Bar Council response to the Reducing Legal Costs in Clinical Negligence Claims pre-consultation paper

1. This is the response of the General Council of the Bar of England and Wales (the Bar Council) to the Department of Health’s pre-consultation paper entitled Reducing Costs in Clinical Negligence Claims.¹

2. The Bar Council represents over 15,000 barristers in England and Wales. It promotes the Bar’s high quality specialist advocacy and advisory services; fair access to justice for all; the highest standards of ethics, equality and diversity across the profession; and the development of business opportunities for barristers at home and abroad.

3. A strong and independent Bar exists to serve the public and is crucial to the administration of justice. As specialist, independent advocates, barristers enable people to uphold their legal rights and duties, often acting on behalf of the most vulnerable members of society. The Bar makes a vital contribution to the efficient operation of criminal and civil courts. It provides a pool of talented men and women from increasingly diverse backgrounds from which a significant proportion of the judiciary is drawn, on whose independence the Rule of Law and our democratic way of life depend. The Bar Council is the Approved Regulator for the Bar of England and Wales. It discharges its regulatory functions through the independent Bar Standards Board.

Overview

4. The Bar Council strongly opposes the introduction of a Fixed Recoverable Costs (FRC) scheme for clinical negligence claims.

5. Part I of the Legal Aid, Sentencing and Punishment of Offenders Act 2012 (LASPO) withdrew all but the highest value claims involving birth and neonatal brain injury from the scope of legal aid. Most clinical negligence claims are therefore funded by conditional fee agreements. Part II of LASPO ended the recoverability of success fees and most of the cost of ATE insurance policies from defendants in these claims.

6. Amendments to the Civil Procedure Rules 1998 (CPR) included three significant revisions which affect clinical negligence claims: first, amendment to the overriding objective to require the court to deal with cases justly and at proportionate cost; second, the introduction

of compulsory costs budgeting; and third, ensuring that on assessment of costs on the standard basis, even if costs were reasonably and indeed necessarily incurred, ensuring that they will be disallowed or reduced if disproportionate in amount.

7. The parties are obliged to exchange and file costs budgets in advance of the first case management conference. The Court will make a costs management order unless the Court considers that the litigation can be conducted justly and at proportionate costs without such an order. When revising and/or approving costs budgets, judges consider every case on its individual merits. They are duty bound to apply the principle of proportionality, which has regard not only to the value of the claim but also other factors including the complexity of the issues involved. For a clinical negligence claimant, the practical effect of a costs management order is prima facie to limit recoverable costs to those in each phase of the approved budget. Following the conclusion of the claim, if the defendant considers the claimant’s costs to be excessive, the detailed assessment process is available, at which apply the revised costs rules will serve to reduce any costs are disproportionate.

8. The combination of (1) the abolition of the recoverability of success fees and most ATE premiums in CFA cases, and (2) the amendments to the CPR, is certain to result in a significant reduction in the costs recoverable from defendants in clinical negligence claims.

9. Because the relevant provisions of LASPO only came into force on 1 April 2013, most claims which have been resolved to date remain under the ‘old’ funding regime. Few costs-budgeted cases have reached their conclusion. The real and significant impact of these changes in reducing costs is yet to become apparent.

10. Patients injured by negligent medical care are amongst the most vulnerable in society. Clinical negligence claims are detailed, complex and difficult. They require specialist and experienced legal advice and expert evidence. The facts upon which such claims are based, the injuries involved, and patients’ individual circumstances are all highly variable; more so than in other areas of litigation where FRC schemes exist.

11. The value of damages recovered is a very poor predictor of the extent of the legal and expert input required to establish liability and ensure that such patients receive proper compensation for injuries. The introduction of a FRC scheme, which does not allow for the factors individual to each case, risks making this highly complex and specialised area of litigation financially unviable for solicitors, counsel and medical experts.

12. The Bar Council has grave concerns about the detrimental impact that a FRC scheme will have on access to justice.

13. The costs regime under the CPR pays proper attention to the individual circumstances of each case: the proportionality of costs is determined not just by the level of damages, but also additional factors such as the complexity of the issues involved and the conduct of the defendant. The Bar Council considers that the current regime (particularly costs budgeting and detailed assessment) operates as a fair and sufficient control on costs in clinical negligence claims.
14. With that overriding position, the Bar Council responds to the Pre-Consultation Questions as follows:

**Question 1:** The Government proposes to introduce fixed recoverable costs for all cases where the letter of claim is sent on, or after, the proposed implementation date of 1st October 2016. Although this could affect cases where solicitors are already instructed but a letter of claim has not been sent, it leaves at least 12 months for such claimants to submit a letter of claim and so avoid the application of the proposed fixed recoverable costs regime.

Do you agree with this proposed approach to the transitional provisions? Yes or No

If your answer is no, please explain how you consider the transitional provision should be set, having regard to the need for the effect of fixed recoverable costs to apply as soon as practicable.

15. No.

16. A claimant who has instructed a solicitor to investigate a claim will have entered into a retainer (almost always under a conditional fee agreement) in which he/she is contractually obligated to pay fees for legal services and disbursements (the fees of experts and counsel) at an agreed rate if the claim succeeds. Costs which are reasonably incurred but are not recovered from the defendant usually remain payable by the claimant. Unless they are waived, these costs reduce the overall sums received by the claimant.

17. A FRC scheme will potentially cap the amount of reasonable costs recoverable from the defendant. The Pre-Consultation implies that the FRC scheme is intended to reduce recoverable costs overall. If so, costs which would currently be recoverable from the defendant following assessment on the standard basis would not be recoverable under the FRC scheme, despite being necessarily incurred, reasonable and proportionate. If this reduction in recoverable costs is capable of having retrospective effect on existing retainers, the Bar Council believes claimants will experience a greater and unpredictable reduction in the financial benefit they derive from their litigation; a situation which was not in their contemplation when entering into their retainer with the solicitor. This is unfair.

18. The Bar Council therefore suggests that the any FRC scheme should apply to all claims in which a solicitor is first instructed after the date upon which scheme is introduced.

**Question 2:** The Government considers that the Fixed Recoverable Costs (FRC) scheme could be applied in clinical negligence to cases up to a value of £250,000 in damages and will apply both to pre-issue costs and post-issue, pre-trial costs.

Up to what value of damages do you think should be applied to the FRC regime?

- a. Up to £25,000
- b. £25,001 - £50,000
- c. £50,000 - £100,000
- d. £100,000 to £250,000

Why do you believe this to be the right threshold?
19. In clinical negligence claims, the level of damages recovered frequently bears little relation to the complexity of the claim and consequent professional resources (lawyers and experts) required to pursue it.

20. Take the following illustration:

16.1 Case 1: A fracture was fixed inadequately by an orthopaedic surgeon, resulting in the claimant suffering months off work before remedial surgery returned him to his pre-injury condition.

16.2 Case 2: A retired patient underwent coronary bypass surgery, suffered ongoing breathing difficulties on the ward, was reviewed by the cardiothoracic, ENT and physiotherapy teams over a number of days, but suffered a respiratory arrest causing brain damage, which led to significant professional and family care for six months before she died.

21. Both claims could have a value of less than £100,000. Case 1 would require factual evidence from the claimant and expert evidence from a single expert, an orthopaedic surgeon. Yet in Case 2, the factual evidence would be from each of the family members who witnessed the patients’ condition on the ward and provided care after her injury; and it would also require expert evidence from, at the very least, a cardiothoracic surgeon, ENT surgeon, a physiotherapist, an intensivist and a neurologist.

22. The costs to be incurred would differ vastly between Case 1 and Case 2.

23. It is unclear to the Bar Council whether the Government proposes a single fixed fee for a case of a particular value irrespective of its complexity and the extent of the evidence required. Under the current regime, these variable are rightly taken into account in determining the proportionality (and hence recoverability) of the claimant’s costs; both at the stage of costs budgeting and detailed assessment. If they are not to be taken into account in determining the level of fees payable to the claimant under an FRC, it is highly unlikely that lawyers will take on complex claims which potentially fall within the scheme.

24. There is a further difficulty linking the application of the FRC to the level of damages. Most clinical negligence claims are settled, taking account of the litigation risk which each party faces on liability. From a claimant’s perspective, this involves accepting a lower level of damages than he/she would otherwise recover at trial. If the application of the FRC scheme were to be arbitrarily linked to the level of damages recovered this is likely to operate as a significant disincentive to a claimant to compromise his/her claim at a level which properly reflects the litigation risks. This could well serve to increase costs for defendants.

25. If the applicability of a FRC scheme were linked solely to the level of damages recovered, the Bar Council contends that the threshold must be at a low level where (1) significant complexity is unlikely to arise; and (2) the applicability of the scheme is unlikely to prove a disincentive to settlement. With those criteria, the appropriate level would be up to £25,000 in value.
26. The Bar Council suggests that there should be judicial discretion to dis-apply any FRC scheme introduced in appropriate cases (see Question 4 below).

Question 3: The Government is also concerned with the number and cost of expert reports obtained in lower value cases, which can add to the disproportionate costs incurred. The Government is therefore considering a proposal to cap experts’ fees at a maximum recoverable sum which fairly reflects the likely number and cost of experts’ reports needed in such cases. Under this proposal, the cap would apply to all reports both on liability/causation and on quantum/diagnosis.

Do you agree that capping experts’ fees in this way would be a useful way forward? Yes or No

If your answer is no, how would you propose that the use of experts and the cost of their reports might best be managed, particularly before the first case management conference?

27. No.

28. The Bar Council does not agree that additional steps are required to manage the use or cost of experts before the first case management conference. Costs and case management orders and the safeguard of detailed assessment are effective in managing both the scope and cost of expert evidence.

29. CPR r.35.1 requires the Court to restrict expert evidence to “… that which is reasonably required to resolve the proceedings.” The Court’s permission is required to rely upon expert evidence. In deciding whether to grant permission for the evidence, the Court already has to consider an estimate of costs of the expert and the issues which the evidence will address. Experience indicates that District Judges and Masters fulfil their duties in relation to the restriction of expert evidence, refusing permission to rely upon expert evidence where appropriate. If permission is not given, the costs of that expert evidence are simply not recovered from the defendant at all.

30. If permission is given to rely upon expert evidence that does not mean that its costs are recoverable in full. Within the costs budgeting process and/or detailed assessment of costs at the conclusion of the case the Court will only order the defendant to pay costs to the claimant on the standard basis if they are reasonably incurred and proportionate.

31. Expert medical evidence is essential in claims of this nature. Clinicians have an entirely free choice whether to undertake medico-legal work. Evidence is frequently required in disciplines where there are small numbers of experts willing to act as such. Experience has shown that many experts are unwilling to act at the rates now payable for ‘legal aid’ cases. Capping expert fees at anything other than a fair professional rate would act as a deterrent to experts accepting instructions.

32. The Bar Council considers that (1) the current scheme for controlling the costs of expert evidence within the CPR is robust and effective; and (2) capping expert costs would inevitably dilute the quality and availability of appropriate expert witnesses.

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2 CPR r.35.4(1)
3 CPR r.35.4(2)
Question 4: Do you agree that no special provisions will be required to control behaviour in clinical negligence claims? Yes or No

If no, what sort of Rules do you feel would assist in controlling behaviour alongside Fixed Recoverable Costs?

33. No.

34. If any FRC scheme is introduced, there must be a judicial discretion to disapply it in whole or part and award costs on either the standard or indemnity basis:

- Having regard to the complexity of the litigation
- In circumstances where the conduct of the defendant makes it unjust not to do so, and
- Any wider factors involved in the proceedings, such as reputation or public importance.

35. Any FRC scheme would also need to retain a sufficient costs penalty for a defendant who fails to beat a claimant’s Part 36 offer.

Question 5: For pre-issue costs, the Government is proposing a sliding scale for the fixed recoverable costs, calculated by reference to the level of damages agreed. This type of approach has been used successfully with other fixed recoverable costs regimes; it has obvious benefits in terms of applying proportionality and it is also acknowledged that it should encourage the solicitor to ensure that damages are recovered at the appropriate level. (The proposal for post-issue, pre-trial costs is likely to be for fixed costs in various stages according to when the case is settled)

Do you agree with a sliding scale pre-issue? Yes or No

If no, please explain what you would consider to be a more appropriate fixed costs structure for pre-issue cases

36. Not as proposed: for the reasons already outlined (see Question 2 above) any fixed cost structure must take account of complexity and the number of expert witnesses involved in addition to the value of the claim.

If an FRC scheme is to be introduced, it must be designed very carefully indeed otherwise it may bring two undesirable elements: first, the potential for unintended incentives to begin proceedings (or, looked at from the opposite perspective, unintended disincentives to settle pre-litigation) which would not otherwise exist; and second, unfairness and inconsistency in situations in which the commencement of proceedings cannot be avoided (e.g. if a limitation deadline needs to be met).

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August 2015
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