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MDU response to MoJ survey of Part 2 of LASPO: Litigation funding and costs

What types of claims do you typically deal with?

The MDU's work includes assisting our medical and dental members with clinical negligence claims. These claims are all dealt with through the multi-track procedure.

How long have you been in that role/dealing with that type of claim?

We have been assisting medical members with clinical negligence claims since claims were first made against them, from the mid-1900s.

Section 44 abolished the recoverability of Conditional Fee Agreement success fees. In your experience what have been the impacts of this reform, and the regulations made under it?

It is still too early to provide a definitive answer in respect of the full range of clinical negligence claims because of their long-tail nature, but our initial data indicates the effect has been as intended with a reduction in costs for medical and dental claims. This results from a combination of the abolition of recoverability of success fees and a reduction in recoverable ATE premiums. While some of the lower value claims costs have halved there is still not sufficient proportionality between costs and damages. For example, in one case settled since April 2013 we paid £30,000 to compensate a patient whose solicitor's costs were £52,000. In a further example, in a case where damages were agreed at £20,000 the bill of costs totalled £48,000. The ATE premium for experts' reports was £5,636. Costs were agreed at £30,000. There was considerable additional work involved in the assessment of those costs and the settlement negotiations. The current system still involves a lot of expenditure in order to agree costs at the conclusion of a case.

Section 46 abolished the recoverability of after the event (ATE) insurance premiums (except in relation to clinical negligence expert reports). Qualified One Way Costs

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Shifting (QOCS) was introduced in its place in personal injury claims. In your experience what have been the impacts of this reform?

The abolition of recoverability of ATE premiums has helped to control costs in some respects, but any gains are offset by the retention of recoverability for clinical negligence expert reports. Our experience is that while we do see some ATE insurance premiums that we believe are reasonable, many appear unreasonable and there is no consistency in the market in terms of costs charged. In many cases it would appear that the premium is assessed by the level of damages and not by an assessment of risk. For example, we received an ATE premium of £13,000 for a case valued at £20,000. While we can see that the premium was calculated by reference to damages we are not able to assess the underlying calculation that produced the premium incurred. The only effective challenge is a legal one. NHS Resolution is currently seeking to challenge ATE premiums in two cases before the Court of Appeal, but such a process is costly and not without risk. It wouldn't be necessary if there was a requirement for greater transparency and proportionality among providers of ATE policies. This aspect of the LASPO changes does not work and needs further reform. If fixed fees were introduced for clinical negligence claims they should be introduced in conjunction with the abolition of recoverability of ATE premiums. One of the main impacts of the QOCS reform has been that unmeritorious claims continue to a far later stage in the proceedings before being discontinued. This because there is no costs penalty which might otherwise influence claimants' decisions.

Section 45 introduced Damages Based Agreements as a funding method for civil cases. In your experience what have been the impacts of this reform?

N/A

Section 55 reformed Part 36 offers to settle. The statutory change introduced by LASPO Part 2 was primarily that where defendant fails to beat a claimant's offer, the claimant's recovery should be enhanced by 10%. In your experience, what have been the impacts of this reform, and the regulations made under it?

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In our experience Part 36 offers were effective before LASPO and they have continued to be an effective means of putting both sides under costs pressures. We have not experienced any material difference and Part 36 offers remain effective.

Sections 56-60 prohibited the payment of referral fees in personal injury cases. What have been the impacts of this reform?

N/A

Overall, what has been your experience of the combined impacts of the LASPO Part 2 reforms?

Our initial experience was that the number of claims started to rise dramatically in 2012 and this continued for the first couple of years where we saw a 20% rise in claims year on year. Claims numbers started to level off in 2016 and dropped slightly in 2017, though they are still higher than pre-2012. The dramatic early rise in claims numbers was without doubt a direct result of claimants' solicitors signing CFAs before the LASPO changes came in to force. The fact that the number of claims remains above pre-LASPO figures might suggest these reforms have not impeded access to justice. Aside from the additional workload, the MDU experienced a dramatic rise in our repudiation rate for medical claims which had been a steady 75% and rose to an average of over 80% in the years following LASPO, where it still remains.

Our experience so far is that the LASPO changes have largely succeeded in their aim of addressing rising costs in clinical negligence claims. It is still too early to form a complete view, but the initial signs are positive and more obvious with dental claims which tend to be less clinically complex and more straightforward than medical claims.

However, we have considerable concerns about the continuing disproportion in and unfairness of costs for ATE premiums for expert reports. We believe the regulations need reform.

Jill Harding

MDU Head of Claims

13 August 2018