

Department of Health – Introducing Fixed
Recoverable Costs in lower value clinical
negligence claims

Consultation response
by Thompsons Solicitors

May 2017

About us

1. Thompsons is a UK-wide law firm with a network of offices across the UK, including the separate legal jurisdictions of Scotland and Northern Ireland. As the largest trade union and personal injury law firm in the UK, we specialise in personal injury and employment law for trade union members and their families, and private clients. At any one time we will, as a firm, be handling over 50,000 cases.
2. The medical negligence team at Thompsons Solicitors works exclusively for medical negligence clients, using a wealth of experience in this specialist area of law to only act for claimants, never for defendants.
3. The dedicated team includes solicitors who are members of the Law Society's Clinical Negligence Accreditation Scheme and/or Action Against Medical Accidents' (AvMA) referral panel.
4. The firm participates regularly in government consultations, on a wide range of issues relevant to our clients.

Introduction

5. As a firm, we are fundamentally opposed to the expansion of fixed costs and believe that there are no grounds for their introduction in clinical negligence claims.
6. In any event, the decision as to whether fixed costs should be introduced in clinical negligence cases should be deferred at least until publication of the National Audit Office's study 'Managing the costs of clinical negligence in trusts', expected later on this year.
7. As fixed costs have been introduced and expanded over the last eight years in personal injury (PI) cases worth up to £25,000, we have seen their negative impact on access to justice for injured victims resulting in an increased inequality of arms between the claimant and the defendant.
8. In clinical negligence, the introduction of fixed costs has potential to create even more harm than in mainstream PI. Clinical negligence cases are generally too complicated and unpredictable for fixed costs to be appropriate.

Firstly, in the majority of PI cases, the process of evaluating the merits of the claim and its value to the claimant is reasonably straightforward. However, in clinical negligence cases, lawyers and claimants must usually obtain at least two medical reports before any sensible assessment of the claim's merits can be made. This means the time taken to advance a claim can be lengthy and can vary considerably between two cases of apparently similar value and complexity.

A fixed costs system in clinical negligence would tend to apply unfair pressure on claimant-side lawyers to make overly-quick decisions on cases, potentially causing lawyers either to proceed with a case without sufficient evidence or to decline to act on cases of genuine but uncertain merit. It could also lead to letters of claim being submitted without a full investigation, which in turn could increase the number of cases reported to the NHSR and therefore increase their costs, rather than reduce them.

9. Since the introduction of fixed costs in PI cases, we have seen a general trend of junior staff doing more of the work on cases to ensure that cases can still be run viably. This trend would be most concerning in clinical negligence cases. Due to their complexity these cases require a high degree of input from senior legal professionals. It would be inappropriate for much or all of the work on cases to be delegated to junior staff. To do so would be a dereliction of a solicitor's duty to their client.

A fixed costs system would either lead to less qualified staff working on cases – meaning injured victims may not get the full compensation they are due – or claimants having to pay the additional costs from their compensation, which they should be able to invest in their ongoing care and treatment needs. Neither of these situations would be desirable in the first-class justice system we all want to see.

The fact that the consultation refers to the fact that most clinical negligence cases of fast-track value are allocated to the multi-track, is clear evidence of the complexities involved. These cases become subject to costs budgeting and therefore the costs are clearly managed by the court, this making a fixed costs regime unnecessary.

10. The consultation document proposes excluding infant fatalities from any fixed costs regime. We welcome this but cannot see how any fatal cases – infant or otherwise – can be justified for inclusion in a fixed costs system. Fatality cases are invariably complex, both legally and emotionally, and where families have lost a loved one through negligence it must be right that their solicitors should be able to recover reasonable, necessary and proportionate costs.
11. The government's consultation suggests that the current proposals are being brought forward in order to bring down NHS litigation costs – money which could otherwise be spent on key clinical services. We agree that more money must be put into frontline services. Nevertheless, the fact that litigation costs are rising while funding for the NHS is falling, in real terms, is no coincidence. Highly-trained medical professionals are being asked to work increasingly long hours, with less rest time and more patients to treat. The pressure on doctors and nurses is extraordinarily high. This is an environment which makes mistakes more likely yet the government's proposals are not addressing these fundamental dynamics.
12. The government should instead be properly funding the NHS and should be training and employing more staff and investing in better equipment to ensure that fewer patients are injured in the course of their treatment. This would be the most effective and sustainable way of reducing the cost of clinical negligence litigation.
13. Furthermore, in the first instance a claimant in a medical negligence case initiates the process through advancing a complaint which the NHS can investigate and respond to. If liability were admitted, the costs of advancing a case on breach and liability are avoided. If the NHS is really interested in avoiding unnecessary costs they should embrace this part of the procedure rather than forcing legal involvement.
14. We would like to see the NHS make better attempts at resolving matters when complaints are made. As it stands the system is so slow and laborious many people do not bother with the process at all. A clear system which sets out response periods would be helpful both to the NHS itself and those who have been affected.
15. The case against fixed costs may be summarised as follows:
- a) It is morally right that when someone has caused injury they should meet not only the compensation for the injury but also the full reasonable, necessary and proportionate costs incurred by the victim in obtaining proper damages. This is the basic principle of social justice – “the polluter pays”.
 - b) Fixed costs remove the financial incentives on insurers to ‘behave’ in litigation. Where defendants can run all manner of fanciful arguments with no fear of punishment through increased cost liability, a perverse incentive is created to deny the undeniable and contest the unarguable in order to force claimants' solicitors to incur costs which cannot be recovered.

If the application of fixed costs is to be extended, we submit that it must be done in association with a mechanism allowing for exit to a standard costs regime which is applied routinely (and not just in 'exceptional' cases), to ensure proper, reasonable and consistent costs are recoverable. Factors such as conduct, complexity and public importance would need to be some of the relevant considerations.

- c) It is notable that those fixed costs already applied have elicited changes in the legal services market place. A dramatic squeeze on firms' operating models has led to ever greater consolidation and alternative ownership models which move away from traditional, small and medium, solicitor-owned firms in favour of large, corporate-led entities which may be managed far more aggressively in order to seek swifter, higher returns for corporate investors. This in turn has led to firms going out of business or getting into major difficulties as witnessed in the notorious example of Slater and Gordon.¹
- d) Some unscrupulous lawyers unfortunately respond to fixed costs by under-settling cases rather than pursuing them rigorously and thoroughly in the best interests of their clients. Such behaviour allows for an unfair competitive advantage against more professional rivals by the recovery of the same fixed costs for less work done. This is precisely what happened in the miners' compensation schemes where Thompsons' average damages were up to 300% higher than other major firms'.²
- e) On conclusion of a matter, if the defendants do not agree with any costs claimed, they have the right to challenge them by way of the Detailed Assessment process and can recover the costs of doing so if they make an early offer which is not beaten on assessment. In our experience the defendants engage with this procedure and a tiny proportion of cases (less than 5%) proceed to a formal Detailed Assessment by the court. To us, this is evidence of an effective, robust system.

The cries by defendants that the system is flawed and that we need the simplicity and certainty of fixed costs are, for us, no more than pleas for special treatment by using fixed costs as a means for the lowering of recoverable costs.

- f) Much of the money paid out by clinical negligence defendants in legal costs does not consist of solicitors' profit costs, but rather of expert fees, court fees and after the event (ATE) insurance premiums. Frequently, insurers benefit from high costs through extortionate ATE premiums which bear no resemblance to the actual figure necessary. So while the legal sector is being attacked for high litigation costs, we would suggest that there should be increased focus on insurance premiums.
16. The original fixed costs Rules were intended to apply to fast-track value cases up to a value of £25,000. That meant that difficult multi-track cases were being caught by fast-track fixed costs. Following the case of *Qader v Esure Ltd* [2016] EWCA Civ 1109, amendments to the Rules were set to clarify that fixed costs do not apply to multi-track claims. Briggs LJ, giving judgment in *Qader*, made a direct suggestion that the Rules Committee revisit the wording of the fixed costs Rules. He proposed that they add the words "...and for so long as the claim is not allocated to the multi-track..." to avoid any doubt that has led to the changes which took effect on 6 April 2017. This is helpful in cases which begin in the portal but then end up being allocated to the multi-track. In those circumstances fixed costs would not apply.

¹ <https://www.lawgazette.co.uk/practice/slater-and-gordon-plans-uk-closures-after-493m-losses/5053906.article>

² Please see our response to Lord Justice Jackson's Review of Fixed Recoverable Costs <https://www.thompsonstradeunion.law/media/2072/lord-justice-jackson-review-of-fixed-recoverable-costs-january-2017-thompsons-solicitors.pdf>

17. As part of the April 2017 changes, all references to “but not more than £25,000” have been removed so cases allocated to the multi-track which settle for less than £25,000 would be excluded from fixed costs. Many clinical negligence cases would be fast-track value but, because of their complexity, would be multi-track if issued. On such cases, fast-track costs should not apply.
18. The headline figure of claimants’ solicitors’ costs totalling £80m is incorrect and is contradicted by Professor Fenn's figures.³
19. The mean cost to a solicitors’ firm for a non-litigated case is £6,063.05. As shown in Professor Fenn’s research showing clinical negligence claims against the NHSLA which were closed between April 2012 and April 2016, there were 3,257 pre-issue cases worth under £25,000, therefore total expenditure is £20m for profit costs.
20. The government professes a wish to deal with unscrupulous solicitors yet the mean figures suggest that the majority of solicitors do not overcharge. The mean cost for litigated cases equates to £13m, giving a total profit cost for all cases, whether issued or not, of £33m. In addition, ATE premiums amount to £13m. The remainder would be taken up in disbursements (including excessive court fees) medical reports and VAT. The solicitors’ fees therefore only amount to 66% of damages. The disbursements, including VAT, exceed the solicitor's costs by a substantial amount.
21. It is suggested in the consultation that the expert's fees should be limited to £1,200 per expert and that this should apply to both the claimant and the defendants. It would, however, be difficult to instruct an experienced expert for this sum. An experienced expert, necessary in clinical negligence cases, can expect a minimum of £1,700 in fees, and even then higher rates would have to be agreed for paediatricians, neurosurgeons and professionals in other highly complex medical specialisms.
22. The specimen protocol suggests claimants should disclose their reports unilaterally, with the letter of claim. This is unacceptable and would put the claimant at a significant disadvantage. Clinical negligence reports on breach and causation, have always been disclosed simultaneously, which protects the claimant from having to disclose their case at an early stage, allowing the Defendant to prepare a report, having knowledge of the claimant’s claim. Concurrent exchange will significantly weaken the claimant’s position and make it more likely that litigation will be necessary.
23. Once a case is allocated to the multi-track it will be subjected to costs budgeting. The majority of cases are allocated to the multi-track. This has been the situation since 2013. This means that all litigated cases settled since that time have had the costs managed and therefore should be indicative of a level of costs approved by the courts. Therefore, fixed costs are unnecessary, as stated in our response to Lord Justice Jackson’s Review of Fixed Recoverable Costs in January 2017⁴, and any fixed cost regime should be based on the assessed costs from actual cases, rather than the fanciful wish list of the NHSLA.
24. In respect of the fixed costs set out in the consultation paper, due to the number of claims in which Thompsons has to decline to act, it is not realistic to accept a reduction in fees for early admission. We believe Thompsons’ position here reflects the state of claimant side law firms generally. Even where the NHSLA makes a concession on breach, it often maintains its arguments on causation and quantum which protract the case unnecessarily. We cannot see any reason why an admission should lead to a reduction in the claimant’s ability to receive costs.
25. If the case settles following issue of a case, where the defendant should have admitted the case under the pre-action protocol, cost penalties should be applied to disincentivise this behaviour.

³ 4.1 on p16 of the consultation document

⁴ Please see our response to Lord Justice Jackson’s Review of Fixed Recoverable Costs <https://www.thompsonstradeunion.law/media/2072/lord-justice-jackson-review-of-fixed-recoverable-costs-january-2017-thompsons-solicitors.pdf>

Response to consultation questions

Question 1: Do you agree that Fixed Recoverable Costs for lower value clinical negligence claims should be introduced on a mandatory basis?

26. Fixed costs should not be introduced in clinical negligence claims under any circumstances so we do not agree with the premise of this question given that it presupposes support for a fixed costs system.
27. Our experience of dealing with fixed costs in PI claims has led us to the inescapable conclusion that they are not compatible with a fair environment for litigation except perhaps in the most straightforward of cases.
28. If a fixed cost system must be introduced – despite all the good evidence and arguments against it, then:
 - a) The protocol involved must provide a level playing field for both parties and the costs involved must be adequate to allow claimants full access to justice. There should be adequate escape points from the fixed costs regime to allow the claimant to fully investigate the issues involved and a penalty should be applied on the defendant for delays for which they are responsible.
 - b) Certain cases should always be excluded from any fixed costs system, including but not limited to clinical negligence, fatal claims, group actions and matters of public importance these are examples of cases that are always far too complicated to have costs limited.

Question 2: Do you agree that Fixed Recoverable Costs should apply in clinical negligence claims:

Option A: above £1,000 and below £25,000 (preferred)

Option B: another proposal

29. Fixed costs should not be introduced in clinical negligence claims under any circumstances. We fundamentally disagree with the premise of this question given that it presupposes support for a fixed costs system.
30. Following on from the points raised above, if fixed costs were to be introduced they would only be suitable for cases which rely on one expert and which can be disposed of in a one day trial. These would be matters which would normally be allocated to the fast-track. Multitrack cases are complex and require a considerable amount of work which cannot correctly be budgeted for in a fixed cost regime. These are, in any case, correctly managed by the court under the existing costs budgeting regime.

Question 3: Which option for implementation do you agree with?:

Option 1: all cases in which the letter of claim is sent on or after the proposed implementation date.

Option 2: all adverse incidents after the date of implementation.

Option 3: another proposal

31. Fixed costs should not be introduced in clinical negligence claims under any circumstances. We do not agree with the premise of this question given that it presupposes support for a fixed costs system.
32. If one is to be introduced, implementation of a fixed costs regime should apply only to all adverse incidents which occur after the date of implementation. This would prevent an unnecessary log jam of cases caused as a result of existing claimants seeking to make claims before the date of implementation.

Question 4: Looking at the approach (not the level of fixed recoverable costs), do you prefer:

Option 1: Staged Flat Fee Arrangement

Option 2: Staged Flat Fee Arrangement plus % of damages awarded: do you agree with the percentage of damages?

Option 3: Early Admission of Liability Arrangement: do you agree with the percentage of damages for early resolution?

Option 4: Cost Analysis Approach: do you agree with the percentage of damages and/or the percentage for early resolution?

Option 5: Another Proposal

33. Fixed costs should not be introduced in clinical negligence claims under any circumstances so we do not agree with the premise of this question given that it presupposes support for a fixed costs system.
34. The approach to fixed costs should follow the costs analysis approach, staged and to involve a percentage of the damages. That there should not be a percentage deduction for the defendants if they make an early admission. This does not occur in the fixed matrix for PI cases.
35. It is also the case that clinical negligence cases can be more complicated than even employers' liability claims let alone RTA claims, and therefore the costs recoverable should be considerably higher than for those cases. This is not currently reflected by the options suggested by the NHS, although it is acknowledged by Professor Fenn⁵, to some extent.
36. Once a case is allocated to the multi-track, it is subjected to costs budgeting and majority of cases are allocated to the multi-track. This has been the situation since 2013. This means that all litigated cases settled since that time have had the costs managed and therefore should be indicative of a level of costs approved by the courts. Therefore, fixed costs are unnecessary and any fixed cost regime should be based on the assessed costs from actual cases, rather than the fanciful wish list of the NHSLA.

Question 5: Do you believe that there should be a maximum cap of £1,200 applied to recoverable expert fees for both defendant and claimant lawyers?

37. Fixed costs should not be introduced in clinical negligence claims under any circumstances so we do not agree with the premise of this question given that it presupposed support for a fixed costs system.
38. The suggestion of a cap on experts' fees at £1,200 is unacceptable. The typical cost of a report at present is at least £1,700 plus VAT. A report from a consultant in a more unusual field of medicine can cost between £2,000 and £4,000 plus VAT. Ordinary claimants ought to be able to access expert opinion absent restriction on cost, a restriction that a wealthy insurer would not be faced with by way of reply. Claimants should be able to operate on a level playing field in litigation.
39. Capping costs would reduce access to justice for claimants. Defendants would be able to fund the unrecoverable portion of a report. Meanwhile, the claimant would not be able to bear the excess of any non-recoverable amount and would therefore be limited to using reports from inexperienced experts who would not have the time or ability to provide equally robust evidence.

⁵ Evaluating the proposed fixed costs for clinical negligence claims: An Independent Review – Professor Fenn – January 2017
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/586644/Annex_C_Fenn_report.pdf

Question 6: Expert fees could be reduced and the parties assisted in establishing an agreed position on liability by the instruction of single joint experts on breach of duty, causation, condition and prognosis or all three. Should there be a presumption of a single joint expert and, if so, how would this operate?

40. Claimants cannot agree to the early, unilateral exchange of evidence. This would allow the defendants to prepare their own evidence having full knowledge of the claimant's expert and their viewpoint. This would not follow other areas of PI litigation, for example disease cases, where engineering reports to establish breach and causation are still exchanged simultaneously.
41. A better option would be an early mediation discussion once both parties had obtained their breach, causation reports to take place before listing questionnaires had been filed. This is not compulsory at present and we urge the government to give further thought to whether it should be made so.

Question 7: Do you agree with the concept of an early exchange of evidence? If no, do you have any other ideas to encourage parties to come to an early conclusion about breach of duty and causation?

42. The trial costs are only suitable for fast-track cases. We have already stated that any case involving two experts for each party would require a two day trial and would therefore require allocation to the multi-track. The directions for fixed costs would therefore only be suitable for low value cases allocated to the fast-track. For a multi-track case, highly experienced counsel would be required. As stated on the question of costs allowed for medical reports, restricting costs would affect the claimant more than the defendant. Because of QOCS, the defendant would not expect to recover costs and would pay for expert counsel. To restrict the limit to an unacceptable amount would restrict access to justice.
43. We can agree with the points set out for multiple claimants, technical exemptions and exit points, except that the circumstances should not be "exceptional". As there are many reasons why costs would exceed the needs of the fixed rate regime, an unduly high burden should not be placed on the claimant. The reason for exit could be as straightforward as instruction of a second expert, which would normally take the case out of the scheme in any case.
44. In respect of the number of experts, the rule should be that where the case requires more than one expert on breach and causation, it should not be allocated to a fixed costs regime.
45. In respect of fatalities, this should relate to all fatalities where the law is complex and grants of probate are required. The low value of claims where there are no dependants under the Fatal Accidents Act 1976 should not mask the complexity or high profile of such claims.
46. We agree with the points regarding interim applications and London weighting.

Question 8: Do you agree with the proposals in relation to:

- Trial costs
 - Multiple claimants
 - Exit points
 - Technical exemptions
 - Where the number of experts reasonably required by both sides on issues of breach and causation exceeds a total of two per party
 - Child fatalities
 - Interim applications
 - London weighting
47. Fixed costs should not be introduced in clinical negligence claims under any circumstances so we do not agree with the premise of this question given that it presupposes support for a fixed costs system.
48. The trial costs are only suitable for fast-track cases. We have already stated that any case involving two experts for each party would require a two day trial and would therefore require allocation to the multi-track. The directions for fixed costs would therefore only be suitable for low value cases allocated to the fast-track. For a multi-track case, highly experienced counsel would be required. As stated on the question of costs allowed for medical reports, restricting costs would affect the claimant more than the defendant. Because of QOCS⁶, the defendant would not expect to recover costs and would pay for expert counsel. To restrict the limit to an unacceptable amount would restrict access to justice.
49. We can agree with the points set out for multiple claimants, technical exemptions and exit points, except that the circumstances should not need to be “exceptional”. As there are many reasons why costs would exceed the needs of the fixed rate regime, an unduly high burden should not be placed on the claimant. The reason for exit could be as straightforward as instruction of a second expert, which would normally take the case out of the scheme in any event.
50. In respect of the number of experts, the rule should be that where the case requires more than one expert on breach and causation, it should not be allocated to a fixed costs regime.
51. In respect of fatalities, this should relate to all fatalities where the law is complex and grants of probate are required. The low value of claims where there are no dependants under the Fatal Accidents Act 1976 should not mask the complexity or high profile of such claims.
52. We agree with the points regarding interim applications and London weighting.
53. The consultation has failed to address the high cost of ATE premiums which are used in 95% of all cases.
54. The government should also ensure that firms carrying out this type of work are specialists who have membership of the Law Society or AVMA panel. Premiums are lower for specialist firms and a cap on the premium would be a better course of action for reducing costs than capping medical fees.

⁶ Qualified one way costs shifting

Question 9: Are there any further incentives or mechanisms that could be included in the Civil Procedure Rules or Pre-Action Protocol to encourage less adversarial behaviours on the part of all parties involved in lower value clinical negligence claims, for example use of an Alternative Dispute Resolution process (ADR)? This would include both defendant and the claimant lawyers, defence organisations including NHS LA, the professionals and/or the organisation involved.

55. A proper analysis of profit costs and disbursements, including ATE premiums post-LASPO (details of which we would be happy to supply to the Department), would show that costs have already reduced dramatically since 2013. Reputable firms are not over-charging and provide a quality service. This should be enough to satisfy the government that costs budgeting has correctly managed the process for multi-track cases and that these cases should not be included within a fixed cost system.
56. Thompsons would be pleased to see less adversarial behaviour and would be happy to discuss our views on this issue in more depth with the Department of Health.

Question 10: Please provide any further data or evidence that you think would assist consideration of the proposal, particularly for other than NHS provision.

We would be interested in hearing views on: the scale of expected savings if Fixed Recoverable Costs outlined is introduced; the expected growth in the number of claims received and settled over the next 10 years to help in modelling the impact of the proposals; any details on the number and size of legal firms involved in clinical negligence (primarily as claimant lawyers), any information on the likely administrative savings and set up costs due to introduction of Fixed Recoverable Costs.

57. Fixed costs should not be introduced in clinical negligence claims under any circumstances so we do not agree with the premise of this question given that it presupposes support for a fixed costs system.
58. If fixed costs must be introduced, a simplified system would be required to speed up the process for low value claims. However, this would require a change of attitude within the defendant organisations and a real attempt made by them to accept responsibility at an earlier stage than is currently the norm. Defendants also need to comply with time limits and directions of the court, without having to apply for an extension.
59. Clinical negligence cases are complex and certainly cannot be handled by Litigants in Person. Litigants in Person would not be assisted by pro bono groups who would be unable to develop the high level of technical, legal expertise required to be effective. Many claimants in clinical negligence have suffered traumatic incidents or bereavements. The value of the case should not be the overriding factor to assess to justice in any case.
60. To cut the fixed costs to a level where the claimant cannot receive expert legal advice would obviously reduce access to justice and would produce a serious inequality between the respective levels of expertise on which the defendants and the claimant can call.

Question 11: The Government has prepared an initial assessment of the impact of Fixed Recoverable Costs on equalities, health inequalities and families. This assessment will be updated as a result of the consultation. Please give your view on the impact of these proposals on: Age; Gender; Disability; Race; Religion or belief; Sexual orientation; Pregnancy and maternity; Carers; Health Inequalities and Families.

61. We do not have anything to add on this point.

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