JUDICIARY OF ENGLAND AND WALES

LORD JUSTICE JACKSON

THE REFORM OF CLINICAL NEGLIGENCE LITIGATION LECTURE

TWELFTH LECTURE IN THE IMPLEMENTATION PROGRAMME

CLINICAL NEGLIGENCE SEMINAR

22 MARCH 2012

"Healing is a matter of time, but it is sometimes also a matter of opportunity."[1]

INTRODUCTION

1.1 Abbreviations. "FR" means the Costs Review Final Report. "CDF" means the Clinical Disputes Forum. "NHSLA" means National Health Service Litigation Authority. "ADR" mean alternative dispute resolution, one common form of which is mediation. "QOCS" means qualified one way cost shifting.

1.2 This lecture. The text of this lecture is being distributed to all present. Like all papers presented this afternoon it forms part of a Festschrift for Stephen Walker, who is today retiring as Chief Executive of the NHSLA. By coincidence at about the same time Michael Napier is retiring as Senior Partner of Irwin Mitchell. Both Stephen and Michael have been towering figures in the world of clinical negligence for many years, albeit on opposite sides. It is a pleasure to see that the speakers today include a close colleague[2] of Stephen and a close colleague[3] of Michael. I pay tribute to both Stephen and Michael for the great contributions which they have made to this field of the law and also thank both of them for the contributions which they made to the Civil Litigation Costs Review. I wish both Stephen and Michael very long and active retirements.

1.3 This lecture forms part of a series of lectures, each of which is focused upon a specific aspect of implementing the FR reforms.

2. LATE SETTLEMENTS

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[1] Hippocrates, Precepts, chapter 1
[2] John Mead, technical director of the NHSLA
[3] David Body, partner in Irwin Mitchell

2.1 The problem of late settlements. Late settlement has been identified as a particular problem in the context of clinical negligence litigation. This is partly because of the complexity of the subject matter, but other factors are in play as well. At an early stage of the Costs Review I identified the worrying fact that the majority of all meritorious clinical negligence claims were not settled until after the issue of proceedings: see Costs Review Preliminary Report chapter 6 (section 2), chapter 11 (section 4) and appendices 12, 21, 22. Chapter 11 para 4.6 states:

"Late settlement of clinical negligence claims. When one looks at the MPS data, it is striking how many meritorious claims are not settled until after commencement of proceedings. The same picture emerges from the APIL schedule. The same picture emerges from the Legal Services Commission data, set out in chapter 6. On one view, the data from these three sources may be said to support the complaint made by many claimant firms that defence organisations delay unnecessarily in accepting liability/settling meritorious claims. If this is the case, it may help to explain why the costs of clinical negligence litigation are so high. On the other hand, I understand that this is vigorously denied by clinical negligence defence lawyers, who maintain (a) that they have much less time to investigate claims than the claimants' advisers and (b) that proceedings are often issued prematurely. I hope to explore these matters during Phase 2. I do not at this stage draw any conclusions."

2.3 Analysis during Phases 2 and 3 of the Costs Review. During Phase 2 of the costs Review I duly explored this issue. In Phase 3 (Final Report) I proposed a package of measures which were designed to tackle this and other problems.

3. RECOMMENDED REFORMS

3.1 Eliminate undue complexity. One of the drivers of high costs is the excessive complexity of the rules, practice directions and protocols: see FR chapter 4, section 3. One of the protocols which requires pruning is the Pre-Action Protocol for the Resolution of Clinical Disputes.

3.2 Recommendations specific to clinical negligence. FR chapter 23 is specifically focused on clinical negligence. That chapter makes eight recommendations, which become recommendations 26 to 33 in the summary at the end of the report:[4]

> "26. There should be financial penalties for any health authority which, without good reason, fails to provide copies of medical records requested in accordance with the Pre-Action Protocol for the Resolution of Clinical Disputes.
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> 27. The time for the defendant to respond to a letter of claim should be increased from three months to four months. Any letter of claim sent to an NHS Trust or ISTC should be copied to the NHSLA.
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> 28. In respect of any claim (other than a frivolous claim) where the NHSLA is proposing to deny liability, the NHSLA should obtain independent expert

[4] See page 465

evidence on liability and causation during the four month period allowed for the response letter.

29. The NHSLA, the MDU, the MPS and similar bodies should each nominate an experienced and senior officer to whom claimant solicitors should, after the event, report egregious cases of defendant lawyers failing to address the issues.

30. The protocol should provide a limited period for settlement negotiations where the defendant offers to settle without formal admission of liability.

31. Case management directions for clinical negligence cases should be harmonised across England and Wales.

32. Costs management for clinical negligence cases should be piloted.

33. Regulations should be drawn up in order to implement the NHS Redress Act 2006."

3.3 Reasons for recommendations. The reasons for making those eight recommendations are set out at some length in FR chapter 23, to which the reader is referred.[5]

3.4 Extend the use of ADR in clinical negligence. In FR chapter 36 I recommended that greater use should be made of ADR, in particular mediation, as a means of resolving civil disputes at proportionate cost. In particular, I rejected the suggestion that personal injury claims (including clinical negligence claims) were unsuitable for ADR. Experience suggests that such claims are entirely suitable for ADR, even in cases where liability and/or causation are in issue.

4. IMPLEMENTATION

4.1 Slimming down the protocol. A CJC working group is currently reviewing and revising a number of the pre-action protocols, including the Pre-Action Protocol for the Resolution of Clinical Disputes. It must be confessed that there is plenty of scope for pruning here. To take one example at random, see para 1.7 entitled "Why this protocol now?" Such a paragraph is of no practical use to any practitioner who is trying to resolve a clinical negligence dispute. If all the guff[6] is cut out, the protocol will be simpler, clearer and more helpful to practitioners.

4.2 Ongoing work of the CDF. The CDF is currently developing a much more detailed protocol to regulate the conduct of clinical negligence disputes both pre and post issue. This document will have to be consistent with the final version of the pre-action protocol, when that emerges from the CJC working group. I hope that the CDF Protocol will be included in the CJC's "Best Practice" website, but the final decision on this will rest with the CJC.

4.3 Recommendation 26. No action has yet been taken on this recommendation. In its consultation paper CP 13/10 the MoJ stated at para 277:

[5] It is not sensible to copy and paste a 16 page chapter into this short paper.
[6] This comment is not meant to be critical of the founding fathers. What now looks like guff may have been very useful in 1999 when the protocol was first introduced.

> "The Department of Health believes the current system for release of information under the Data Protection Act 1998 contains sufficient provision to meet Sir Rupert's recommendation. The Information Commissioner has enforcement powers, which includes from April 2010 monetary penalties against bodies failing to comply with the statutory requirements."

4.4 I have discussed para 377 with the Information Commissioner. He tells me that the paragraph is not correct. Late or inadequate disclosure of medical records by health authorities is not the kind of matter which his office would handle or indeed could handle within a realistic timescale. There remains therefore the need for some incentive to encourage health authorities to give prompt and proper disclosure in accordance with their duties under the Protocol for Obtaining Medical Records. Perhaps FR recommendation 26 might now be reconsidered?

4.5 Recommendation 27. This recommendation was implemented with effect from 1st October 2010. The Pre-Action Protocol for Resolution of Clinical Disputes was amended to allow 4 months (instead of 3 months) for the letter of response. The Protocol was also amended to require that any letter of claim sent to an NHS Trust or to an Independent Sector Treatment Centre be copied to the NHSLA.

4.6 Recommendation 28. This recommendation was implemented by the NHSLA by June 2010. The NHSLA adopted the policy of obtaining independent expert evidence in any case where it proposed to deny liability, save in exceptional circumstances.

4.7 Recommendation 29. This recommendation was implemented in February 2011. See the notice, which is an appendix to this lecture and was first published on 7th February 2011. Since then four cases have been referred to Emma Hallinan at MPS under the scheme. One case has been referred to Jill Harding at MDU under the scheme. No cases have been referred to Stephen Walker at the NHSLA under the scheme. Following his retirement the NHSLA will appoint a successor for the purposes of recommendation 29.

4.8 Recommendation 30. I have drawn this recommendation to the attention of the CJC working group for inclusion in the revised draft of the Pre-Action Protocol for the Resolution of Clinical Disputes. Hopefully, therefore, this recommendation will be implemented by April 2013, which is the general implementation date for the FR proposals.

4.9 Recommendation 31. A project is currently proceeding to establish standard directions and model directions for use at all court centres in a wide variety of cases.[7] These will include directions for the management of clinical negligence cases in accordance with procedures developed by the Queen's Bench Masters in London. These standard directions and model directions will come into general use on 1st April 2013.

4.10 Recommendation 32. There has been extensive discussion about the clinical negligence costs management pilot proposed in FR chapter 23. So far it has not been possible to commence such a pilot because the Queen's Bench masters do not have the additional resources which this will require.

[7] See implementation lecture 5. *Achieving a Culture Change in Case Management*

4.11 Recommendation 33. I understand that this recommendation has been put on hold pending discussions about an alternative scheme for the swift resolution of low value claims against the NHSLA. These discussions involve a number of different interest groups all of whom, perfectly properly, have their own perspective on matters. As long ago as November 2010 I saw a draft of the scheme in its then current form. Without wishing to sound unduly pessimistic, I must confess to some doubt as to what will emerge from these interminable discussions.

4.12 The Government has recently announced that it will consider extending the RTA Portal to include low value clinical negligence claims. That decision is to be welcomed, but it will only affect claims where liability is admitted. The NHS Redress Scheme by contrast will embrace low value cases where liability is disputed.

4.13 The NHS Redress Act 2006 was enacted by Parliament following, and on the basis of, a successful pilot conducted in 2002.[8] It cannot be brought into force unless the Department of Health draws up the necessary regulations. There is no point in Parliament passing legislation (an arduous process as I have recently discovered) if no-one then troubles to bring the legislation into force. It is therefore respectfully suggested that action should now be taken on this front.

4.14 Extending the use of mediation in clinical negligence. The steps being taken to implement my general recommendations in relation to ADR were set out in the previous lecture in this series.[9] In relation to clinical negligence, it is interesting to see that the Marsh Report on the NHSLA[10] commends greater use of ADR, in particular mediation, as a means of achieving satisfactory resolution of claims at proportionate cost.[11] I am told by those who practise in this field that amongst some solicitors and counsel there is still a wall of opposition to mediation in clinical cases where liability and/or causation are in dispute. Attitudes have been changing steadily over time. I have no doubt that this opposition will be overcome, but a firm steer will be required both in CPD training and in judicial training.

4.15 Qualification. That is not to say, however, that mediation should be used as a means of extracting cash in "try on" claims or as a means of achieving "nuisance value" settlements. I have every confidence that mediators, defendants and all reputable practitioners will not allow the mediation process to be abused by any such strategies. Claimants in this small category of cases would do well to remember that they will not be protected by QOCS.

5. CONCLUSION

5.1 Nine separate FR recommendations relevant to clinical negligence litigation are identified in section 3 above. Out of that group, six recommendations either have been implemented already or will be implemented by 1st April 2013, the general implementation date. The other three recommendations have not yet been implemented and the jury is still out on them.

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[8] See FR chapter 23, section 7.

[9] Eleventh lecture in the implementation programme; see the Judiciary Website on http://www.judiciary.gov.uk/

[10] *NHS Litigation Authority Industry Report*, Marsh, April 2011.

[11] See para 7.2.2

5.2 As to the final matter, promoting greater use of ADR, I believe that attitudes are steadily changing. Hopefully the publication of the ADR Handbook next year and the increasing emphasis on ADR in judicial training and CPD training will contribute to this process.

5.3 It is right on the occasion of Stephen Walker's retirement that I should pay tribute to the substantial contribution which he has made to the process of necessary procedural reform. I am sure that his successors will continue to work with claimant representatives to secure the swift, cost effective and fair resolution of meritorious clinical negligence claims.

APPENDIX

REVIEW OF CIVIL LITIGATION COSTS FINAL REPORT IMPLEMENTATION OF RECOMMENDATION 29

Recommendation 29 is as follows:

> "The NHSLA, the MDU, the MPS and similar bodies should each nominate an experienced and senior officer to whom claimant solicitors should, after the event, report egregious cases of defendant lawyers failing to address the issues."

The thinking behind that recommendation is set out in chapter 23 of the Final Report, which deals with clinical negligence litigation.

That recommendation has been accepted by the National Health Service Litigation Authority (NHSLA), the Medical Protection Society (MPS) and the Medical Defence Union (MDU).

For the purposes of recommendation 29:

- The NHSLA have nominated Mr Stephen Walker, Chief Executive.
- The MPS have nominated Ms Emma Hallinan, Director of Claims and Litigation.
- The MDU have nominated Ms Jill Harding, Head of Claims Handling.

The contact details of the three nominees are as follows:

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