

LORD CARTER'S REVIEW OF LEGAL AID

RESPONSE OF THE MEDICAL LAW GROUP OF HAILSHAM CHAMBERS

INTRODUCTION

1. On 5 July 2005, the Government commissioned an independent review of legal aid procurement by Lord Carter of Coles, with a view to reporting in early 2006. The terms of reference state:

“The review is considering the means by which to deliver the Government’s vision, set out in A Fairer Deal for Legal Aid, for procuring publicly funded legal services, particularly criminal defence services. The findings of the review will be presented as a plan for delivering a procurement system that achieves maximum value for money and control over spending whilst ensuring quality and the fairness of the justice system.”

The secretariat to the review commission has invited the views of those directly or indirectly affected by the work of the review commission.

2. Hailsham Chambers is a set of approximately 40 Barristers practising in common law, with a large number practising in the field of personal injury and clinical negligence. The medical law group, consisting of some 25 Barristers comprising both Silks and Juniors, carries out work which includes representation and advice in clinical negligence claims, in which the majority of Claimants are funded by a public funding certificate. This response is on behalf of those Barristers, who are all directly or indirectly affected by this review.
3. Hailsham Chambers does not practise in the fields of criminal law or family law or asylum work. In the circumstances, we do not wish to respond to, or comment upon, those parts of the review which address criminal legal

aid or legal aid for family law matters (including childcare) or applications for asylum. This response is confined to issues surrounding the granting of public funding certificates for Claimants and potential Claimants in relation to claims for damages for alleged clinical negligence.

The DCA's Document: "A Fairer Deal for Legal Aid"

4. Given the terms of reference, it is appropriate to start by a consideration of the DCA's Document: "A Fairer Deal for Legal Aid" (hereinafter referred to as "A Fairer Deal") as it impinges upon legal aid for clinical negligence. The first challenge is to separate out the figures and statistics for this type of work. This is not done, in terms, in A Fairer Deal and can only be done by extrapolation. It is a matter of concern that there is no clear differentiation in A Fairer Deal between clinical negligence claims and other work and we would wish to emphasise to the review that clinical negligence work embraces a particular, vulnerable, section of the community, especially those who have sustained brain damage at birth but including all those with actual or potential claims for clinical negligence, who are as deserving of legal aid as anyone else. We note that the earlier "New Focus" consultation confirmed that clinical negligence was not yet an appropriate area for conditional fee agreements. We are in no doubt that this remains the case. We are concerned to ensure, so far as possible, that reforms introduced to deal with perceived problems in public funding in criminal cases or in other high cost civil claims, do not have unintended adverse consequences for the provision of public funding in clinical negligence.

5. Figure 3, which compares the number of self-employed/independent barristers with total legal aid expenditure is of no relevance to those concerned solely with clinical negligence claims, encompassing, as it does, all legal aid expenditure including criminal legal aid. Figure 5, differentiating between criminal legal aid (up 37%) and civil legal aid (down 10%) comes closer but still does not address the part played by clinical negligence claims. Figure 6, which excludes asylum work, comes closer still and shows that legal aid spending on civil work excluding asylum claims has fallen by 24%, but again legal aid for clinical negligence claims is not separated out. If, for example, spending on childcare matters or family law has increased, then there would have been an even greater fall in legal aid spending on clinical negligence claims, but the information is not provided. In addition, it should be borne in mind that legal aid was withdrawn for ordinary personal injury actions in 2000. This may be a significant factor as it means that to compare expenditure between 1997 and 2005 may be not to compare like with like. Following the reference to Figure 6, a Fairer Deal states:

“2.17 Like all areas of public expenditure, legal aid has to live within an overall budget and the demands on the scheme must be met from within that budget. The growth in criminal spending has meant we have had to reduce the spending on civil, particularly on legal help, and family legal aid, which is undesirable for society as a whole.”

We do not understand why there should be an overall budget for legal aid and why growth in criminal spending necessarily implies a reduction in spending on civil legal aid. How the budgets are divided up and allocated is a matter for the government, and there is no reason why the one should be dependent upon the other. It makes no logical sense that this should be the case, as the social and political interests respectively protected by

civil legal aid and criminal legal aid are wholly different. A Fairer Deal is wrong to assume that it is justified to reduce civil legal aid in favour of criminal legal aid, without considering the issue or making any attempt to justify that assumption. We would respectfully suggest that the review commission should examine that assumption and question the political and social policies which lie behind it. Furthermore, we do not understand why asylum seekers, or those whose relatives have died in custody, should be regarded as more deserving of legal aid than victim of NHS negligence. The entitlement of the former to legal aid may be associated with the rights guaranteed under the European Convention on Human Rights and decision of the ECtHR. Even if victims of NHS negligence are not covered by Convention rights, they should be given access to legal aid if they are considered to be just as deserving as those who get legal aid because they are so covered. We would suggest that they should be considered just as deserving: brain damage or other serious injuries may be said to impact on the life of the victim at least as profoundly as does a death in custody on a parent or partner, or an adverse decision on an asylum seeker.

6. At section 2.29, A Fairer Deal addresses the question of diminishing civil legal aid and refers to Figure 11 which, it is stated, shows that there has been a 39% drop in the number of people being represented and a 45% drop in the number of people receiving legal help. It is asserted that the fact that the drop in the number of people being helped is significantly greater than the drop in spend on civil and family justice “implies significant growth in the average cost of legal aid cases.” Whether or not this is correct, no information is provided as to whether this is true for clinical negligence claims as opposed to other claims. Information is required as to the amount spent from the legal aid budget on clinical negligence claims, whether this has increased in real terms and, if it has,

the reasons for those increases. Without such information, any proposals seeking to reduce or limit legal aid spending on clinical negligence claims would not be reasonable or based upon sound principles. For what it is worth, it is the experience of these chambers that, since the implementation of the Civil Procedure Rules and the Pre-Action protocols, fewer cases of clinical negligence progress to trial, there are fewer Claim Forms being issued (ie many more claims are resolved without recourse to litigation) and there has been a significant overall reduction in spending on clinical negligence cases from the legal aid budget. At paragraph 2.35, A Fairer Deal acknowledges that “Advice and representation on family matters is the most significant element of non-criminal legal aid spending.” Before any changes are proposed or implemented which have the effect of reducing legal aid spending on clinical negligence claims, the case needs to be established that such a reduction is justified and would have a significant effect on the legal aid budget without thereby withdrawing from a very vulnerable section of the community access to proper legal advice (see paragraph 9 below).

7. Finally, so far as A Fairer Deal is concerned, Chapter 6 addresses the question of “delivering a fairer deal: helping vulnerable and disadvantaged people to solve their disputes faster”. Having (correctly) stated that the Government’s aims for promoting earlier and more effective resolution of disputes and the work carried out have had positive effects on the proportion of people receiving suitable assistance, it is asserted that

“still not enough problems are resolved in a timely and proportionate manner. This is particularly relevant to people who are, or are at risk of being, socially excluded.”

We are not aware that this is generally the case in relation to clinical negligence disputes, and it is our experience that the Civil Procedure

Rules, together with the application by the Courts of the costs provisions designed to penalise parties have not made proper use of the facilities for resolution of disputes without recourse to litigation or trial, have been effective in reducing costs and relieving the burden on the legal aid fund. In relation to the New Focus proposals, which include restricting the Very High Cost Civil Cases budget to ensure that disproportionately expensive cases do not preclude access to justice for small cases, it is stated (at paragraph 6.18) that the New Focus changes to legal aid “will encourage the greater use of existing complaints systems in preference to litigation, especially in cases of clinical negligence and actions against the police.”

8. Again, we see no evidence in A Fairer Deal that there is any requirement to reduce or refocus legal aid for clinical negligence claims in order to increase access to justice and we see no evidence that there has been any mushrooming of spending from the legal aid budget on such claims to justify any radical reappraisal or adjustment of the legal aid budget for such claims. Rather, the information quoted in the Chief Medical Officer's report "Making Amends" indicates that even in the period 1995 to 2002 the proportion of clinical negligence cases which settled was 47%, while 2% were won by the Claimant at trial and 1% by the Defendant at trial, with another 28% abandoned and 22% awaiting settlement (Paragraph 34 Chapter 3). Our experience is that since 2002 those figures are likely to have shifted even further in the direction of early settlement or disposal, and even fewer cases reaching trial.

The Nature of Clinical Negligence Claims

9. As stated above, no assessment of the impact of clinical negligence claims on the legal aid budget is possible without such claims being separated out and an appraisal of the true spending on such claims and how (and why) such spending has changed over the past 5 years or so. Furthermore, no such assessment is possible without an understanding of the mechanisms already in place to encourage and facilitate resolution of disputes without recourse to litigation, the mechanisms in place to achieve resolution of litigated claims without recourse to trial, and details of the number of cases brought to trial which cause expense to the legal aid budget because they are unsuccessful, with the amount such cases cost the legal aid budget and the reasons for the lack of success. However, before that, it is right to point out the particular problems posed by clinical negligence claims. First, the victims are often extremely vulnerable members of society, for example children who have sustained brain damage at birth or families who have been deprived of breadwinners when men or women have died or been seriously injured in consequence of clinical negligence. Secondly, it is in the nature of such claims that they require extensive and searching investigation: allegations of negligence should not be made lightly against clinicians, without proper investigation and evidence. This is an appropriate expense for the legal aid fund, even where the conclusion is that the evidence does not reveal a viable claim. Thirdly, the government has a moral responsibility to provide funding for actual and potential victims of clinical negligence given that the vast majority of clinical negligence claims arise out of treatment under the National Health Service. The government is in the position of having a conflict of interest as it is the body which provides the treatment in the first place and has an interest, through its funding of the National Health Service, in not paying out for the consequences of its own negligence. In other words, it is morally and socially unacceptable for the Government first to provide a service which negligently injures its citizens, and then to fail to provide the funding for those citizens to investigate and pursue such

injuries. Finally, such claims have long been recognised to require particular levels of expertise and experience, and legal aid is only available to firms of solicitors who have satisfied the legal services commission that they have that necessary experience and expertise. The corollary of this is that they will involve more senior practitioners and may justify higher fees. To fail to provide proper fees within the legal aid budget would be a false economy.

10. There are already mechanisms in place to reduce the cost of clinical negligence claims and avoid the waste of unnecessary costs. These include:

- (i) The Pre-Action Protocol for the Resolution of Clinical Disputes, which states that the general aims of the protocol are to maintain/restore the patient/healthcare provider relationship and to resolve as many disputes as possible without litigation, and then contains specific provisions to facilitate and enable those general aims; it is our experience that those provisions have been very successful in achieving those aims;
- (ii) The provisions of CPR parts 3.1(4), 3.1(5), 3.9, 44.3(5) and 48.1 which provide sanctions for parties who have failed to comply with the pre-action protocol;
- (iii) The increasing use of mediation and other forms of Alternative Dispute Resolution, including Round Table Conferences; it is the practice in some courts (Newcastle being an example) to make an attempt at settlement by ADR a pre-condition of trial.

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(iv) The criteria for the grant of legal aid: before legal aid is granted, it is necessary for the claim to satisfy these criteria including the cost/benefit ratio, which is intended to ensure that claims are not brought where the cost of doing so unreasonably outweighs the potential benefit.

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11. The complexities of clinical negligence disputes are such that there will often be quite a high level of expense in investigating whether there is a valid claim, including the instruction of experts. Without legal aid, it is a fact that many potentially valid claims would go uninvestigated and would not be brought at all because the funding would not be available for such investigation in the absence of legal aid. It is our view that any restriction in legal aid for clinical negligence cases would result in a denial of access to justice for a particularly deserving section of the community.

12. Alternative Dispute Resolution is not a cost-free alternative. Funding is still necessary to work up the case adequately for mediation or other ADR. The main alternative to public funding is the Conditional Fee Agreement. Our practical experience of such agreements in the clinical negligence context is wholly in line with the comments and criticisms made by the Civil Justice Council (Clinical Negligence and Serious Personal Injury Committee) Response dated October 2004 to a proposal from the Legal Services Commission.

Conclusion

13. In conclusion, we would invite the review commission to consider and answer the following questions before making recommendations which have the effect of reducing public funding support for Claimants or potential Claimants in cases involving clinical negligence.

- (i) Should the budget for legal aid encompass one fund for all cases including both civil and criminal cases and, within the civil budget, family law, childcare and asylum applications as well as clinical negligence claims, when the social and political interests protected are wholly different?
- (ii) How much of the legal aid budget has been consumed by clinical negligence claims over the last 10 years, both in real terms and in percentage terms?
- (iii) In relation to the amount spent annually on clinical negligence claims, how much is spent on payments on account which are subsequently recouped from the Defendants when the case is eventually concluded, so that such spending is more of a cash flow exercise than a real expense?
- (iv) In relation to real spending, ie payments from the legal aid budget which are not subsequently recouped because the case is either lost at trial or abandoned before trial, how much is spent on investigation of potential claims which are found to have no sound basis, and how much is spent on trials which are lost?
- (v) In respect of trials which are lost, in how many such trials can it properly be said that they should not have been brought at all, as opposed to having been lost because, for example, a judge has

simply preferred the views of one expert over another or has made findings of fact adverse to the Claimant? Is there any evidence that a disproportionate number of claims are being wrongly brought and lost, at the expense of the legal aid budget? If so, why are the criteria for the funding of clinical negligence claims not being applied to prevent such claims being wrongly brought?

- (vi) In respect of spending from the legal aid budget on the investigation of claims which are then abandoned, why is this not a good and socially acceptable use of resources given the legitimate concerns of patients who have had adverse outcomes after treatment, and their families, and given the position of conflict in which the government finds itself as being the main provider of such treatment in the first place?

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29 September 2005.