Written evidence submitted by The Bar Council (NLR0069)

About us

The Bar Council represents approximately 17,000 barristers in England and Wales. It is also the Approved Regulator for the Bar of England and Wales. A strong and independent Bar exists to serve the public and is crucial to the administration of justice and upholding the rule of law.

Scope of response

This submission has been drafted by the Bar Council's Remuneration Committee and Law Reform Committee. The following addresses questions 1 to 4 posed in the call for evidence and provides an overview of the generic issues which tend to arise in relation to proposals to reform clinical negligence litigation. An **Appendix** is included which summarises some of the technical aspects of clinical negligence litigation which may clarify some of the issues raised.

Executive Summary

1. The Bar Council identifies five key factors driving dissatisfaction with clinical negligence litigation:
    a. difficulties proving liability;
    b. expense;
    c. increasing damages awards;
    d. disparity between the costs of litigation and the amount of damages awarded; and
    e. dissatisfaction with the experience of litigation. (§12)
2. The Bar Council notes the history of previous calls to reform clinical negligence. Previous calls for a 'no fault' scheme had not progressed, and it is unclear how such a scheme would be appropriate for clinical negligence cases. A possible test for compensation based on a patient suffering an 'avoidable injury' may conflate notions of breach of duty and causation which may not assist in the swift and cost-effective resolution of potential claims. (§15)
3. Any statutory scheme must have eligibility criteria. The Bar Council draws a distinction with the tort law system which has a degree of flexibility, allowing novel claims to be made, and for the law to develop. Recent developments in clinical negligence include claims based on consent, damages for psychiatric injury, and claims based on illegal acts by third parties. (§16)
4. The Bar Council is opposed to caps on compensation which would deny injured patients the right to full compensation. (§17)
5. A statutory scheme may be more effective if it is targeted on a specific and narrowly prescribed set of facts. (§18)
6. Any statutory scheme should be voluntary and not restrict the patient's right to seek a civil remedy. (§18)
7. The Bar Council affirms its view that full compensation is an essential aspect of access to justice. (§19-20)

Introduction

8. The Bar Council welcomes the opportunity to respond to the Committee's call for evidence on NHS Litigation Reform. The current system by which claims are made against the NHS are a proper subject for review and scrutiny. Reform of NHS litigation is a large and complicated subject, involving an inevitable interplay between political and legal policy considerations. We set out below our answers to the specific questions put by the Committee, limited to those we considered it was appropriate for us to answer and which fall within our professional experience.

9. We also considered that it may assist the Committee to have a more general paper which sets out some aspects of clinical negligence claims which we hope provides useful background, and we include those further observations as an **Appendix**.

10. In this paper we have highlighted several factors that may inform this debate and answered questions listed in the NHS Litigation Reform: Terms of Reference. The Bar Council would be very happy to assist the Committee further by providing more detailed evidence in relation to the points we make below.

The Cost of NHS Litigation

11. Discussion about the 'cost' of NHS litigation must be approached with a degree of care, in particular an important distinction must be made in relation to actual compensation payments (damages) and the costs of litigation, lawyers and experts' fees. It is a concern that the cost of litigation can be misrepresented. Clinical negligence claims are expensive for reasons which are discussed further below. In relation to damages, it is important to emphasise that a significant proportion of larger claims will include very substantial claims for future care. These represent the costs of providing reasonable care and treatment to those who have suffered catastrophic injuries. It would be helpful to know how much of the budget figures set out in the call for evidence represent claims for future care and therapy.

Reforming Clinical Negligence Litigation

12. There are five key factors that appear to drive current concerns about NHS Litigation:

    a. Clinical negligence claims are hard to prove. The burden of proving negligence is on claimants and successful claims will only proceed if there is supportive expert evidence. Solicitors' firms will be able to provide valuable data on the number of inquiries they receive in relation to potential claims which fail to proceed either because the facts are unlikely to give rise to a claim or because the expert evidence obtained is negative. Similarly, many claims will not proceed if the claimant receives a reasoned letter of response denying liability.

    b. Clinical negligence claims are expensive. Solicitors are better placed than the Bar Council to provide data on the factors that drive costs, but three factors are readily apparent:

        i. the cost of obtaining and considering expert evidence;

        ii. completing inquiries that must be made before the claim can be presented to the relevant defendant;

        iii. and the costs and delay of litigating a case from the issue of the claim to trial or settlement if sooner.

    c. Damages awards are high and getting higher. There are several reasons why damages awards are getting larger, in catastrophic injury cases in particular: increases in the cost of living accompanied by rising house prices and wages, the

setting of the discount rate at a negative rate[1], and the Court of Appeal's decision in *Swift v Carpenter*[2] in relation to accommodation claims. Developments in medical technology and the increasing sophistication of the actuarial methods used to calculate damages are likely to further increase the size of claims.

d. There is a disparity (lack of proportion) between the award of damages and the amount of costs. The lack of proportion between costs and damages is a common feature of many aspects of civil litigation including property disputes and professional negligence actions. In clinical negligence claims there are several factors that will limit the amount of compensation. Claims settled for a modest amount of damages may incur the same or very similar levels of costs as larger claim, as the complexity of issues such as breach of duty and causation bear no necessary relationship to the level of financial loss suffered. A significant factor limiting the size of claims will be life expectancy. It follows that claims brought by elderly claimants can be disproportionate. Claims that result in death can also incur significant costs that exceed the level of damages: neonatal death is a common example of a claim where significant expert evidence and investigation will be required, but damages can be modest.

e. There is dissatisfaction with the experience of litigation on both sides. The cause of such disenchantment is partly explained by the factors listed above: the difficulty of proving negligence, delay, and cost. Litigation is adversarial and poor relations between claimants and defendants can exacerbate tensions already created by delay and cost.

Proposals for Reform

13. There is a history of dissatisfaction with the current tort system giving rise to calls for reform. The Pearson Commission recommended a no-fault scheme for personal injury claims in 1978. In 1997 Patrick Atiyah wrote a visceral polemic calling for reform, *The Damages Lottery*.[3] More recently Lord Sumption re-visited this theme, giving an eloquent critique of the fault principle of tort claims in a lecture to the Personal Injuries Bar Association.[4] In 2017 Sonia McLeod and Christopher Hodges edited a valuable guide to both domestic and international statutory schemes for compensation for personal injuries.[5] Some of the features of statutory schemes and criticisms of current tort law are discussed by the Health and Social Care Committee in its report "*The safety of maternity services in England*".[6]

14. The reform of the current system poses a dilemma for the Bar Council as it may for other organisations responding to this call for evidence. While there are legitimate criticisms that can be made of the system, there are profound difficulties in framing an alternative which either cures the perceived defects or saves money without limiting compensation or the right to make a claim. Such difficulties and complexities may explain why no significant reform has been made to the fundamentals of the system since the Pearson Report in 1979. It is notable that Lord Sumption does not anticipate the 'abolition' of personal injuries law but foresees some potential legislative intervention to limit the recoverability of certain heads of claim.

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[1] See Appendix §49, and ftn. 19

[2] For Swift v Carpenter, see Appendix §49 and ftn 20

[3] (London, 1997).

[4] "Abolishing Personal Injuries Law – A Project", reprinted in *Law in a Time of Crisis* (London, 2021).

[5] Sonia MacLeod and Christopher Hodges (eds), *Redress Schemes for Personal Injuries* (Oxford, 2017).

[6] https://committees.parliament.uk/publications/6578/documents/73151/default/

15. One of the aims of the Bar Council is to secure and expand access to justice. Any statutory scheme that afforded the victims of clinical negligence access to a remedy without having to prove fault would achieve such a purpose, but it is not clear to us whether a 'no fault scheme' along the lines recommended by the Pearson Report works well in the context of personal injury. It is notable that during the Health and Social Care Committee's evidence sessions on maternity services the suggestion was made that a fault-based system be replaced by one in which the criterion for compensation would be that injury was "avoidable". "Avoidable" injury is a problematic term in the context of clinical negligence as causation is the most contentious issue and very often the reason many claims will fail.[7] From a clinical negligence lawyer's perspective, the term appears to eschew the duty element of the tort while conflating factual causation and causation of injury.[8] Any statutory scheme must provide greater clarity, which will require the identification of appropriate eligibility criteria based on policy considerations: would, for example, such a scheme apply a concept like breach of duty or award compensation on a "no fault" basis? Would an applicant have to prove causation of injury and by what criteria? In so far as causation remains a part of any statutory scheme many of the criticisms made by claimants about the difficulty of proving claims may continue, and involve investigation, delay, and cost.

16. Another factor that requires careful consideration is the eligibility test for any statutory scheme that is not based on the failure to provide adequate treatment. The most obvious is cases based on consent. Since the Supreme Court's decision in *Montgomery v Lanarkshire Health Board* [2015] UKSC 11, cases based on or including allegations of the failure to obtain full and informed consent have increased significantly.[9] Developments like this reflect one of the positive features of the tort law system in that it is able to develop the law in relation to new circumstances and novel claims. Other examples of where the law is currently developing are in relation to claims for psychiatric injury caused to the family of the 'primary' victims of clinical negligence, and the liability of trusts for the illegal acts of third parties. It is hard to see how a statutory scheme can retain the same or similar ability to develop the law or achieve just satisfaction for an injured claimant, though part of the answer to this issue would be retaining the claimant's right to bring a civil claim.

17. A more fundamental problem with any statutory scheme is the application of limits on compensation. Caps in most statutory schemes are significantly lower than common law damages. Part of a claimant's access to justice is the right to fair and equitable compensation: it is difficult to support any scheme in which a claimant's right to compensation would be significantly reduced. One answer to this is for the claimant to retain the right to make a civil claim. The choice of forum would be for the claimant. They could choose to accept compensation under the statutory scheme, and this may be advantageous if the eligibility criteria reflected a less restrictive application of the usual rules in relation to liability. Conversely, claimants with strong claims would be less likely to accept less compensation than they would if they were to make a negligence claim. It follows that any statutory scheme would have to consider the relationship between applications under the scheme and the continuing right to bring a civil action. This may involve issues of timing but would also include consideration of whether claims could be brought both at common law and under the statutory scheme.

18. A new statutory scheme for clinical negligence claims is a project of phenomenal ambition. For all its defects the tort system can adjudicate on a range of claims and novel situations

[7] For the reason set out in the Appendix, see §§ 42-47.

[8] For an explanation of these terms, please see Appendix §§ 42-47.

[9] This statement is based on experience of the number of claims with which our members are involved rather than a statistical analysis. It may be that the data does not support the impression that we have.

giving it a flexibility which a statutory scheme may lack. Existing statutory schemes in the UK have developed to deal with very specific circumstances, for example the pneumoconiosis scheme for miners. The advantage of a narrowly prescribed scheme is that there are a smaller number of cases, with similar facts, requiring evidence from the same experts. However, such a scheme would also have to consider the points made above about the relationship between any statutory right to redress, limits on compensation, and the right to bring a civil claim.

19. The essential basis upon which compensation is awarded is the 100% principle.[10] The current basis upon which claims for care and loss of earnings are calculated is consistent with this principle. An important further aspect of the law as set out by the House of Lords in *Wells v Wells* is that the court is concerned with the assessment of damages, not with how claimants spend the money.[11] This is not just an acknowledgment that the court cannot impose restrictions on what a successful claimant may do with a damages award, but a recognition that an injured claimant may have to meet their immediate needs by spending money theoretically earmarked for other heads of loss: the cost of accommodation is the most obvious example.

20. A system which puts claimants back into the position they would have been in had the accident not occurred is the basis of assessment. In setting the discount rate at minus 0.25% previous Lord Chancellors specifically expressed their commitment to this principle. The Bar Council has consistently affirmed its commitment to this principle as well. In our view it is an essential aspect of access to justice that claimants receive full compensation.

Question 1: How important is it that any clinical negligence system encourages lesson learning and commitment to change as the result of any action?

21. The purpose of the tort system is to enable those who have been injured by negligence to recover compensation to put them in the same position they would have been in (or as close as can be achieved with money) but for the negligence[1]. In law there is no 'clinical negligence' system rather clinical negligence is a label given to one type of tort claim. To put it another way the NHS is in law no different to any other tortfeasor. Litigation has never really been understood to encourage lesson learning and commitment to change and indeed to suggest the tort system should encourage this, as a principal aim, is to misunderstand the purpose of tort law which is to compensate the victim and not to punish or prevent recidivism by the tortfeasor. Insofar as the fact of litigation and any compensation paid either pursuant to a judgment or in settlement prompts the NHS to reflect, learn and, where appropriate, institute change, that is a desirable outcome. It is within the gift of the NHS to do this as a matter of course within the existing litigation framework and in some NHS trusts a culture exists whereby some form of review and lesson learning takes place in the aftermath of litigation or indeed as part of clinical practice following any serious medical accident (see further below). Lesson learning can also take place and is already promoted within NHS Resolution's claims mediation service. Increase in recourse to early alternative dispute resolution (ADR), and in particular mediation, provides a less adversarial forum for resolution of disputes and can promote lesson learning in a positive way.

22. There is a fundamental split between, on the one hand, the processes followed in respect of good clinical governance, including Datix reporting, mortality and morbidity meetings, 72-hour reports and serious incident reviews and, on the other, the tort system when dealing

[10] See Appendix § 49
[11] [1999] 1 AC 345 (HL).

with claims against the NHS. In the former, the aim is indeed to ascertain what went wrong, why, and how such mistakes can be avoided in the future. The usual methodology adopted by those tasked with investigating Datix reports and serious incidents (formerly known as serious untoward incidents or 'SUIs') is to perform a root cause analysis (RCA). An RCA does not seek to attribute blame to any person but examines where things have gone wrong and where this may have its origins in training issues or systemic problems as much as the clinical decisions and judgments involved. Clinical negligence claims analyse duty, breach, causation and loss and contributory negligence which is usually a fact intensive process. To expand the scope of the litigation beyond that, with the aim of the NHS learning lessons, would be a radical change to what civil justice means. It might, however, be a potential feature of a statutory scheme for certain types of claim. Such a scheme might have as one of its aims the identification of failings (without necessarily the apportionment of blame to individuals) and remedial action.

23. Whereas clinical negligence claims are not per se about learning lessons and clinical governance is very much focused on learning lessons, NHS trusts do not always perform a holistic assessment of facts based on *both* elements in order to learn lessons as often as possible. Here there is scope for meaningful change. This is not a change which requires any change in law but a change in the culture and/or systems of NHS trusts as it would be for those trusts to reflect upon and institute improvements from lessons learned from civil litigation, internal and external investigation.

24. Where there is an admission, or finding, of liability by the NHS trust, there may be an argument for creating a system whereby a further review, the focus of which is lessons to be learned, should be triggered irrespective of whether any serious incident investigation has occurred. We note that there are instances in which substantial compensation is awarded or agreed where the preliminary clinical governance assessment has been not to proceed beyond a 72-hour report. In some cases, the reports are not even completed by or with regard to the relevant clinicians and may be superficial, inaccurate or incomplete resulting in a failed opportunity to review and learn.

Question 2: What changes should be made to clinical negligence claims to enable a move away from a blame culture and towards a learning culture in the NHS?

25. As set out above clinical negligence claims cannot become a vehicle in law for enabling clinicians and health professionals to reflect, review and learn lessons without a change which strikes at the very heart of the civil justice system. We are not satisfied that the tort system (or clinical negligence claims) is fairly described as giving rise to a blame culture: the requirement of fault in the civil justice system is as old as the system itself (in fact much older) and if the system gave rise to a culture of blame this would have been an issue since the creation of the system, yet the so-called 'blame culture' is a very modern phenomenon.

26. Clinical negligence claims have the aim of providing redress where someone has been harmed by the actions of the tortfeasor. Any reform which diminishes the objective of restoring so far as possible the victim of the tort to the position that he or she would have been in but for the negligence would be to change the fundamental nature of civil litigation.

27. Sharing of information with those tasked with clinical governance could assist with improving the learning culture within the NHS which would, if effective, reduce the number of acts of negligence and claims going forward.

Question 3: How can the Healthcare Safety Investigation Branch work to improve short term responses to patient safety incidences and therefore reduce the number of those who are forced to pursue litigation as a means of obtaining non-financial remedies?

28. The question presupposes that individuals are 'forced' to pursue litigation. This is wrong. Civil litigation is only brought if an individual institutes a claim which is brought about by free choice.

29. Evidence does support that an early apology provides sufficient redress for some individuals (perhaps those with less serious injuries). It is an internal matter of the culture of NHS trusts as to how and if they make early (and fullsome) apologies and not a matter which requires any change to the civil justice system. An acknowledgement that a wrong has been suffered is part of the civil litigation system and an early acknowledgement may be enough for some individuals (perhaps weighted towards those cases where the consequences of the negligence were short-lived or relatively trivial).

30. The actions of the Healthcare Safety Investigation Branch (HSIB) would not directly influence whether an individual chose to bring a claim as it is the actions of the NHS trust in question which would have most effect on whether an individual felt the need to seek redress if they considered the wrong they suffered had not been acknowledged.

31. The HSIB or any other external investigative body (such as one of the Royal Colleges) may have an indirect impact on the number of claims. This may arise if

    a. it provides a report in a timeous manner

    b. the report findings are adopted by the NHS trust and

    c. the NHS trust clearly and fully communicates this to the patient so that the patient has acknowledgement that they have suffered a wrong.

32. However, in any case where there have been serious consequences or financial impact it is unlikely that many patients would be satisfied with acknowledgement they had suffered a wrong, as they would probably want financial redress to put them in the same position they would have been but for the negligence (which is the main purpose of civil litigation). While an increase in short-term responses from the HSIB could reduce the number of claimants who issue proceedings in order to obtain non-financial remedies, much more data would need to be gathered as to the number of claims which are brought with the purpose of securing *non-financial* remedies to reach meaningful conclusions in this regard.

33. Plainly, questions of HSIB funding and emphasis are matters for the government.

Question 4: What legislative changes would be required to support these changes?

34. Any change to the civil justice system, which is what parts of the terms of reference suggest, would require primary legislation to be passed in Parliament.

35. The principle of 'full compensation' also known as 'the 100% principle' (the right to be put back into the same position as far as is possible with money) and fault as an essential ingredient of common law negligence claims are longstanding and have been approved by the Supreme Court and before then by the House of Lords. They are fundamental principles of the common law which could only be interfered with by Parliament or the Supreme Court.

36. The Bar Council would very much welcome an opportunity to comment on any framework of proposed changes as part of a consultation at a later stage.

APPENDIX: SOME ASPECTS OF CLINICAL NEGLIGENCE LITIGATION

Proving Negligence

37. A singular feature of the tort law system is that a patient making a claim must prove all aspects of the elements of a tort law claim: breach of duty, causation, and damage.

Breach of Duty

38. In order to prove that a clinician is in breach of duty, a claimant must prove that no reasonable clinician would have done what the Defendant did or failed to take steps which should have been taken. It must be shown the taking such a step or failing to take such a step was below the standard of care that a patient could reasonably expect. In proving such a failure, the claimant must have supportive expert evidence from a clinician in the relevant field: for example, if a claim is made that an orthopaedic surgeon failed to identify a fractured wrist on x-ray, the claimant would have to have supportive evidence from an orthopaedic surgeon that the failure to identify the wrist fracture was below the standard of care the patient could reasonably expect: the *Bolam* test.[12]

39. A particular feature of the *Bolam* test is that a claim can be defended successfully if it can be established that a reasonable body of medical opinion would have acted in the same way as the defendant. A clinician will only be found to have been negligent if they acted in a way that no other reasonably competent clinician in that field would have done. It is not a test that is judged with hindsight nor is it resolved by determining what a majority of clinicians might have done.

40. In circumstances when the court is faced with divergent opinions about what is reasonable, the court can consider the logic and rationality of the expert opinion being put forward by either party, an important development of the *Bolam* test set out by the House of Lords in the case of *Bolitho.*[13]

41. The importance of the *Bolam/Bolitho* tests is that they establish the centrality of expert evidence in clinical negligence cases. Without appropriate supportive expert evidence, most potential claims cannot progress.

Causation

42. Causation is one of the most difficult concepts in law[14] and is central to most clinical negligence litigation. The way in which the test works is best illustrated by an example[15]:

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[12] *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582.

[13] *Bolitho v City and Hackney Health Authority* [1998] AC 232.

[14] The definitive study is still Hart & Honoré, *Causation in the Law*, 2nd Edition (Oxford, 1985).

[15] The facts are based on an actual case, *Barnett v Chelsea and Kensington Hospital Management Committee* [1969] 1 QB 428 (Neild J.)

43. I

> *A patient attended A & E complaining of stomach pains after drinking a cup of tea. He is examined by A & E staff. No active intervention is suggested, and the patient is discharged. A few hours later he collapses. He is rushed to hospital but subsequently dies. The cause of death is that his tea has been poisoned with arsenic. A & E were in breach of duty in that they failed to undertake proper investigations that would have detected arsenic poisoning before discharging the patient, however the claim fails because the patient would have died of arsenic poisoning in any event.*

n many clinical negligence cases breach of duty is admitted, but causation is in dispute. This is very often a difficult concept for patients who bring a claim: the trust admits that a mistake was made, that care fell below a reasonable standard, but the claim will fail because the injury would have occurred in any event. The ordinary clinical negligence case is resolved by the application of this test, commonly called the "but for" test: "but for" the negligence the claimant would not have suffered an injury. A claimant will succeed if they can show that injury could have been avoided "on the balance of probabilities", i.e., more likely than not.

44. Proving causation can be extremely complex and involve multiple experts: for example, in spinal injury cases the parties may often require evidence from a neurosurgeon, urologist, and colo-rectal surgeon; in birth injury cases obstetrics, neurological, and radiological evidence will usually be required.

45. The type of causation arguments discussed above are concerned with the causation of injury: the defence is that the patient would have suffered the same injury in any event so there is no actual loss as there is no 'actionable' injury. This aspect of causation is sometimes described as legal causation. The claimant must prove that they have suffered injury (damage) and if they cannot prove this the case will fail.

46. There is another aspect of causation which is also essential to the claim: factual causation. Factual causation is concerned with what would have happened had there not been a breach of duty. Again, this is best illustrated by an example:

> *A nurse calls a doctor to attend a child with respiratory difficulties. In breach of duty the doctor fails to attend. The child collapses and suffers brain injury as a result of respiratory system failure. The child could have survived had the doctor attended and arranged for intubation. The claim fails because the doctor's evidence is that had she attended she would not have intubated, and a reasonable body of medical opinion would have supported this course of action.*

47. This example[16] illustrates the difficulties that face claimants trying to establish factual causation. First, the issue of what treatment would have been provided is factual evidence that will be given by employees or former employees of the defendant trust. Secondly, such evidence is based on an inquiry about hypothetical rather than actual events. The need to establish factual causation also causes practical difficulties for defendants whose employees may have moved on or whose memories have faded over time. The focus of many clinical negligence trials is about inferences that may or may not be drawn from evidential gaps.

Damage

48. The third limb of the tort of negligence is damage: suffering injury and loss. Damage is intimately linked with causation: the tort is only complete if an injury has been caused by the

[16] These are the basic facts in *Bolitho,* op cit.

alleged negligence. A particular feature of clinical negligence litigation is that the issue is about the extent of injury caused by breach of duty: in many cases minor injury may be admitted but a more significant injury which would give rise to a larger claim in damages is denied. This aspect of clinical negligence litigation can again be illustrated by an example[17]:

> *The Claimant suffered from ischaemia in his left leg. The defendant's clinicians failed to implement an appropriate treatment plan. After some delay he was admitted to hospital, but his leg could not be saved and had to be amputated. The claimant failed to prove that his leg could have been saved had it not been for the breach of duty; however, he was entitled to a claim for pain suffering and loss of amenity for the period of delay in treatment. His claim for the consequences of amputation agreed at £ 525, 000 was dismissed; he received a general damages award of £ 2, 000.*

The Assessment of Damages

49. The essential principle of the assessment of damages is that the compensation received should put the claimant in the position they would have been in had the negligence never occurred, as defined by Lord Blackburn in *Livingstone v Rawyards Coal Co*: "*that sum of money which will put the party who has been injured, or who has suffered, in the same position as he would have been if he had not sustained the wrong for which he is now getting his compensation or reparation."*[18] A modern re-statement of the principles of assessment is given by the House of Lords in *Wells v Wells*.[19] An essential principle of the assessment is that the claimant is entitled to 100% of their damages: 'the 100% principle'. The practical importance of the 100% is recently illustrated in the decision to set the discount rate at -0.25%[20] and the Court of Appeal's decision on the approach to be taken in calculating claims for accommodation for severely injured claimants.[21]

Funding Litigation

Conditional Fee Agreements

50. Since the abolition of public funding for personal injury and most clinical negligence, most claims are funded through Conditional Fee Agreements ['CFAs']. Most CFAs have two essential attributes: first, the client is only liable to pay his legal representatives' costs if the claim succeeds ("no win, no fee"), secondly, if the claim is won the client is liable to pay their legal representatives a 'success fee'. Since 2013 success fees in clinical negligence claims cannot be recovered against an unsuccessful defendant. Where success fees are claimed

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[17] The facts are based on *Medway Primary Care Trust & Dr Ashiq v Marcus* [2011] EWCA Civ 750.

[18] (1880) 5 App Cas 25 .

[19] [1999] 1 AC 345 (HL).

[20] https://www.gov.uk/government/news/lord-chancellor-announces-new-discount-rate-for-personal-injury-claims The Discount Rate reflects the rate of return on investment of the Claimant's compensation. It is intended to ensure that the money received will last the Claimant's lifetime, and not result in overcompensation. The rate is used to determine a "Multiplier" for the relevant period of time derived from the Ogden Actuarial Tables. The annual loss is referred to as the Multiplicand. So, in calculating damages Multiplier x Multiplicand = the level of damages awarded for the relevant head of loss. The current discount rate which determines the appropriate multiplier is -0.25%.

[21] *Swift v Carpenter* [2020] EWCA Civ 165 (CA). One of the problems with the actuarial multiplier/multiplicand method lies in dealing with the costs of accommodation: verry often a significant immediate outlay which will be incurred by seriously injured claimants. In *Swift v Carpenter* the Court of Appeal gave guidance on the calculation of these claims having regard to the reversionary value of the property.

these are deducted from the clients' damages, capped at 25% of general damages and past loss. Prior to 2013 success fees could be recovered from unsuccessful defendants.

After the Event Insurance

51. Clients can insure themselves against adverse costs orders by taking out After the Event Insurance ['**ATE**']. Prior to 2013 the costs of an insurance premium could be claimed as part of a successful claimant's costs against the unsuccessful defendant. Since 2013 ATE premiums are no longer recoverable against defendants in most claims. However, there is still a need for ATE. Claimants can still have adverse costs orders made against them: for example, if they fail to beat the defendant's (Part 36) offer to settle the case within an appropriate time, see discussion on Part 36 below. ATE insurance can also cover the very considerable expenses that are incurred in obtaining the experts reports which the claimant requires to prove, breach of duty, causation, and injury as set out above.

Litigation Costs

Costs in Clinical Negligence Cases

52. For reasons explained above, clinical negligence cases are complex and as a result this is an expensive form of litigation. Care needs to be taken in assessing the overall costs of litigation to the NHS. All successful claims are subject to assessment by the court. The overall costs of litigation must be considered in more granular detail: how many cases make up the total? What is the average costs bill/damages bill per case? Do a relatively small number of high-value cases contribute most of the damages and costs liabilities of the NHS?

The Costs Shifting Rule

53. The costs shifting principle is the normal rule in civil litigation: the loser pays the winner's costs.

Qualified One-Way Costs Shifting

54. An exception to the costs-shifting principle is Qualified One-Way Costs Shifting ['**QOCs**']. Since 2013 unsuccessful claimants in personal injury and clinical negligence actions do not have to pay the successful defendant's costs.[22] The rule is 'qualified' in that in certain circumstances an unsuccessful defendant can recover its costs against a successful claimant.

Part 36

55. The most important 'qualification' to QOCs is the effect of Part 36 offers. The Civil Procedure Rules ['CPR'] mitigate the effect of the basic costs shifting rule by providing in Part 36 that offers to be made and costs consequences to flow from a party's failure to beat the other side's offer. Part 36 provides a significant means by which defendants can protect their position by making offers which place the claimant at significant costs risk and encourage the parties to settle the claim in advance of trial. Part 36 plays a huge role in the settlement of most clinical negligence claims and is an aspect of the CPR which operates extremely well.[23]

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[22] The rule works in a slightly convoluted way: an order will be made for the unsuccessful claimant to pay the successful defendant's costs, but the order will not be enforced by the court.

[23] A useful illustration of how Part 36 can work in practice is illustrated by the example of *Marcus v Medway* discussed at §13. This case came to the Court of Appeal on a costs point. The defendant had not made a Part 36 offer and the issue was in effect who had 'won' the litigation because the claimant only recovered £ 2, 000. A Part

Fixed Costs

56. The costs shifting rule and its variations establish who has the burden of paying costs. In most clinical negligence cases the amount of costs will be subject to the process of detailed assessment.[24] An alternative to assessment within the CPR are various schemes for fixed costs, for personal injury claims worth up to £ 25, 000. The Government has recently announced the expansion of fixed costs in the fast track to most categories of civil litigation worth up to £ 100, 000, but these proposals specifically exclude clinical negligence.[25] The Bar Council has been an active participant in the Department of Health's proposals to introduce a fixed costs scheme in clinical negligence claims worth up to £ 25, 000. An important aspect of the fixed costs regime emphasised by the senior members of the judiciary who have had to adjudicate on its operation is that it works on a 'swings and roundabouts' basis: there will be some cases where fixed costs do not adequately compensate the claimant and their legal representatives for the time spent on the case, however, there will be other instances when the level of fixed costs is generous as the time spent is minimal.[26]

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36 offer of £ 2, 000 would have protected the defendant's position and avoided any argument about the costs of trial. However, there is sometimes a problem with the operation of Part 36 in cases such as this which is usually due to the timing of the offer. An early offer of £ 2, 000 would have allowed the defendant significant costs recovery but a more modest costs liability; however, a late offer would expose the defendant to the costs of litigation up until the time the offer was open to acceptance and a potentially significant costs liability.

[24] The procedure of 'summary' assessment usually applies when a hearing lasts less than a day and the costs are assessed at the end of the hearing.

[25] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1015019/extending-fixed-recoverable-costs-civil-cases-government-response.pdf

[26] Simon J (as he then was) in *Nizami v Butt* [2006] 1 WLR 3307 described the intention of the fixed recoverable costs regime: "*was to provide an agreed scheme of recovery which was certain and easily calculated. This was done by providing fixed levels of remuneration which might over-reward in some cases and under-reward in others, but which were regarded as fair when taken as a whole.*"