially acted for a man who claimed to have sustained his badly broken ankle when he stepped in a pothole on a path in a local authority park.

Alarm bells rang when it became apparent that the details of what happened before and after the accident were contradictory and unclear. The claimant was unable to explain why he had taken the particular route home and his account, and that of his witness, differed as to when and how many times the emergency services were contacted and why the ambulance crew had to attend to him some considerable distance from where the accident was said to have happened.

The defendant insurer's medical expert's opinion did not support the claimant's version of events. The claim had no reasonable prospects of success and we discontinued it.

The defendants suspected the claim was fraudulent and rightly commenced contempt proceedings in the High Court against the claimant, his witness and the claimant's father (who had encouraged him in his claim). The court agreed that the three were in contempt and each received custodial sentences.

Recent case law also demonstrates that insurers can succeed if they suspect and challenge fraud by bringing contempt proceedings, but also that the courts will control what is fair.

In **Zurich Insurance Co v Hayward [2011] EWCA Civ.641** it was decided that the insurance company was entitled to launch an action against a claimant to seek damages for a fraudulent claim which the insurer had settled seven years earlier.

In **Montgomery v Brown [2011] EWHC 875** the insurer sought to have a claimant imprisoned for contempt. It was held that it was necessary to satisfy the criminal burden and so show that statements made by the claimant were false and known to be false at the time they were made.

The consultation paper suggests that insurers do not fight fraud because it is cheaper to settle the case. That is a nonsense suggestion. If the case is fraudulent, the insurers stand under the current regime to save having to pay the damages and claimant's costs and will get an order for their costs to be paid. For it not to be cheaper to settle the case, the insurer's costs would have to exceed the damages and claimants costs currently payable. So if the damages were £4,000 and the claimant's costs £3,000, the insurer's costs would have to exceed £7,000.

Under the proposals, that calculation tilts even further towards the insurers settling the claim. In the same case there would, under the proposals, be no claimant's costs to pay. So the economic balance would mean it would be cheaper to not seek to challenge a fraudulent claim if the costs of proving fraud exceed £4,000.

In any event, the idea that insurers don't challenge fraudulent claims suggests that they connive with fraudsters. It must be fundamental to insurers that they do not give into fraud. Even if in a single case it costs more to prove fraud than it costs to settle the case, it is still worthwhile incurring that cost. Giving in to fraud is like giving in to blackmail, hostage taking or other forms of criminality – it just encourages more criminality and is a false economy.

We note that paragraphs 65-6 identify the risks to genuine claimants, yet nothing it seems is proposed to prevent this. It is wrong to punish the many because a few have broken the rules.

These proposals are being driven by insurers and hit entirely the wrong target. They impact on genuine claimants while doing nothing to tackle the actual problem.

Insurance practice behind the increase in claims

We do not dispute that there has been a big increase in whiplash claims and that this is an issue. We welcome the government's decision not to include all PI claims in these proposals, but it is clear that the insurance industry will not stop asking for more until the market looks like it wants it to. It is therefore critical that the government examines the reasons for the rise in whiplash claims and not just those which the insurers cite.

Third party capture

For years we have called for the Financial Services Authority (FSA) or government to investigate the insurance industry practice of third-party capture. Our objection was always that it denied victims their right to independent legal advice and time and again the cases we have seen have proved the point.

We are also convinced that it is encouraging claims. If the Association of British Insurers (ABI) genuinely wants to tackle what it calls a burgeoning RTA claims culture it would take measures to tackle the abuses by insurers and others in the industry (including claims firms, many of which are owned by or linked with insurers), including third party capture and selling cases on for substantial referral fees.

The ABI claimed in its Frontier Economics report *Outcomes for legally represented and unrepresented claimants in personal injury compensation, July 2006* that unrepresented claimants receive as much if not more than represented ones. An independent critique of it by Brian Critchley of London Metropolitan University, commissioned by Thompsons, concluded that the statistical analysis was deeply flawed, did not make like for like comparisons and came to unreliable and meaningless conclusions.

In fact the evidence of third party capture techniques actively and even blatantly taking advantage of unrepresented injury victims is by now well documented.

A freedom of information request to the FSA regarding the work they had done on third party capture in 2009 revealed:

- The data provided found that on average 3rd parties were awarded 274.95% or £1,003.07 more through court proceedings than the initial rejected out-of-court offer from a [insurance] firm.
- Only about 3% of third party capture offers are rejected.
- Third party capture is more widespread than [the FSA] initially assumed, and that the impact and probability of consumer detriment is greater. Based on these findings [the FSA] propose a risk rating of MH [I assume this means 'medium to high'] for impact as well as probability.
- Splitting insurance firms into personal injury (PI) and employment liability (EL), of those surveyed, all PI firms engaged in third party capture (equating to 75% market share) while about half of EL firms engaged in third party capture (equating to about 47% market share).

(Source: Financial Services Authority: 3rd Party Capture Risk report 2009)

We have three recent case examples which suggest that claimants are first being nudged by insurers to make a claim and then become victims of insurer attempts to undersettle:

1. A union member was allocated solicitors through their motor insurers following an RTA. The insurer advised the claimant to accept an offer of £2,250. The claimant was unhappy with this offer and the service they had received. Thompsons was instructed to take over the file. The insurer made an increased offer of £3,000 which we advised client to reject. We made a part 36 at £8,537 and advised our client to accept any offer of £5,000 or more prior to issue of proceedings. The offer was rejected and proceedings were issued for an amount over £5,000.
2. We settled a claim for a client who suffered whiplash and back injuries when her car was hit by another vehicle. Before we were instructed, and within hours of the accident, the Royal and Sun Alliance – the other driver's insurer – were on the phone admitting liability. The victim was then repeatedly called over a weekend in what became a campaign of harassment to get her to accept £1,000. A colleague then advised her to seek legal advice through her trade union. Thompsons was instructed, medical reports revealed the extent of her injuries and her claim settled for five times the amount first offered by the insurer.
3. Another client was written to by Esure offering its Direct Claims Service "free of charge" as though this was a very special benefit. She was persuaded by this marketing ploy, but after she received a very low offer for what she knew was not a minor injury, she too turned to her union's legal service and received substantially higher damages as a result.

These are all clients who may not have thought about making a claim until they were subjected to hounding by an insurer, a claims firm or an insurer panel law firm (tipped off by the insurance company).

Piecemeal approach

The fact is that the MoJ is already dealing with the increase in compensation claims. It has consulted on reducing costs both in and outside of the claims portal and has responded recently to that consultation. How can it hope to know what changes, if any, have been effective when it isn't allowing any of them to be established before doing something else alongside?

Fraud is a red herring. The real motivation is to reduce legitimate claims and drive up insurer profits. The insurance industry has to stop using the premiums stick to beat and disenfranchise legitimate claimants and acknowledge that it instinctively goes against the grain to reduce premiums, whether or not costs come

down. The noises made by insurers at the No 10 summit last February that there will be a move towards a reduction in premiums is not nearly enough to justify any of these measures and the attack on access to justice that they represent.

The fact is there can never be an honest debate around compensation culture as long as the insurance industry, its shareholders and its political allies have a profit motive for stoking society's belief that it exists and that only still more draconian measures than those already taken to stop claims will rein it in.

It is clear from this consultation, and other recent ones on extending the RTA portal and cutting fixed, recoverable costs, that there is no effective strategy for reducing fraudulent whiplash claims. It is a piecemeal approach being taken for no reason other than it is what the insurers want.

Response to questions

1. Do you agree that, in future, medical reports for whiplash injury claims should be supplied by independent medical panels, using a standard report form, and should be available equally to claimants, insurers, and (for contested claims) the courts?

We do not agree. It is not, in our view, independent to have panels of doctors chosen by government and insurers outvoting claimants' representatives on the selection board.

Apart from the close relationship between the government and insurance industry making such a proposal manifestly weighted against the claimant, it is also the case that the government may itself be a defendant in a claim. It is therefore wholly inappropriate that the government has a role in appointing medical panels.

2. If no, how would you address the problems listed at paragraphs 35 to 39 of part two of this consultation document?

We do not agree with the problems listed in the document. Currently either side can propose a doctor and the parties agree between them who the doctor should be or they get their own doctor where they can't agree. That is both fair and independent and allows insurers to object. If they are not using that opportunity then that is not a reason to fundamentally change the system.

It is the courts who weigh up the medical evidence. If the insurers say there are experts who can determine genuine whiplash claims, why don't they currently use those experts and put them before the courts? Are they seriously saying that the courts are incapable of giving both parties a fair hearing on this issue?

If there is to be a change to a system, even though it works well and appears to have suited insurers until now, then any appropriately qualified expert should be allowed to apply to the panel and they should be chosen by an appropriate medical professional body (such as the BMA or the Royal Colleges) or by the Law Society.

3. Which model should be used for the independent medical panels – accreditation, national call-off contract or some other variant?

Neither should be used as both are flawed. As said above, the government is not an objective party and it is not appropriate for it to be involved in the selection of panels and this includes establishing standards for accreditation.

It is worth reminding the MoJ that a key aim of Lord Woolf's civil justice reforms was to get rid of the 'hired gun' expert culture. The Jackson review of civil costs did not criticise the current regime established by the Woolf reforms.

Standard forms, as currently referred to here, will simply encourage the approach that insurers claim some doctors take of churning out standard reports.

A national call-off contract is no more independent that an accreditation scheme. Again, the government "working with interested parties such as the insurance industry and representatives of claimants' legal service providers" is unfairly weighted against claimants because of the relationship between the government and the insurance industry.

We do not understand what is meant by medical organisations being invited to bid to be placed on a list of approved suppliers under the contract. Who will be paying them? If the insurance industry has agreed to pay then in what way can the medical panels be described as independent?

Such an arrangement is in direct contrast to the current regime where a claimant can get a report and if the insurer doesn't like it then can get their own. If, under the proposed system, a claimant disagrees with a report, or the report misunderstands their condition or it alleges fraud, will that claimant be able to go to another panel member and if so who will pay?

4. Do you consider that an element of peer review should be built into every assessment, or only for a sample of assessments for audit purposes?

The current system allows a party to get a report from another expert if it is not agreed with or is wrong. It is then a matter for the court to decide which report it prefers. We see no justification for building in an element of peer review when a thorough system for independent judicial review already exists.

5. How should costs be dealt with and apportioned?

Costs should be dealt with apportioned by the court. Any other method would be unfair and would lead to satellite litigation.

6. Should the Small Claims track threshold be increased to £5,000 for RTA related whiplash claims, be increased to £5,000 for all RTA PI claims or not changed?

There should be no change, for the reasons given in our introduction above.

7. Will there be an impact on the RTA Protocol and could this be mitigated?

It is not clear which RTA protocol is being referred to as it is currently being amended and the finalised version is awaited. But clearly there will be a significant impact on the RTA portal. Increasing the small claims threshold for RTA whiplash claims will take the majority of claims away from the portal, and that is before it has been given a chance to properly bed down and establish an impact on speeding up claims and reducing costs.

As unrepresented claimants (which many using the small claims track inevitably will be) will be unable to use the portal, the increase in the threshold will simply undermine the project to extend the portal. Clearly the protocols (there is an existing one and one proposed for the proposed extended portal) would have to be amended to reflect this.

8. What more should the Government consider doing to reduce the cost of exaggerated and/or fraudulent whiplash claims?

Encourage the insurance industry to do what every other industry does when it faces criminality – fight it at source and provide resources so that public agencies can work with insurers in doing so.

We suggest that the government does more to encourage the CPS to prosecute those making fraudulent claims and produces a code of practice with the police so that there is closer, more effective liaison with insurers. Fraudulent claims should be treated as serious crime.

We have suggested many times to the insurance industry that it can do more to challenge fraudulent claims, especially as it claims to know which claims firms and in which regions such claims come from. If the insurance industry was serious about tacking fraud it would target the challenge and its resources more effectively.

9. Do you agree with the equality impact assessment published alongside this document? If not, please explain why.

No. The full impacts on claimants have not been properly considered.

We do not agree that raising the small claims track might [our emphasis] raise a risk around equality of arms. It undoubtedly will.

It is not just "possible that victims may undervalue their claims and be disadvantaged accordingly in

negotiations with defendants who may continue to utilise legal representation, resulting in inequality of arms" – it is inevitable.

An assumption is made in the Impact Assessment that claimants without BTE insurance for legal expenses will be subject to the greatest impact. It is not enough for the equality impact assessment to simply refer to BTE being "geared to high earners" without any attempt at an analysis of how the protected characteristics are dispersed across those without BTE.

The low paid, the unemployed and non-home owners are the least likely to have BTE. This is because it is commonly attached to household and motor policies. The Office for National Statistics and many voluntary sector organisations compile data on the characteristics of the low paid and those living in poverty. It must therefore be possible for the government, working with the insurance industry, to undertake an analysis of the characteristics of those with BTE.

A number of potential impacts have not been considered either by the IA or the EA. These include the fiscal impacts of reduced case volume and therefore the impact on tax payers.

The main channels through which the proposals will reduce government revenues are:

- taxes on the revenues of law firms serving claimants;
- The reduction in the recovery of expenditures related to personal injuries by public sector bodies such as the NHS, local authorities and other public sector employers (such as medical costs and social care);
- social security benefits paid as a result of an accident, injury or disease, where a compensation payment has been made (Compensation Recovery Scheme).

10. Please provide evidence of any ways in which the procedure under current arrangements affects people with different protected equality characteristics.

We refer to our response to Q9 above.

11. Do you consider that the introduction of independent medical panels to assess whiplash injuries will affect people with protected equality characteristics? If so, please give details.

We cannot comment without more information about the panels. See our response to Q3 above.

12. Do you consider that an increase in the small claims limit for Whiplash/RTA personal injury claims from £1,000 to £5,000 will affect people with protected equality characteristics? If so, please give details.

We refer to our response to Q9 above.

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