Response to proposed reforms

May 2014

Introduction

Browne Jacobson LLP is a law firm with a national leading insurance practice and responds to the Ministry of Justice consultation with the benefit of views expressed by a number of our clients across the insurance sector.

Definition of 'soft tissue injury claim'

You have not invited views in relation to the definition of injuries within scope of the new rules, however this will be relevant to the remainder of our response.

We support the terms used which have a clearer medical meaning than 'whiplash' and which reduce the risk of claims falling out of scope due to minor symptoms beyond the neck and upper back.

It is necessary to recognise that 'soft tissue injuries' may include a range of injuries beyond 'whiplash' and the definition explicitly contemplates psychological injuries falling within the process. This is reasonable, in our view, as minor injury claims should be capable of efficient resolution. Of course, more serious injury claims will be excluded by the financial upper limit on the process.

The process must, however, be able to deal with the whole range of injuries with equal efficiency. We will address areas of concern in this regard below.

1. Mandatory fixed fees for medical reports

We agree that fixed fees are appropriate, and in practice these do apply in most cases by virtue of the MRO agreement. However, a balance must be struck between maintaining quality of evidence and the efficiency and savings of fixed fees. Pro forma reports and accreditation for experts is likely to assist in this regard and we look forward to seeing the Governments proposals in relation to that project.

The types of specialist who may be instructed are also a key consideration. In most instances we would expect a GP's report to be appropriate in this type of case. However, in some (such as a more serious soft tissue injury to a joint) a GP may lack the expertise to comment on the prognosis. In such cases it is preferable that an orthopaedic surgeon be instructed from the outset, to avoid the need for two reports. We therefore support both experts being included in the process.

We are concerned that physiotherapists may not have the expertise to provide an adequate report in relation to the types of injury included within the process. In particular, most physiotherapists would lack the medical training necessary to comment on issues such as causation or inconsistencies in reported symptoms. Given the Government's view that a more robust medical reporting process is an appropriate means of controlling fraudulent and exaggerated claims, this is, in our view, a particular concern. If a physiotherapist lacked the relevant expertise to deal with the range of injuries being presented to him then a further expert will be instructed to prepare a report. We are deeply concerned that this new procedure does not lead to unnecessary secondary reports being obtained, particularly if there was a suitable medical expert to report in the first instance.

It is also of concern at a time when a new accreditation scheme is proposed – we anticipate that those responsible for the scheme will face high demand for accreditation at the outset and in our view physiotherapists applications will require the most detailed consideration, for reasons outlined above.

Therefore we propose that physiotherapists should be excluded from the list of experts at the outset. If it is thought that they may contribute to the claims process, then we would support a limited trial, managed by the accreditor before a decision is taken.

2. Level of fixed costs

We cannot comment on the level of fixed costs, but presume that they have been reached through consultation with bodies representing the report providers.

3. Defendant version of events

In our view this would be an important development, as it would ensure an expert can deal with all issues in a single report. In many cases it may assist early settlement, as a difference perceived by the parties as significant may be shown at an early stage to be irrelevant to the injuries.

Where there are a range of possible factual circumstances in a case, we would generally expect a party instructing an expert to raise these, in order that the expert can deal with all relevant matters.. In any event, we envisage that the Defendant's comments (which might be in a pro-forma document) would simply require printing and submitting to the expert with instructions. Therefore this ought not to add an additional layer of cost and may indeed save costs in the long run.

4. Independence of experts

We agree that the independence of experts is crucial, but do not agree that additional rules are required in order to achieve this. The independence of an expert is enshrined in the Civil Procedure Rules and is confirmed by a declaration in the expert's report. The proposed accreditation scheme for soft tissue injury reports will add a further check on the independence of experts.

The draft rules which would prohibit referral of an expert in the event of a financial interest would have a significant impact on existing ABS arrangements under which many medicolegal agencies operate. It would therefore amount to a significant policy shift and have a substantial impact on the market. We would envisage that this may in turn damage the effectiveness of the new process. For example, medicolegal agencies are set up to operate in a fixed fee regime, and if their operation is affected then sourcing a fixed fee report may become more difficult. Litigants may become increasingly reliant on a small pool of experts, which does not, in our view, encourage quality reporting and may lead to backlogs and delays in resolving claims.

We do favour accreditation with associated monitoring of work sources and quality of reports to ensure that 'unhealthy' relationships do not develop. However we would like to see further detail on this proposal such as where the funding would come from for the accreditation scheme and who would be administering it. We believe that interested parties should have the opportunities of considering those proposals and commenting on the same.

5. Limiting the proportion of referrals to a particular agency

We do not favour a fixed limit on the proportion of claims set to an agency. This may lead to inflexibility and backlogs and potentially places the solicitor in a position of instructing an agency known to be less efficient, slower, or to produce a poorer quality report, which is against the interests of either party. It is difficult to see how the rule would be accurately monitored and enforced.

We do consider that the accreditor and the SRA should monitor referral levels, and if these indicate a cause for concerns should investigate them.

6. Implementing a rota for reports

We do not favour this for reasons set out above.

7. Ensuring independence

As discussed above, we consider there are effective measures already in place to ensure independence in most reports.

We do have concerns regarding the quality of some reports at present, and some experts tend to give views which are more favourable to one party than another as a result of their own opinion in relation to the medical issues. However, these are separate matters.

As we have discussed above, the accreditation scheme which has already been proposed and which e understand is being taken forward will, in our view, be the most effective means of tackling both issues.

8. and 9. Non-payment of the cost of a report obtained outside the protocol

We agree that this sanction is appropriate and sufficient, together with the additional provision proposed at question 9.

10. Pre medical offers

We recognise that there are good reasons why pre-medical offers many not be appropriate in some cases, particularly as they may result in some fraudulent cases being settled which might otherwise have been detected by an expert. However, in our view it is for defendants to take a view on their strategy in respect of such offers (as the ABI have done) and to implement their on approach.

Of course, the rules cannot prevent parties from agreeing a settlement (which is a matter of contract) should they wish to do so. We have reservations in relation to the merits and the likely effectiveness of attempting to prevent pre-medical settlements via the rule change proposed.

However, if the change is to be introduced then we do agree that an effective offer should be permitted following a non-protocol report. The alternative would be to prejudice the defendant's ability to settle due to the claimant's default.

talk to us...

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