BAR COUNCIL RESPONSE
TO THE CONSULTATION ON INTRODUCING FIXED RECOVERABLE COSTS IN LOWER VALUE CLINICAL NEGLIGENCE CLAIMS

INTRODUCTION

1. This is the response of the General Council of the Bar of England and Wales ("**the Bar Council**") to the consultation Introducing Fixed Recoverable Costs in Lower Value Clinical Negligence Claims published by the Department of Health in January 2017.[1]

2. The Bar Council represents over 16,000 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.

SUMMARY OF BAR COUNCIL'S POSITION

4. The Bar Council opposes the introduction of Fixed Recoverable Costs ("FRC") to lower value clinical negligence claims, with the *possible* exception for those allocated to the fast track.

[1] 'Introducing Fixed Recoverable Costs in Lower Value Clinical Negligence Claims: A Consultation' (2017)https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/586641/FRC_consultation.pdf

5. The Bar Council's central concern is in relation to access to justice. The FRC regime proposed by the Department of Health for clinical negligence claims with a value of between £1,000 and £25,000 will save the NHS and healthcare providers expense, but at the price of denying access to justice to many patients injured by negligent medical treatment. The Bar Council does not consider that consequence to be in the public interest.

6. The Bar Council considers that the proposals are premature in any event:

7. In April 2013, significant reforms of civil litigation funding and procedure were introduced: the abolition of the recoverability of success fees in claims funded by conditional fee agreements, a more stringent test of proportionality for recoverable costs, and compulsory costs budgeting. These reforms will achieve a significant reduction in the cost of litigation to healthcare defendants and ensure that recoverable costs are proportionate for each individual case. The economic case for extending FRC to multi-track claims between £1,000 and £25,000 in value is largely based upon data from cases to which this new regime did not apply. Until the measures introduced in April 2013 have flowed through the system and their effect properly analysed, any further changes would be flawed. In particular, the "new" proportionality test and costs budgeting provisions will allow the Court to control costs in cases beyond the fast-track whilst balancing the rights of the parties in the more complex cases.

8. Lord Justice Jackson is due to report on 31 July 2017 on a proposed regime of FRC. Clinical negligence claims fall within the scope of his review. He has been receiving data in relation to costs budgeting and costs recovered on assessment more current than that relied upon by the Department of Health. This data will take better account of the 2013 reforms. Following his report, the Ministry of Justice will then frame and consult on proposals for FRC. Any introduction of FRC in clinical negligence should be dealt as part of that process, which will take account of better and more up-to-date evidence at an appropriate time as part of a package of fair and coherent reform.

ACCESS TO JUSTICE

9. The Bar Council recognises that NHS expenditure on clinical negligence claims has risen in 2015/2016 to nearly £1.5 billion, and that legal costs formed a substantial portion of that figure. Reducing the overall cost of clinical negligence to the NHS (and indeed, other healthcare providers) is a commendable aim.

10. Various potential reasons for the rise in the overall cost of clinical negligence litigation were canvassed in the responses to the 2015 Department of Health Reducing Costs in Clinical Negligence Claims Pre-consultation: a wider awareness of and willingness to sue; higher patient expectation; that medicine is more complex; poor

handling of patient complaints; more thorough investigations into the quantum of claims; changes in the law in some areas of quantum; the behaviour of claimant lawyers; but also the behaviour of defendants and their lawyers.[2] The Bar Council offers no view on the merits of these factors.

11. Patients who are injured by negligence in their medical treatment are amongst the most vulnerable in society. Clinical negligence claims are detailed, complex and difficult. They require specialist and experienced legal advisors and expert witnesses. The facts upon which such claims are based, the injuries involved, and patients' individual circumstances are all highly variable; far more so than in other areas of litigation where FRC schemes exist.

12. The Bar Council fully supports the principle that access to justice should be a priority for all clinical negligence claimants with claims worth between £1,000 and £25,000, not just the most straightforward or strongest. The introduction of fixed costs must accommodate and be consistent with the principle of access to justice.

13. Access to justice must be real and effective. A facet of this is that claimants must be able to retain as much of their damages as possible. Damages are not a windfall, but are compensation for a negligently inflicted injury and aim to put the claimant in the position she would have been in but for that injury and not to improve upon that position. The more they are eroded by legal costs, the more the principle of effective access to justice is eroded.

14. The effect of this consultation is to single out the costs of claimants' lawyers for particular intervention amongst the various factors which may be responsible for the rising financial burden of these claims.[3] The Department of Health has an obvious financial interest in reducing the cost of clinical negligence claims. The fact that these proposals emanate from, in practical terms, the funding body of most of the defendants to clinical negligence claims, means that they require particular scrutiny to ensure access to justice is preserved.

15. Take the following notional cases:

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[2] The National Audit Office is due to publish the results of its study *'Managing the costs of clinical negligence in trusts'* in summer of 2017. The study is examining will examine whether the Department of Health and the NHS LA (now NHS Resolution) understand what is causing the increase in clinical negligence costs, and evaluate their efforts to manage and reduce the costs associated with clinical negligence claims.

[3] The proposed FRC regime will not affect defendants in the same way, as qualified one-way costs shifting (QOCS) means that in the overwhelming majority of cases they will not recover their costs from unsuccessful claimants.

15.1. *Case 1:* A claimant fell onto his wrist. He attended the Accident and Emergency Department where he was x-rayed. A fracture of the scaphoid bone was missed by the junior doctor who interpreted the x-ray. He presented 6-weeks later with ongoing pain. He underwent surgery and was able to return to work in 6 months.

15.2. *Case 2:* A mother with a long history of psychiatric illness suffered a delay in the delivery of her baby. There were abnormalities on the CTG trace during the labour. No attempt was made to expedite delivery. When the fetal bradycardia was recognised, a crash call was put out but, despite undergoing attempted instrumental delivery, the baby was pronounced dead during resuscitation. The mother suffered an exacerbation of her psychiatric illness in the form of a bereavement reaction.

15.3. *Case 3:* A man cohabiting with his partner developed an acute onset of severe upper abdominal pain due to acute pancreatitis. He was admitted to Intensive Therapy Unit ("ITU") where he developed renal, cardiac, respiratory and clotting dysfunction, and then signs of sepsis. He underwent a wide range of investigations. He was managed by the ITU team with assistance from the surgical team. His condition fluctuated day by day before an intra-abdominal collection was suspected for which he underwent laparotomy, before succumbing to complications of his sepsis. He died two days later from septic complications. He would have died many months later due to the severity of his acute pancreatitis. Issues included whether sepsis should have been suspected from abnormal biochemical markers and clinical signs, whether the CT scan showed a sign of bowel perforation which was missed, and whether surgery should have been undertaken earlier.

16. Each of these cases would fall with the proposed FRC scheme, as their value is between £1,000 and £25,000 and they require no more than two experts. The costs to be incurred in investigating and pursuing each would differ significantly, yet they would be subject to the same 'one size fits all' approach:

16.1. The first case is by far the most straightforward: it relates to a single attendance, a discrete act of negligence (missing the fracture on x-ray) and would probably only require an Accident and Emergency expert.

16.2. The second case would require both an obstetric expert as well as a psychiatric expert, but the psychiatric report is likely to be complex and difficult given the pre-existing history of illness and the nature of the psychiatric injury resulting from the negligence alleged. Legally, the claim is far from straightforward given the difficulties involved in the categorisation of

the mother as a primary or secondary victim, and whether the control mechanisms for a secondary victim claim are met.

16.3. The third case would require both ITU and surgical experts. The medical records will be voluminous. The facts are detailed, highly technical and complex, requiring very close analysis by the experts. There are numerous different allegations of breach and potential paths of causation to consider.

17. In Table 4 at p.20 of his report (Annex C to the Consultation), Professor Fenn helpfully calculates the gap between the revenues claimant solicitors have received in recent years in cases valued at between £1,000 and £25,000 and those they would receive under Option 1 for the fixed costs regime (see footnote 14 to his report). His Table must be treated with some caution because of the difficulties in identifying which cases involved pre- or post- LASPO CFAs, and because the figures do not take account of the 'cap' on the recovery of success fees from clients that was introduced by Arts.4 and 5 of the Conditional Fee Agreements Order 2013. Nevertheless, the figures are alarming for claims in the bracket £1,000 to £25,000. If the proposed FRC were introduced, to maintain current revenue, claimant solicitors would have to make the following deductions from their client's damages or suffer a commensurate loss of profit:

- before the issue of proceedings, £5,658;
- after issue but before allocation, £22,687;
- between allocation and listing for trial, £25,584;
- after listing for trial, £25,303.

18. Even if the procedural rules are streamlined, and a different option is used to set FRC rates, it is clear that claimant solicitors will suffer a serious shortfall in recoverable costs.

19. There is no evidence that fixed costs will reduce what claimant lawyers will charge to their clients. It is completely speculative to assume that any improvement in the predictability of cash flow under an FRC regime will allow solicitors to reduce their profit costs.

20. Furthermore, the opportunities to cross-subsidise these claims by recovery of costs on higher value claims does not exist.

21. That is because:

21.1. Higher value claims are a minority of the overall basket of cases.

21.2. The costs recovered on those higher value claims are based upon their complexity: to be recoverable, the work for which solicitors are recompensed has to be reasonably and necessarily incurred, proportionate to the individual claim, and within the costs budget set by the Court.

21.3. Following LASPO's removal of legal aid from all claims except those involving perinatal brain injury, our experience is that a high majority of claims which are now funded by a CFA.

21.4. Before-the-Event ("BTE") insurance frequently excludes clinical negligence claims altogether or requires solicitors to undertake work under a CFA (see above).

21.5. The effect of the April 2013 changes mean the loss of the ability to recover success fees from the defendant and a cap on the success fees that can be recovered from clients (see below).

21.6. Claimant solicitors try (in our experience) to avoid deducting unrecovered profit costs from their clients' damages.

22. Reductions in fees of this scale will inevitably have a major impact on the ability of claimants to secure legal assistance and representation.

23. It is inevitable that claimant solicitors will simply decide that claims worth less than £25,000 are uneconomic to litigate and therefore simply refuse to take on such cases on conditional fee agreements or select only the very strongest where the merits of the claim are overwhelming.

24. Because this basket of cases represents 60% of more of clinical negligence litigation, that, in turn would create a serious problem with access to justice for most claimants wishing to sue a healthcare professional: not only does it mean that most litigants fall within that value bracket, it also means that many claimant solicitor firms face real risk to the viability of their business.

25. If claimants are unable to instruct solicitors, it is most unlikely that they will be able to litigate their case. To conduct such technical litigation is beyond the capability of almost all litigants in person, in the unlikely event that they had the necessary means to instruct the necessary expert witnesses.

26. This situation is simply unfair. If a party has been put to the expense of going to court in order to vindicate its legal rights then the party which has lost should compensate it for its reasonable costs of doing so. This is the principle that has governed English law in this area for centuries and is based on fundamental fairness.

27. As Professor Fenn rightly observes at p.21 of his report, any major reduction in the propensity of patients to identify negligence could of course have wider implications for patient safety.

28. It is in the public interest that clients are able to access the advice of appropriately experienced and specialist barristers. This applies not just for claimants, but also healthcare defendants. Junior barristers in the early years of their career gain the necessary skills by gaining experience in claims within this value bracket. However:

- Fewer claims would be pursued in which the junior Bar would be involved. Deprived of their formative experience, the proposed FRC regime is likely to affect the quality and effectiveness of counsel available to litigate clinical negligence claims for both claimants and defendants.
- It is the experience of the Personal Injuries Bar Association ("PIBA") that the current fixed costs regime in personal injury work has already led to a reduction in work undertaken by counsel, as solicitors' firms keep the shrinking pool of work in-house. There is no reason why the same should not follow in clinical negligence with the proposed FRC scheme. Indeed, we would suggest that it is inevitable.
- Under the current fixed costs applicable to personal injury claims, counsel's involvement is usually last minute and then only in those cases presenting the greater risk. They tend to be the cases which have been poorly prepared and the barrister's late involvement leaves them with little ability to influence the outcome of the case. The extension of fixed costs would lead to the same outcome in clinical negligence claims to which FRC apply.

THE PROPOSALS ARE PREMATURE

29. Because of the potential damage to access to justice for patients injured by clinical negligence that the introduction of FRC would cause, it is particularly important that the government has particular regard to the raft of substantive and procedural legislative changes which have only relatively recently been introduced.

30. The package of reforms introduced in April 2013 were specifically designed to address the incidence of high costs in civil claims with emphasis on ensuring that costs were kept proportionate to the value and complexity of the individual claim. This aim applies just as much clinical negligence claims as to any other.

31. It is imperative, therefore, that before *any* scheme of FRC is introduced, the government gives adequate and evidence-based consideration to the question of whether or not the April 2013 reforms (a) have had sufficient time to 'bed in' with a view to assessing confidently their effect on the costs of clinical negligence claims valued at between £1,000 and £25,000 and (b) if they have, whether they are achieving

their objective of reducing costs. There would be no need or basis for the introduction of yet further substantial changes to this area of litigation if the existing reforms designed to reduce the costs of litigation had either not been allowed to work, or indeed, were working in practice.

32. The Jackson reforms resulted in the abolition of recoverable success fees and After-the-Event insurance ("ATE") premium (save in relation to the cost of expert reports) in all clinical negligence claims.

33. In footnote 15 at p.21 of his report, Professor Fenn assessed the mean success fee for pre-LASPO claims at 58%. In Table 2 at p.16 of his report, he quantified the mean net success fee in CFA claims at various stages and values of claim from the NHS LA data provided to him. In claims valued at between £1,000 and £25,000, he identified the mean success fee for claims concluding at each of the following stages as:

- before the issue of proceedings, £2,726;
- after issue but before allocation, £6,046;
- between allocation and listing for trial, £10,694;
- after listing for trial, £11,418.

34. Professor Fenn did not have data available to assess the extent to which ATE premiums would fall in post-LASPO claims, but considered that one-way costs-shifting should keep the premiums relatively low.

35. The problem perceived by the Department of Health with the costs in claims with a value of between £1,000 and £25,000 is that costs recovered by the claimant have reached 220% of the damages. The data in Table 2 at p.16 of Professor Fenn's report shows that 70% of claims in this bracket settle before the issue of proceedings, 94% have settled before allocation, and less than 5% settle after the exchange of expert evidence. If the mean success fees and ATE premiums given for each of these stages are stripped out, rather than claimant solicitors' recoverable costs representing 220% of the damages recovered, they would vary between 65% of damages in cases settled pre-issue to 159% in cases which are listed.

36. We accept that this calculation does not take account of the fact that not all claims are funded by CFAs. Nevertheless, it underlines the point that as the tail of pre-LASPO claims works through the system, the costs of clinical negligence claims to the NHS and healthcare defendants will fall significantly.

37. Neither Professor Fenn's report, nor the consultation itself, make *any* attempt to quantify that effect.

38. Costs budgeting was a central new mechanism introduced with a view to reducing the level of costs in multi-track cases. Particularly so in the lower reaches of the multi-track where the risk of costs being disproportionate to the financial value of the claim are higher. Whilst budgeting is ahead of the proportionality rule in terms of usage and application, it nevertheless remains the case that consumers, litigation service suppliers and the courts are still getting to grips with the concepts of costs budgeting; all the more so in cases where the new rule on proportionality is also fully engaged. There are very few reported cases on the effect of budgeting on the costs of a concluded claim.

39. Costs budgeting is still in relative infancy. The government has not undertaken any evidence-based appraisal or analysis of the impact of costs budgeting upon costs control in clinical negligence claims. It seems inconceivable that costs budgeting has not had a positive effect on the control of costs in claims worth up to £25,000. Used properly and effectively costs budgeting ought to be able to provide sufficiently robust costs controls over cases falling within this value bracket in the multi-track.

40. A short (but nonetheless informative) review of the costs management regime was carried out in early 2015 with a view to suggesting how the budgeting rules might be developed. The results of the exercise were set out in Sir Rupert Jackson's lecture[4] of 13th May 2015, "Confronting Costs Management". The lecture extolls the virtues of the budgeting regime, particularly as a means of ensuring that recoverable costs are controlled and limited to proportionate costs (paragraphs 2.6 and 2.7 in particular).

41. The costs budgeting process (when it is carried out in the way intended) gives the Court a far greater range of powers to achieve justice in any individual case by taking a more tailored approach to matching the directions required justly to resolve the issues between the parties with the proportionate costs of meeting those directions. The twin aims of the proposed extension of fixed costs i.e. (1) consistency and certainty (2) reducing overall costs to proportionate levels can each be addressed, in principle, by the costs budgeting process, as practitioners and the judiciary become more accustomed to it.

42. To put it another way, in a budgeted case the Court, if it is persuaded that particular directions are necessary, can adjust the budgeted costs to fairly match to those directions. Litigants still have the certainty and proportionality issues must be considered by the Court under the current regime.

43. In the FRC scheme proposed in the consultation, the Court's ability to adjust the budgeted costs to meet the required directions would be lost. The Court would be

[4] https://www.judiciary.gov.uk/wp-content/uploads/2015/05/speech-jackson-lj-confronting-costs-management-1.pdf

faced with a stark choice of either: (i) giving directions regardless of the relationship between the cost of compliance and the recoverable fixed costs; or (ii) trying to give directions which might not enable justice to be done in a case but which put the parties on a level playing field/ensure equality of arms (particularly in the case where one party was of limited means).

44. Costs budgeting would produce an individual and tailored result in each of the three notional cases we have described above.

45. The introduction of a new more stringent rule on proportionality under the Jackson reforms represented a radical shift from the pre-Jackson era of courts limiting recoverable costs to those that were reasonable and necessary.[5] The overriding objective requires the Court to deal with cases justly and at proportionate cost. This obligation includes saving expense, and dealing with the case in ways that are proportionate not just to the amount of money involved (which appears to be the erroneous way in which proportionality is used throughout the consultation) but also to the importance of the case, the complexity of the issues, and the financial position of each party.

46. The Court's ability now to reduce costs on the grounds of proportionality (CPR 44.3(2)(a)), even if the costs are themselves reasonable and necessary, will have a significant downwards impact on the level of recoverable costs. Before any radical further changes are introduced with a view to reducing costs, the reforms already introduced for that very purpose should be allowed to "bed in".

47. The Bar Council has concerns over the relationship (or, apparent lack of relationship) between this consultation and Lord Justice Jackson's review of Fixed Recoverable Costs.

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[5] CPR 44.3

(2) Where the amount of costs is to be assessed on the standard basis, the court will –
(a) only allow costs which are proportionate to the matters in issue. Costs which are disproportionate in amount may be disallowed or reduced even if they were reasonably or necessarily incurred; and
(b) resolve any doubt which it may have as to whether costs were reasonably and proportionately incurred or were reasonable and proportionate in amount in favour of the paying party.
(Factors which the court may take into account are set out in rule 44.4.)

(5) Costs incurred are proportionate if they bear a reasonable relationship to –
(a) the sums in issue in the proceedings;
(b) the value of any non-monetary relief in issue in the proceedings;
(c) the complexity of the litigation;
(d) any additional work generated by the conduct of the paying party; and
(e) any wider factors involved in the proceedings, such as reputation or public importance.

48. Lord Justice Jackson will produce his report on the introduction of FRC on 31 July 2017. He has considered clinical negligence. At the London 'roadshow' on 13 March 2017, he explained that his team of assessors had been provided with extensive data by the judiciary including costs judges in relation to the level of costs allowed in costs budgets and recovered on detailed assessment in a wide range of claims. It can reasonably be assumed that his recommendations in relation to clinical negligence will have used a wider and more current evidence base, and will have focused on the important factors that the Department of Health has not; the abolition of CFA success fees, the new proportionality test, and the efficacy of costs budgeting.

49. If the government were to proceed with the introduction of FRC for clinical negligence claims with a value between £1,000 and £25,000 separately from the Jackson review and Ministry of Justice consultation that will follow, there is a real prospect of an inconsistency in approach. For instance, Jackson LJ may recommend that FRC is not extended to clinical negligence claims at all, or not extended to those in the multi-track, or he may propose an FRC regime with a greater reach. He may recommend the introduction of a further intermediate track. It would create both uncertainty and expense if any regime of FRC introduced by the government in response to this consultation required modification or reversal following the subsequent Ministry of Justice consultation. Such a situation cannot be to the advantage of the public, the government or the legal profession.

50. The Bar Council therefore considers it premature to introduce FRC to *any* clinical negligence claims, even those allocated to the fast-track, at this stage (1) without allowing the existing April 2013 reforms to bed in, (2) without a proper assessment of whether those reforms alone have reduced the costs of litigation as intended, and (3) as a separate process from Lord Justice Jackson's review.

51. Without detracting from that overarching position, the Bar Council responds to the Consultation Questions as follows:

Question 1: Do you agree that Fixed Recoverable Costs for lower value clinical negligence claims should be introduced on a mandatory basis? If not, what are your objections?

52. No - See paragraphs 4 - 50 above.

53. The Bar Council accepts that there *may* be a place for an FRC scheme which applies to more straightforward claims allocated to the fast track with a value of between £1,000 and £25,000. But the Bar Council is *strongly opposed* to the introduction of a mandatory FRC scheme into claims allocated to the multi-track.

54. Access to justice is our main concern for the reasons already stated.

55. At allocation, the Court considers the matters set out in CPR 26.8, including the financial value of the claim, its factual and legal complexity and the amount of oral evidence to be required. More straightforward claims which are determined by the Court as suitable for allocation to the fast track on existing criteria are the least likely to be claims where the introduction of FRC will harm access to justice. For claims where the factual and expert evidence is more detailed or complex, where oral evidence may be required, or which may last more than 1 day, we have serious concerns that the introduction of an FRC regime will damage access to justice: in particular, that it is inevitable that claimant solicitors will investigate and pursue only the very strongest of claims; and claimants' damages will be significantly reduced because pressure on revenue will inevitably mean that solicitors will recoup more of the shortfall between costs recovered and costs incurred from damages more than already occurs.

56. The position that FRC should not apply to cases which have been determined as being suitable for the multi-track, notwithstanding that the value may be less than £25,000, is consistent with the Court of Appeal's reasoning in *Qader v Esure* [2016] EWCA Civ 1109, [2017] PIQR P5.

57. For the reasons already stated, we consider that further and more discerning data is required to determine that the Department of Health's policy objective of reducing legal costs is not already being achieved through the April 2013 reforms.

Question 2: Do you agree that Fixed Recoverable Costs should apply in clinical negligence claims above £1,000 and up to £25,000 (Option A) or another proposal (Option B)?

58. No, as per Q1. But if FRC are to be introduced for clinical negligence claims beyond the fast track following this consultation, they should go no higher than the band £1,000 to £25,000.

Question 3: Which option for implementation do you agree with: all cases in which the letter of claim is sent on or after the proposed implementation date (Option 1); all adverse incidents after the date of implementation (Option 2); or another proposal?

59. As stated above, we do not agree that the proposal should be implemented. If any change were introduced, it would be wholly wrong for a claimant entering into a CFA or other funding arrangement with his or her lawyer not to know what costs may not be recovered from the defendant, and, in turn what costs they themselves would have to pay from their damages. That information will be highly material in the

claimant's decision over whether to litigate at all. The duration of pre-action investigations is highly variable and not fully within the control of claimants or their lawyers.

60. Option 1 does not provide the necessary certainty to a claimant as to what scheme of costs recovery will apply to their claim at the point of instruction of their lawyer. Option 2 would therefore be preferred.

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; or another proposal?

61. The Bar Council repeats its objection to the proposals. If a scheme was to be introduced, the Bar Council considers that the arrangement which most closely relates to the cost of the actual work to be done on a case is the most likely to be fair to parties' lawyers, and the least likely to give rise to perverse incentives to claimant solicitors to fail to maximise their clients' damages.

62. Of the approaches suggested, Option 4 (using the same methodology that was used to calibrate the costs in part 45 of the CPR based upon estimated average levels of observed base costs recovered for differing stages of litigation) would clearly be the most appropriate, as the fundamental pattern of work is unlikely to change fundamentally even if the amendments to the Civil Procedure Rules proposed in Annex D are implemented.

63. The Bar Council notes that in paragraph 4.13 of the consultation, the government has asked Professor Fenn to undertake further work with claimant lawyers and other interested parties to refine the cost analysis in option in parallel with the consultation. We consider it essential that the Bar is involved in this process, whether through the Bar Council or one of the Specialist Bar Associations and invite the Department of Health to contact us to ensure this occurs.

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

64. No.

65. Expert witnesses have a genuine choice over whether to undertake medico-legal work or not. Many do so when they would otherwise be working in private

practice, where their fees are largely based upon their time. The proposed cap of £1,200 applies irrespective of whether one or two experts are instructed. That is wholly illogical. It would act as a clear disincentive for an expert to become involved in a claim where a report would be needed from another experts; to do so is likely to limit his/her charges to £600 for work which may include a pre-action report, revisions to the report for service, attending a conference, consideration of the other parties' case, expert meetings and attending a trial lasting more than one day.

66. High quality expert witnesses are vital in this area of litigation. The more cogent and reliable their views, the more likely the party in question will be well-advised in relation to the merits and value of the claim. That aids early settlement and in turn, a reduction in costs.

67. It has been the experience of the profession that very many good quality experts will not undertake work at 'legal aid rates' (e.g. £108 per hour for a psychiatrist or £115.20 per hour for an orthopaedic surgeon). Even if the proposed cap of £1,200 relates to a single expert, it is extremely unlikely to be sufficiently remunerative for experts to accept instructions, in the knowledge that the claim may ultimately involve very many hours of work and attendance, particularly if it were to proceed to a trial.

68. This is an issue which will disproportionately affect claimants. NHS Resolution (previously, the NHS LA) and the medical defence organisations will have no difficulty paying experts the difference between the fees recoverable under the cap and their actual and higher charges. For individual claimants, the position is different: any shortfall between the fees of an expert they instruct and the cap will simply erode their damages. There is a serious risk of inequality of arms. Claimants will simply not have access to the same pool of quality expert witnesses as defendants.

69. If expert fees are to be capped at all, the cap should increase in step-changes commensurate with the extent of the work an expert is likely to undertake at each stage of the litigation.

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. Should there be a presumption of a single joint expert and, if so, how would this operate?

70. If parties instruct an expert jointly on issues of liability, the opinion of that expert will effectively decide the case. Yet in many claims there are legitimate and differing opinions from different experts upon which the Court must adjudicate. The level of recoverable fees, and any cap on expert costs, is unlikely to allow any party who is (legitimately) dissatisfied with the single joint expert's view to instruct an alternative expert having already incurred fees in relation to the first expert.

71. The Bar Council has no objection to a requirement for the parties to *consider* joint instruction, but considers that in our adversarial system, each party should retain the right to instruct an expert of their choosing, unless he/she voluntarily decides on a joint instruction.

72. We therefore oppose a presumption for joint instruction of liability experts.

Question 7: Do you agree with the concept of an early exchange of evidence (claimant's expert reports with letter of claim and defendant's reports with letter of response)?

73. The Bar Council does not agree that a claimant should be obliged to disclose expert liability evidence with the Letter of Claim.

74. The claimant's expert will have had access to the claimant's account, the medical records, and in a minority of cases any documentation disclosed as a result of a complaint or the statutory duty of candour. Factual accounts from the healthcare professionals for litigation purposes supplement details in the clinical records and, most particularly, will explain the rationale or their actions. Those explanations are, or should be, reflected in the Letter of Response. Under the current regime, the claimant's expert is able to review that explanation, the formal Defence, and the clinicians' witness statements before finalising a report that will be disclosed. With this proposal, there will be a forensic disadvantage to the claimant in disclosing a report based upon an incomplete understanding of the defendant's position.

75. Whilst it could be said that disclosure of a claimant's report with a Letter of Claim could be to his/her advantage in that it might influence the healthcare defendant into making an early admission, that is not our experience. The defendant will still tend to rely upon the views of the clinicians and any expert it instructs.

76. The Bar Council does agree that early exchange of expert evidence is appropriate, but would suggest that it takes place by *mutual* exchange during the 'Stocktake' phase identified in the Illustrative Pre-Action Protocol (Annex D, p.16-17).

Question 8: Draft Protocol and Rules:
Do you agree with the proposals in relation to the following:

77. *Trial Costs:-* The proposal is that there is a fixed cost for trial advocacy set at the current level for fast track RTA/EL/PL claims. Clinical negligence claims are normally more technical and require more preparation by the advocate. Most multi-track clinical negligence claims in this bracket are listed for 2-3 days. An advocacy fee for a 2-3 day trial that is the same as a single day RTA/EL/PL claim is wholly inadequate.

It would operate as a significant disincentive to advocates of appropriate skill and experience undertaking claims with the FRC regime.

78. *Multiple Claimants:-* Yes.

79. *Exit Points:-* Yes, with one addition. There must be a general discretion in the Court to direct upon application at any time that the FRC do not apply due to the exceptional nature or circumstances of the claim (rather than the present proposal, which is an ability to do so only at the end of the case when costs are determined).

80. *Technical Exemptions:-* Yes, but with the addition of adult protected parties as well as children. There is no logical distinction between the two categories of protected party.

81. *Where the number of experts reasonably required by both sides on issues of breach and causation exceeds a total of two per party:-* Yes.

82. *Child fatalities:-* Yes, but the exemption should relate to all fatalities. Claims in this category are particularly important to the family of the deceased. Furthermore, litigation in such claims can be an integral part of the state's investigative obligation under Art.2 ECHR.

83. *Interim applications:-* Yes.

84. *London Weighting:-* Yes.

Question 9: Behavioural Change
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)?

85. The Bar Council does not consider it appropriate to make formal ADR compulsory. There is a risk that it would simply increase costs. If early ADR beyond simple negotiation by correspondence is to be encouraged, a proper and specific ADR element must be included in any FRC fixed costs.

Question 11: 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.

86. All claims involving stillbirths should be exempt from FRC, otherwise the lack of access to justice inherent in these proposals risks giving rise to inequality issues on the grounds of gender.

CONCLUDING COMMENTS

87. For all the reasons set out above, the Bar Council is opposed to the proposed extension of fixed costs to lower value clinical negligence claims.

Bar Council
28 April 2017

For further information please contact:
Dominique Smith: Policy Analyst (Remuneration and Employed Bar)
The General Council of the Bar of England and Wales
289-293 High Holborn, London WC1V 7HZ
Direct line: 020 7092 6802
Email: DSmith@BarCouncil.org.uk