FACULTY OF ADVOCATES

RESPONSE
by
FACULTY OF ADVOCATES
to

SCOTTISH GOVERNMENT
on
Draft Proposals for a "No-blame" Redress Scheme in Scotland for Harm Resulting from Clinical Treatment

---

Overview

Contributors

- **Impartiality**

  This response has been informed by the experience of Advocates who act on behalf of both pursuers and defenders in clinical negligence claims. It is intended to provide comments in an objective and impartial manner.

Support for Reform

- **Redress Without Lengthy Court Process**

  The Faculty supports steps which will improve the system of justice in Scotland. It shares the Review Group's desire to ensure that wrongly injured persons receive appropriate and efficient redress. Civil court processes are not inherently lengthy. Delay in the resolution of civil disputes, including clinical negligence

claims, is often due to the shortage of court resources and time. Statistics received from the Central Legal Office in response to a Freedom of Information request[1] show (in the period from 2010 to 2015) a significant reduction in the time taken to resolve claims in both the Court of Session and the Sheriff Court. Any system of redress operating outwith the court process would require to be structured and resourced so as to avoid reproducing delays that exist in the current system of redress. It should also be capable of dealing with the volume of claims brought.

It is not clear to the Faculty how many claims would fall within the proposed scheme. Both the least and most serious claims are excluded from its ambit. The Faculty notes that the research quoted in the introduction to the consultation paper includes an incidence of "avoidable events" in general practice and that such events would not be covered by the proposed scheme. The Faculty also notes that some 70% of payments made under the current system are below £100,000. However, a payment does not necessarily reflect the value of the claim made: claims are frequently compromised by payment of amounts below full value. The statistics received from the CLO show that in the period from 2010 to 2015 an average of some 31 court cases a year were settled at below £100,000. This might suggest that few claims would fall within the ambit of the proposed scheme

- **Success of Recent Reforms**

Reform of procedure in personal injury cases in the Court of Session has been extremely successful. Clinical negligence actions have tended to be excluded from the personal injury procedure on the grounds of their additional complexity. Further reforms have sought to replicate the success of the personal injury procedure in clinical negligence and catastrophic injury cases through the creation of the specifically modelled Chapter 42A procedure in the Court of Session. This has helped focus the issues in dispute earlier than was formerly the case: although the waiting time for a proof (civil trial) currently remains long, this will improve with the transfer of smaller claims to the Sheriff Court. The success of Chapter 42A procedure has led to its adoption in the Sheriff Court (as Chapter 36A procedure in that Court).

[1] The response to the FOI request made of the CLO is appended to this response.

Claims in which the sum sued for is below £100,000 now require to be brought in the Sheriff Court.

The Faculty is concerned that further reforms are being considered for claims arising from medical treatment before the new procedure for clinical negligence cases in the Sheriff Court has been given the opportunity to work and its effectiveness measured.

- **Chapter 36A Procedure**

  The new procedure for clinical negligence cases in the Sheriff Court includes provision for, and the power for the Court to order or take steps to ensure:

  - early access to individuals to facilitate precognition (the taking of statements from key personnel);
  - early exchange of essential information and expert evidence;
  - early focussing of the issues between the parties and a narrowing of those issues;
  - candour;
  - meetings between the parties to resolve issues;
  - the avoidance of delay; and
  - proof only as deemed necessary on remaining issues that cannot otherwise be resolved.

  The introduction of a compulsory pre-action protocol in clinical negligence claims is a further measure likely to improve the handling of such claims in the courts. The Faculty understands that the pre-action protocol is currently in an advanced stage of negotiation.

  The Faculty believes that implementation of these procedures is likely to lead to greater openness, speedier and less costly

resolution of claims, and a higher level of satisfaction with the litigation process.

The Faculty remains of the view that the current system, with the improvements recently introduced under Chapters 42A and Chapter 36A, is a better means for compensating persons injured as a result of errors in diagnosis and treatment than the proposed scheme.

- **Other comments**

The Faculty notes that the combination of the requirement that a claimant suffer harm for a continuous period of at least six months and the financial cap would operate to exclude from the proposed scheme both claimants with the least and the most serious injuries. The Faculty questions whether it is truly the intention to exclude those cases involving the least serious injuries, not least because there is likely to be a greater disproportion between the cost of litigating these claims and the sums of compensation likely to be awarded in them than in other cases. Furthermore, the Faculty questions whether, as would be the case if the proposed scheme were to be adopted, it is desirable to differentiate between classes of claimants and the "route" they require to follow to secure redress.

It is stressed in the Ministerial Foreword to, and paragraph 3.1 of, the Consultation Document that the proposed scheme should be "trusted as fair" by patients. The Faculty is concerned that if the proposed scheme is to be administered by the CLO it might not be seen by patients as independent or impartial.

Question 1: Do you agree that it is appropriate to integrate the process for the redress scheme with the incident investigation, duty of candour and complaints processes to ensure consistency, improvement and shared learning?

Yes, in theory.

The Faculty notes the Ministerial commitment to integration at page 6 of the foreword to, and paragraphs 3.2 and 3.3 of, the Consultation document. The Faculty is concerned that the piecemeal approach to this matter taken to date may make integration more problematic than is implied. For example, the National Framework dealing with adverse events proceeds on a number of bases, including:

- The need to secure co-operation and compliance from witnesses (including staff) with a view to securing an effective process which facilitates relatively swift conclusion and the identification and adoption of changes in practice which minimize the risk of repetition and future harm.
- The need to respect confidentiality and data protection rights.
- The need to strike a balance between the potentially competing interests of those who participated in the review.

While final reports are shared with patients (or their families) the Faculty understands this is usually on a redacted and anonymised basis. Much of the focus of the procedure is on learning experiences for the health service, and to this end “near misses”, where no patient has been harmed, may be subject to the procedure.

The duty of candour regime (found in Part 2 of the Health (Tobacco, Nicotine, etc. and Care) (Scotland) Act 2016) is not yet in force; the practical details of how it is to work are to be prescribed in secondary legislation. We understand that a group under Professor Craig White is currently considering what the content of the secondary legislation should be. It remains to be seen how the duty of candour can be integrated satisfactorily with the National Framework dealing with adverse events. However, in terms of the Act, the duty of candour is triggered when a person who has received a health service, care service, or social work service from a responsible person was, during its provision, subjected to an unintended or unexpected incident which in the reasonable opinion of a registered health professional appears to

have resulted in, or "could result" in, one or more of a list of prescribed outcomes; but only if the outcome relates directly to the incident rather than to the natural course of the person's illness or underlying condition.[2] The statutory procedure does not have "eligibility criteria for redress" such as is now proposed.

It appears to the Faculty that the suggestion in paragraph 3.3 of the Consultation document that a duty of candour report "will be used in consideration of whether the eligibility criteria for redress has been met", might be more problematic than is envisaged. Nor is the Faculty clear whether the existence of such a report is to be a prerequisite for consideration for redress under the proposed scheme and, if so, whether it is (subject to appeal) to be determinative as to findings of fact made in the candour report.

The duty of candour regime applies to unintended or unexpected incidents. These are not necessarily the same as is proposed in the redress scheme – namely harm that could have been avoided by reasonable care. If the two schemes are to work together, the processes and terminology used should be consistent, coherent and integrated.

Question 2. Do you agree with these broad principles?

Yes.

The Faculty agrees with the broad principles of compensating quickly and fairly for avoidable harm, defending medically reasonable care and reducing patient injuries. However, and in addition to the observations above, it is difficult to reconcile a test of whether "reasonable care" would have avoided the harm (which involves judging the conduct of a medical professional) with the aim of creating a "no-blame" scheme.

The Faculty notes that, so far as claims arising from NHS care are concerned, the Scottish Ministers already possess the ability to require Health Boards to process claims quickly and fairly, and to adopt systems whereby compensation is paid in cases where legal liability is thought to exist.

[2] On the duty of candour see: David Stephenson QC: The Scottish Statutory Duty of Candour, Edin L Rev Volume 20, pp. 224-229.

Question 3: Do you agree that eligibility should be structured around the notion of "avoidability"?

Yes.

The Faculty has no criticism of the eligibility being structured around the notion of "avoidability". It is observed, however, that if "avoidable" means a failure to take reasonable care, that would be more difficult to establish than "sub-optimal" care. There is likely to be less debate or dispute amongst medical professionals as to whether care was "sub-optimal".

The Faculty considers that the potentially "chilling" effect of an avoidability scheme on medical innovation and progress should be recognised.[3]

Question 4: Do you support the proposal that the non-retrospective scheme should be restricted to harm which has or is likely to be experienced by the person for a continuous period of at least six months?

As noted above, the requirement that harm be suffered for a minimum period of six months and the financial cap operate to exclude from the proposed scheme both the most serious and the least serious cases. The Faculty questions whether this result is intended. The Faculty notes that the six month period would introduce another inconsistency with the duty of candour procedure: see the definition of prescribed outcomes in section 21(4) of the 2016 Act. It would also appear to exclude cases where death results within six months of the harm occurring, or where death due to another cause intervenes before the six month period has expired. The Faculty is unsure what is meant by "continuous" and is unclear whether the intention is to exclude a condition in which harm in the form of symptoms is experienced intermittently, even if permanently. It is not clear why any arbitrary time limit should be applied – the harm caused is either avoidable or it is not. If a qualification period is to be part of the scheme, other than the fact that there should be consistency

[3] Some 60 years ago, in the leading case on the standard of care in clinical negligence cases (Hunter v. Hanley 1955 SC) Lord President Clyde observed (at page 206) that a deviation from ordinary professional practice "is not necessarily evidence of negligence", warning that "…it would be disastrous if this were so, for all inducement to progress in medical science would then be destroyed."

with other schemes, the Faculty does not have a view on the duration of that period.

Question 5: Do you support the proposal that the proposed non-retrospective scheme should in the first instance be restricted to clinical treatment provided by directly employed NHS staff in Scotland?

The Faculty does not have a view on the restriction of the scheme to NHS staff but shares concerns about the potential cost of a wider scheme. Professional indemnity insurance for certain independent contractors is already prohibitively expensive. Restricting the scheme in the first instance to NHS staff would have the benefit of providing an opportunity for insurers to assess whether no-blame compensation is an insurable risk before it is extended further.

The Faculty notes that the acts or omissions of pharmacists who are independent contractors would not be covered by the proposed scheme. The acts or omissions of pharmacists employed by the NHS (in a hospital pharmacy) would appear to fall within the ambit of the proposed scheme. It is unclear if this result was intended.

Question 6: Do you support a cap of £100,000 on the level of award under the proposed scheme?

The Faculty notes that the financial cap of £100,000 is in line with the new exclusive competence of the Sheriff Court. The observations made above about the suitability of the reformed Sheriff Court procedures are repeated. The Faculty accepts that whatever limit is set there will be cases at the cusp of that limit. The Faculty is concerned that some claimants with legitimate claims above the level of the financial cap might be induced into making claims below the level of the financial cap in order to benefit from the proposed scheme with the result that they will be under-compensated.

The Faculty is unclear how the cap would work in the event of claims by relatives following upon the death of a patient. Are relatives to be entitled to claim under the redress scheme? If so, is the cap to apply separately to each individual claimant, or are the claims to be aggregated? Is the six-month eligibility requirement to apply to the deceased's suffering, or to the relatives' own suffering?

Question 7: Do you agree that levels of award should be based on the Judicial College Guidelines with patrimonial loss assessed on an individual basis?

The harm suffered by claimants is almost infinitely varied. The Judicial College Guidelines, whilst extremely useful, do not provide exhaustive guidance as to what might be the appropriate level of compensation in a particular case. The Guideline figures are arrived at by considering awards in litigation in England and Wales. They do not take account of awards in civil jury trials which although uncommon are competent in both the Court of Session and Sheriff Court, but not in England and Wales. Moreover, the valuation of fatal claims in Scotland differs substantially from the approach taken to such claims in England and Wales. It seems odd to the Faculty that the Scottish Government would introduce a redress procedure that only looked south of the border for guidance on quantum. The Faculty agrees with the suggestion that existing principles including case precedent should continue to be used in the assessment of compensation. The Faculty agrees that patrimonial losses should be assessed on an individual basis.

Question 8: Do you agree that the primary legislation should be flexible enough to allow the eligibility criteria and the scope of the scheme to be extended at a later date?

Whilst the Faculty is in favour of flexibility as regards certain matters, such as the definition of medical treatment and increasing the financial cap in order to keep the scheme up to date, other matters should require primary legislation. For example, an extension of the proposed scheme beyond the NHS or a change to the eligibility criteria from a failure to exercise reasonable care to the occurrence of sub-optimal care would benefit from the level of scrutiny that comes with primary legislation, and specific consultation with all those who may have an interest.

Question 9: Do you agree that the legislation should protect against "double dipping"?

The consultation paper describes "double dipping" as meaning that if a patient accepts an award offered under the proposed scheme the patient would not then be able to use that to raise a legal claim for negligence.

The Faculty is unclear as to what is meant in context by “double dipping”. Is it the intention that a patient who makes a claim under the scheme would be prevented from litigating his or her claim after it has been compensated under the proposed scheme? Is it the intention that the “successful” claimant under the proposed scheme would be unable to use the *finding* of avoidable harm in subsequent litigation? (A finding of avoidable harm would not be proof of professional negligence in a court.) Is it the intention that the “successful” claimant would be unable to use the *financial award* made under the scheme to fund a subsequent litigation? Is it the intention that there is a bar on double recovery – a rule that a claimant cannot recover the same loss both under the scheme and in a subsequent litigation?

If litigation is to be allowed in tandem with the proposed scheme, the Faculty considers that the Court should be entitled to take account of any sums awarded under the proposed scheme so as to avoid double recovery. Consideration will require to be given to whether and how payments under the proposed scheme can be integrated with the current scheme for recovery of state benefits from damages. Is a payment under the proposed scheme to be set-off against the whole of a claim for damages or only certain heads of damage? By the time litigation commences, the factual position upon which damages are assessed may have changed from that prevailing at the time of the assessment of the claim under the proposed scheme. Further, it should not be assumed that the approach to liability or causation will be the same in each case.

The Faculty considers that the existing law on the time within which litigation must be commenced (Prescription and Limitation (Scotland) Act 1973, as amended) should not be altered. Arguments might arise as to whether a claim made under the scheme was sufficient to interrupt the running of the limitation period and the Faculty suggests that to avoid doubt there ought to be specific provision dealing with this.

Question 10: Would you support the repeal of section 2(4) of the Law Reform (Personal Injuries) Act 1948 in relation to continuing care costs providing, as proposed, the care package is independently assessed and quality care guaranteed in each case?

The Faculty appreciates that the rising cost of continuing care is a concern. If section 2(4) of the 1948 Act were to be repealed, and the Court was able to take account of the availability of NHS provision for care in the assessment of damages, the burden of providing that care

would fall on the NHS. Purchasing care packages from the NHS represents a major shift in the provision of care for patients and sits uneasily with the statutory obligation to treat patients. Repeal would affect claims of all sorts and not just those arising from medical treatment. The implications of repeal could be wide and far-reaching. The Faculty suggests that a separate and wider consultation process be undertaken if repeal of this provision is proposed. A much larger number of persons is liable to be affected than those with a direct interest in clinical negligence claims.

The following illustration might suffice:

- A is rendered tetraplegic in a road traffic accident caused by B's fault.
- A sues B who is insured.
- As there is no defence the insurers accept liability and pay damages.
- A's life-time care costs are calculated on the basis of private provision and the insurers pay £8 million under this head of claim.

Repeal of section 2(4) would allow the insurers to argue that the NHS would provide adequate care. If that argument succeeded the cost of providing care could transfer from the insurer to the NHS.

The Faculty also feels obliged to note that private care packages are often sought by claimants because of their previous experience with NHS care and/or a perception that private care packages will better serve their needs.

Question 11: Would you support the development of a "fast track" element of CNORIS, utilising expertise with independent medical expert input?

The Faculty does not believe enough information is available at this stage in order to come to a view on the desirability of a fast track scheme. It would be of assistance to have statistical data available. However, in any event, it seems that the involvement of the CLO as decision maker and later as legal advisers to a party in litigation could lead patients to question their independence in administering the proposed scheme.

Question 12: Do you agree that the creation of an independent appeal panel combined with independent medical input in consideration of the claim and award would provide the appropriate level of independence?

The Faculty does not believe enough information is available at this stage in order to assess whether the appeal panel would be compliant with the European Convention on Human Rights.

The proposed right of appeal on fact and on law strikes the Faculty as potentially problematic.

Relatively few claimants under the redress scheme are likely to be able to navigate it, or any appeal process, without assistance. It is not clear how this would be provided, or funded.

APPENDIX

(Calendar years)

CLINICAL NEGLIGENCE CLAIMS

1. The number of such claims made within each year.

No of claims received these years that are settled by payment of compensation as at 31 May 2016

2. The number of court actions commenced in each year. - No of claims received these years that were settled as at 31 May 2016 and a court action

3. The number of court actions commenced in each year in which the sum sued for was (a) £100,000 or less, - No of claims received these years that were settled as a court action and the Award was for £100k or less

(b) more than £100,000.- No of claims received these years that were settled as a court action and the Award was greater than £100k

4. Of those claims that do not result in an action being raised the number of days between intimation of claim and (a) repudiation, and - The average no of days between claims being received and repudiated for claims received these years - note that may have subsequently been reopened and closed for reasons other than repudiation

(b) settlement, in each year. - The average no of days between claims being received and being settled by non-court action for claims received these years

5. The number of court actions raised in the Sheriff Court in each year. - of the total number of claims received these years, these are the number indicated as being in the Sheriff Court

6. The number of court actions raised in the Court of Session in each year.- of the total number of claims received these years, these are the number indicated as being in the Court of Session

5. Of those claims in which an action is commenced in the Sheriff Court the number of days between the making of the claim and settlement or determination by the Court. - Average of No of Days between Receipt of Claim and Settlement

6. Of those claims in which an action is commenced in the Court of Session the number of days between the making of the claim and settlement or determination by the Court. - Average of No of Days between Receipt of Claim and Settlement

2010	2011	2012	2013	2014	2015	2016
425	403	438	453	762	612	213
173	147	144	134	95	41	1
54	59	61	56	22	4	
37	38	45	48	16	3	
17	21	16	8	6	1	
248	200	273	235	179	129	
736	533	519	436	370	222	66
89	83	67	76	74	75	18
107	100	111	120	292	162	26
1051	918	769	572	435	220	
1115	1051	976	656	445	260	

(2016 as at 31 May 2016)

The increase in years '14, '15 and '16 is due to Mesh