

18. Clinical Negligence

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18.1 Scope

1. Applications for the funding of legal representation for proceedings in the clinical negligence franchise category are subject to the General Funding Code save to the extent that different Criteria are specified in section 9 of the Funding Code.
2. Clinical negligence proceedings mean:
 - (a) a claim for damages in respect of an alleged breach of duty of care or trespass to the person committed in the course of the provision of clinical or medical services (including dental or nursing services); or
 - (b) a claim for damages in respect of alleged professional negligence in the conduct of such a claim.
3. Applications for funding can only be made by firms with a clinical negligence contract which is restricted to solicitors with expertise in clinical negligence claims. This is demonstrated by the franchise category supervisor having membership of the specialist panels of the Law Society or Action Against Medical Accidents (AvMA).
4. All applications for funding for clinical negligence cases required to be sent to the Commission (whether initial applications or those for both scope and costs amendments) should be checked and approved by the franchise category supervisor before being sent to the regional office. A note that this has been done (or at least a copy of the application form countersigned by the supervisor) should be retained on the file. This function may also be carried out by other clinical negligence panel members in the firm (or during short periods when the supervisor or panel member is temporary unavailable by a deputy), provided that the authority to do so has been delegated to them by a category supervisor.

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18.2 NHS Complaints

1. Clinical negligence proceedings are subject to standard criterion 5.4.3 which allows legal representation to be refused if there are complaints systems, Ombudsman schemes or forms of alternative dispute resolution which should be tried before litigation is pursued. Guidance on mediation in clinical negligence disputes is at section 18.8 below. However, applications for investigative help are subject to an additional criterion (9.2.2) under which an application may be refused if it is more appropriate for the client to pursue the NHS complaint procedure than litigation. This is an important criterion which ensures that litigation against the NHS is not pursued unless it is the appropriate remedy for the client.
2. Criterion 9.2.2 applies only to investigative help, not full representation. It is very rare for clinical negligence certificates to start as full representation but those that do are still subject to the general ADR criterion 5.4.3.
3. Since April 2004 NHS complaints in England have operated under the supervision of the independent Health Care Commission. NHS complaints in Wales are administered somewhat differently, with complaints reviewed by an independent reviewer or the Health Service Ombudsman. The complaints procedure is not designed to resolve allegations of clinical negligence and cannot provide the client with the same remedies as litigation. The primary purpose of a complaints procedure is to provide the client with an explanation of what occurred and, if appropriate, an apology or reassurance as to future standards. This may allow the client to make a better-informed decision as to whether litigation is the appropriate remedy.

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4. Refusal under 9.2.2 is discretionary. The private client test will be considered in each case. The question for the Commission is: would a reasonable client of moderate but sufficient means be prepared to pay solicitors privately to investigate a potential claim before first pursuing a formal complaint against the NHS and considering the response received? Examples of circumstances in which it would not be appropriate to refuse funding under this criterion include where:
 - i. Proceedings must be issued as a matter of urgency, for example because of a limitation deadline and a satisfactory explanation has been given for any delay in making the application. Any funding granted in such circumstances is likely to be limited to the issue of protective proceedings only;
 - ii. The potential claim is of such severity that legal investigation is inevitable and should be pursued without delay. Cerebral palsy claims typically fall within this category;
 - iii. The potential claim is likely to be severely prejudiced by delay, for example, statements need to be obtained from witnesses who are critically ill or departing overseas;
 - iv. The case falls outside the NHS complaints scheme or the client has been told that a complaint may not be pursued further.
5. Note that the decision whether to refer a case to the complaints procedure does not depend on the case having a particular size of potential damages or on the importance of the case to the client. However, the smaller the damages claim the harder it would be to establish on private client principles that pursuit of the complaints procedure is not reasonable. In cases where financial compensation is not the client's primary motivation, for example when seeking an explanation of circumstances leading to the death of a family member in hospital, pursuit of the complaint procedure may be particularly appropriate.
6. If the complaints procedure has been pursued in good faith and with full co-operation by the client but no satisfactory formal response has been made to the complaint within 6 months of it being made, a grant of investigative help may then be appropriate. There is no requirement that complaints must be pursued to the Health Care Commission (or its equivalent in Wales) in all cases before legal aid can be considered. Where a complaint has not been dealt with adequately from the client's point of view, the private client test must again be applied to decide whether it is reasonable to ask the Healthcare Commission to review the complaint or to proceed with legal remedies.
7. Where the complaints procedure has been followed and a response obtained, this must be included with any subsequent application for funding. If it is felt that the response does not adequately deal with the issues of concern to the client, the reasons why litigation is thought to be appropriate must be set out on the application form.

18.3 Investigative Help (Criterion 9.2)

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1. The investigative stage is of vital importance in clinical negligence cases. Specialist practitioners will have carried out initial screening (under Legal Help if appropriate). The purpose of initial screening is to identify cases which are unlikely to satisfy the relevant funding criteria.
2. Investigative Help may only be granted where the prospects of success of the claim are unclear, and substantial investigative work is required before those prospects can be determined. Applications for funding for this level of service should only be made where a specialist practitioner is satisfied, on the basis of the limited information available, of the real possibility that negligent acts or omissions were responsible for the injury, or for an outcome which is not an acceptable one in view of the clinical procedures involved.

3. Certificates limited to Investigative Help will be issued subject to the following limitation, referred to as a Formal Investigation. (The limitation allows for but does not make the use of either external counsel or external solicitors with higher court advocacy rights).

“Limited to obtaining medical/clinical notes and records (including, if necessary, an application for pre-action disclosure), obtaining one medical report per specialism, complying with all steps under the Clinical Disputes Pre-Litigation Protocol, considering the relevant evidence with external counsel or an external solicitor with higher court advocacy rights and expert(s) (if necessary) and thereafter obtaining external Counsel’s Opinion or the opinion of an external solicitor with higher court advocacy rights, (again if necessary), to include settling proceedings if external counsel or an external solicitor with higher court advocacy rights, so advises.” – (CV089 – Formal Investigation – Clin Neg)
4. In addition to the scope limitation there will be a costs limitation of £3,500 (to include costs and disbursements but to exclude VAT). Although it is expected that full investigations will be concluded well within £3,500 under most certificates for Investigative Help, this cost limitation can be varied subject to the breakdown of the work to be undertaken and costs to be incurred, details of which must be submitted with an application for an amendment. Where steps with associated costs exceeding £3,500 are immediately foreseeable, that additional work must be justified and fully detailed in the breakdown of work and costs. Note that any subsequent amendment to the costs limitation will not be made other than to cover additional steps which were not previously foreseeable, and therefore were not included in the original estimate.
5. Following initial screening specialist practitioners will be expected to carry out a preliminary investigation which allows for further merits screening before the commitment of the substantial levels of time and costs involved in all the steps covered by a Formal Investigation. A preliminary investigation is particularly relevant in cases where the estimate of damages is modest, i.e. less than £25,000, or where there are specific concerns about a case at this very early stage.
6. When carrying out a preliminary investigation a specialist practitioner will be able to identify the relevant and necessary notes and records and to obtain an expert’s preliminary view, but not to investigate subsidiary issues in detail until a positive view has been obtained. In some cases this preliminary investigation may result in the specialist practitioner advising the Commission that the case should not be taken further because of a failure to satisfy the prospects of success or cost benefit Criteria.
7. There may be circumstances where a preliminary investigation would not be a necessary pre-requisite to taking the steps covered by the scope limitation to the Formal Investigation. An example is where liability is admitted and causation is not in issue but where Formal Investigation is necessary to establish quantum.

Potential for a Conditional Fee Agreement (Criterion 9.2.1)

8. Criterion 5.6.1 of the General Funding Code does not apply to applications for funding for clinical negligence unless the application relates to a multi-party action. This means that the potential to obtain a Conditional Fee Agreement will not be a ground for refusal of Investigative Help for a clinical negligence case. The remaining Criteria in 5.6 do apply.

Minimum Damages Level

9. Criterion 5.6.3 of the General Funding Code applies to applications for funding for Investigative Help in clinical negligence cases. This means that if the client’s claim is primarily a claim for damages, Investigative Help will be refused unless the damages

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are likely to exceed £5,000. However, this damages cut-off does not apply to claims which have a significant wider public interest or are not primarily claims for damages. Although most clinical negligence actions are simply damages claims, a claim concerning the death of a loved one may not be primarily concerned with damages, especially where the death engages Article 2 of ECHR. However, in Article 2 cases, participation in the inquest, covered if appropriate by exceptional funding under section 6(8)(b) of the Act, will sometimes be a more appropriate vehicle by which to investigate the circumstances of the death than a civil damages claim.

10. The £5,000 damages threshold applies only to Investigative Help so that a clinical negligence claim in which the merits were clear from the outset, for example, a failed sterilisation case, could receive Full Representation even if the damages were likely to be under £5,000, provided that the other Criteria for Full Representation were satisfied.

Cost Benefit

11. Investigative Help may only be granted if there are reasonable grounds for believing that when the investigative work has been carried out the claim will be strong enough, in terms of prospects of success and cost benefit, to satisfy the relevant criteria for Full Representation. (Criterion 9.6.4). This criterion has particular importance for clinical negligence cases. From July 2005, clinical negligence damages claims are subject to cost benefit criteria in the General Funding Code. Cases with merits of 50-60%, which will be the case for many clinical negligence cases post-investigation, will need a damages to costs ratio of at least 4:1. The likelihood of this criterion being satisfied must be carefully considered in the initial application for Investigative Help.

18.4 Full Representation (Criterion 9.3)

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Conditional Fee Agreements (Criterion 9.3.1)

1. Criterion 5.7.1 of the General Funding Code does not apply to applications for funding for clinical negligence unless the application relates to a multi-party action. This means that the potential to obtain a conditional fee agreement will not be a ground for the refusal of Full Representation for a clinical negligence case.

Applications for amendment

2. Unless the limitation period is about to expire, an amendment to cover the issue of proceedings will not be granted before the completion of the Formal Investigation in accordance with the Clinical Disputes Pre-Litigation Protocol. Information on prospects of success and cost benefit must also be provided before an application for Full Representation can be determined. This is because the relevant Criteria will be applied to that information.

Prospects of Success

3. Criterion 5.7.2 of the General Funding Code applies. This means that an application for Full Representation for clinical negligence proceedings will be refused if:
 - (a) prospects of success are unclear (however in these cases Investigative Help may be appropriate);
 - (b) prospects of success are borderline (this means that although prospects of success are not poor there are difficult disputes of fact, law or scientific evidence which make it impossible to say that prospects of success are better

- than 50%) and the case does not appear to have a significant wider public interest or to be of overwhelming importance to the client; or
- (c) prospects of success are poor which means that they are clearly less than 50% so that the claim is more likely to fail than not.

Cost Benefit

4. For Certificates issued prior to July 2005, Criterion 5.7.3 of the General Funding Code is replaced for clinical negligence claims with Criterion 9.3.2. This means that the minimum cost-benefit ratios of damages to costs for clinical negligence claims are as follows:
- (a) 1:1 – for cases with 80% plus prospects i.e. likely damages must exceed likely costs in cases with very good prospects of success;
 - (b) 1.5:1 – for the 60–80% bracket i.e. if prospects of success are good likely damages must exceed likely costs by at least 1.5; and
 - (c) 2:1 – for the 50–60% range i.e. if prospects of success are moderate likely damages must be at least twice likely costs.

These minimum cost benefit ratios apply whether a claim is proceeding to settlement or to trial. “Likely Costs” are defined at Section 2.2 of the Funding Code. At this stage in the proceedings, costs to disposal will take into account the prospects of settlement.

5. From July 2005 the General Funding Code applies to all clinical negligence cases that are primarily damages claims. For clinical negligence claims which are not primarily damages claims, for example claims arising from deaths which engage Article 2 of ECHR, the private client cost benefit criterion applies (Criterion 5.7.4 and see section 4.8 of the Guidance).
6. If the prospects of success and the cost benefit Criteria are satisfied on an application for Full Representation, following the conclusion of the Investigative Help stage, an amendment will be issued in the following terms:

“Limited to all steps up to and including mutual exchange of statements and reports and Part 35 questioning of experts and thereafter obtaining external Counsel’s Opinion or the opinion of an external solicitor with higher court advocacy rights.”–(CV085–Mutual Exchange of Statements).

7. The prospects of success and the cost benefit Criteria will be re-applied if it is necessary to apply to amend the scope of Full Representation to cover trial. At this stage costs will include all costs incurred and those to be incurred up to and including the trial. Such costs will consist of estimated profit costs (at the appropriate prescribed rate with enhancement if appropriate) and estimated disbursements to include counsels’ fees. VAT should be excluded. If the Criteria for Full Representation continue to be satisfied, an amendment will be issued in the following terms:

“Limited to all steps up to and including trial/final hearing and any action to implement (but not enforce) the judgement or order”–(CV073–Trial)

8. All applications to amend funding certificates to increase costs limitations at any stage in the proceedings will be considered in the light of the prospects of success and cost benefit Criteria. In addition, as with applications for increases in costs limitations before the issue of proceedings, increases in costs limitations will only be approved where the costs directly relate to an additional step, which itself can be justified. Amendments will not be approved to cover additional costs associated with work for which a breakdown has already been provided unless the additional costs associated with that work can be justified, and could not have been anticipated at the time of the original application.

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Very Expensive Cases (Criterion 6.6)

9. Criterion 6.6 of the Funding Code applies if a clinical negligence case meets the Criteria for referral to the Special Cases Unit at C23 of Section 6 of the Funding Code Procedures. This means that the minimum cost benefit ratio where prospects of success are moderate is not 2:1 as under Criterion 9.3.2 (iii) but 4:1 as under the General Funding Code. (See below at 18.7 and further at Section 15 for guidance on the approach taken where high cost cases are referred to the Special Cases Unit).

Offers to settle/Part 36 – Payments into court

10. Section 12 of the Funding Code Procedures deals with reporting obligations. The solicitor must report to the Director in accordance with the requirements of C43.2(vi). The Director must be informed in all cases where the client has declined to accept an Offer to Settle, a Payment into Court, an offer to mediate any issue in the proceedings or to refer it to Early Neutral Evaluation or any other offer of settlement of the proceedings which the solicitor considers may be reasonable. When considering whether a payment into court is reasonable the approach taken must reflect that of a private client who would consider the risk in costs of failing to better the payment in when determining its reasonableness.

18.5 Requests for a change of solicitor

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1. Amendments to funding certificates to change from one franchised firm to another are unlikely to be granted except where the client or solicitor moves and an amendment can be justified on the basis of significant inconvenience in relation to access, and where limited additional costs only will be incurred.
2. Given that clinical negligence work can only be undertaken by specialist franchised firms, client dissatisfaction with service or advice will not usually be considered acceptable justification for a change of solicitor unless the client has exhausted the complaint/service improvement procedure at the original firm and/or where the client is able to demonstrate, to the Commission's satisfaction, that the service or advice provided fell below the franchised standard.

18.6 Reviews and the use of AVMA merits screening

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1. If a regional office refuses an initial application for funding, or an application for an amendment which leads to a notice to show cause and subsequent discharge, and there is an application for a review by the Independent Funding Adjudicator, there must be consideration of whether an AVMA merits screening report is appropriate in the particular circumstances.
2. No request for a report, following the refusal of an initial application for funding, can be made until the specialised solicitor has had the opportunity to respond to the reasons for refusal. All applications for funding are now made by or under the supervision of specialist clinical negligence practitioners. In these circumstances the Commission would not expect refusals of applications for Investigative Help on the basis of prospects of success criteria to be common.
3. If AVMA is asked to prepare a report it will be provided with all the information supplied to the regional office. In order to prepare the merits screening report, AVMA may also contact the specialist practitioner directly to discuss the case, and to clarify issues if necessary. A copy of AVMA's report will be sent to the specialist practitioner.
4. If the AVMA report is unfavourable, the review will be listed for a Independent Funding Adjudicator hearing.

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5. However, if the AVMA report is favourable, the Director will review the original decision by re-applying the relevant criteria in the Funding Code in accordance with this guidance, and in the light of any additional information including the report from AVMA.
6. If the application is not granted on review by the Director, the regional office will confirm its refusal, providing amended reasons as appropriate. The matter will be listed for a review by the Independent Funding Adjudicator.
7. Requests for review following refusals of funding, or discharge or refusals to amend may involve referral to AVMA if:
 - (a) the refusal or discharge is based on criteria relating to prospects of success, as opposed to cost benefit or any other criteria, and the request for a review is supported by the specialist practitioner; or
 - (b) the refusal or discharge is based upon a combination of criteria relating to prospects of success and cost benefit (as opposed to those based solely upon grounds of cost benefit) and the request for a review is supported by the specialist practitioner; or
 - (c) the refusal or discharge is based upon a significant dispute with the specialist practitioner as to quantum; or
 - (d) a funded client is refusing to accept the advice of his/her specialist practitioner (who is not supporting a merits related request for review) and wishes to change solicitors.

Provided that in all cases the regional office is satisfied that in the absence of clear and unambiguous evidence an AVMA report is necessary because there are relevant disputed, complex issues.
8. All reviews of decisions relating to clinical negligence cases will be dealt with by an Independent Funding Adjudicator with at least one clinical negligence panel member.

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18.7 The Special Cases Unit

1. The Very High Costs Case criteria are set out in Section 6 of the Funding Code Criteria. The requirements apply to both funding certificates for Investigative Help and Full Representation in cases where costs are likely to exceed £25,000. Copies of the key documentation can be obtained by contacting the Special Cases Unit at the Brighton office on telephone number 01273–878870. The documentation includes standard Case Plan formats for use in Investigative Help and in Full Representation funding cases.
2. Additional criteria apply to very high cost clinical negligence cases. In particular the minimum cost benefit ratio where prospects of success are moderate is not 2:1 as under Criterion 9.3.2(iii) but 4:1 as under the General Funding Code. Moreover these cases are subject to an “affordability test” and the proposals put forward for progressing the case must be satisfactory.
3. Each case has an individual contract based on the agreed Case Plan. The contract allows the progression of the case stage by stage, with an agreed price fixed in advance for each stage. The stages are linked to the court stages in multi-track cases. The Case Plan changes as the case develops; in the early stages of a case future events are more difficult to predict and the plan contains fewer details relating to later stages.
4. The stage price is made up of the solicitor’s profit costs, counsel’s fees, experts’ costs and other disbursements. It is possible to amend the price of a stage by agreement for additional work which could not reasonably have been foreseen or in other exceptional circumstances.
5. The Case Plan for the Investigative help stage requires details of the work to be done at that stage and its cost. This will inform costs and other limitations to be placed on the certificate for Investigative Help. Before the completion of this stage the plans for

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future stages would only need to include the possible options for the outcome (settling on acceptance of liability, proceeding to a hearing on quantum alone or proceeding to a full hearing with disputed liability) the major steps and estimates of the likely costs.

6. At the end of the case, if the opponents are not ordered or do not agree to pay costs in full there will be “Community Legal Service only” costs. These are paid in line with the agreed case plan. The statutory charge applies to these costs. For this reason clients must be provided with copies of the case plans and their likely liability for costs to be paid out of their damages must be explained to them.
7. If the Commission pay all of any of the costs of the case the first £25,000 costs are paid at the present regulatory rates. After this initial “risk assessment” stage in clinical negligence cases solicitors’ hourly rate is £70, with junior counsel at £50 and senior counsel at £90. There is no mark-up.

18.8 ADR in Clinical Negligence Disputes

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Background

1. In the past mediation and other ADR techniques have seldom been used to resolve clinical negligence disputes. This is unfortunate since many clinical negligence cases, because of their complexity, involve lengthy and costly litigation. Although most successful claims settle they often do so at a very late stage, sometimes just before trial. In such cases a fair settlement might be achieved much earlier through the use of mediation.
2. The Civil Procedure Rules encourage parties to consider ADR in all types of case. ADR is also encouraged in the clinical negligence pre-action protocol. The NHS Litigation Authority, which is responsible for handling most of the larger clinical negligence cases, is actively encouraging its solicitors to try mediation. The Legal Services Commission believes that it is in the interests of clients and the CLS Fund for ADR to be used much more often than it is at present to resolve clinical negligence disputes.
3. The Clinical Disputes Forum is currently working on this area with a view to producing a guide on the use of mediation in clinical negligence disputes. See the Forum’s website at www.clinical-disputes-forum.org.uk for details. In time the Commission may wish to adopt the Forum’s guide. What follows is therefore guidance which will be qualified and developed in the light of experience in practice.
4. Although all forms of ADR may be used in clinical negligence disputes, the guidance below is essentially concerned with Mediation and Early Neutral Evaluation (see section 7 of this guidance for further explanation of these terms). The term “ADR” is used below to mean either of these two approaches or any combination of them.
5. This guidance applies both to certificates issued under the Funding Code and those issued under the Legal Aid Act 1988. This guidance applies with effect from 1 June 2001.
6. The aim of this guidance is to:
 - (a) ensure that the use of ADR is considered by clients and their solicitors at certain key points in a clinical negligence case;
 - (b) require solicitors to report to the regional office at appropriate stages explaining the reasons why ADR has not been pursued;
 - (c) explain the approach regional offices will take in deciding whether to limit a certificate to work necessary to progress ADR;
 - (b) help parties set up mediation or early neutral evaluation when they decide to do so.

When to Consider Using ADR in a Clinical Negligence Dispute

7. Parties should keep the possibility of ADR in mind at all stages of a case. However, at the very outset of a clinical negligence case ADR is unlikely to be an appropriate way forward because the client and his or her representatives will be unlikely to have the information available to enter into a fair settlement of the case. If a case is not suitable for settlement it may well be suitable for ADR.
8. The clinical negligence pre-action protocol exists to ensure that appropriate disclosure of information takes place before issue of proceedings. As a general rule for clinical negligence cases ADR may well not be appropriate until the steps set out in the pre-action protocol have been complied with. However, once all steps in the protocol have been completed the presumption is that most cases should be suitable for ADR unless there are specific circumstances which make them unsuitable (see below).
9. Solicitors should therefore consider and discuss with their clients the use of ADR at the following points in a clinical negligence case:
 - (a) prior to issue of proceedings (or if issue is urgently needed for limitation purposes, immediately after issue);
 - (b) before and immediately after each case management conference;
 - (c) before and immediately after any pre-trial review;
 - (d) whenever the other side offer to put the case or any issue in the case to ADR;
 - (e) whenever the parties are specifically encouraged to consider ADR by the court or the Commission;
 - (f) whenever pursuing ADR is delayed because certain specific information is awaited, and that information is then received.
10. If it is decided at any of the above points not to pursue ADR, that fact and the reasons for the decision should be recorded on the solicitor's file. The next time an application is made to extend the scope of the certificate the decision and reasons for not pursuing ADR must be reported to the Regional Office when submitting the APP8 amendment form. If the reason why ADR is not being pursued is that further information is required before ADR or settlement can be considered, that information must be specified together with the time or stage in the proceedings at which it is likely to be available. When that information then becomes available ADR should be considered again.
11. ADR cannot proceed unless the other side show a genuine willingness to pursue it. In cases funded by the NHS Litigation Authority solicitors may write directly to that authority if it appears that ADR is being rejected for no good reason.

When is a Clinical Negligence Case not Appropriate for ADR?

12. As explained above a case is unlikely to be suitable for ADR until the pre-action protocol steps have been completed (or an equivalent stage has been reached in old cases which pre-date the protocol).
13. At the pre-issue stage a claimant should have a reasonable picture of the facts and areas of dispute and should be in possession of:
 - (a) a full letter of response from the defendant making it clear what issues are in dispute;
 - (b) relevant medical records;
 - (c) key expert evidence on liability and causation;
 - (d) enough information to make a reasonable estimate of quantum.
14. The following are examples of situations where at the pre-issue stage or during proceedings ADR is unlikely to be appropriate:

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- (a) where the essential basic information set out in the preceding paragraph is not available, for example because the other side has failed to provide full records or a proper letter of response;
 - (b) there is no clear prognosis for the condition of the client (especially if the client is a child) and time is needed to see how the client progresses before settlement can be considered;
 - (c) the parties are already negotiating effectively and are progressing towards settlement so that ADR is unnecessary;
 - (d) proceedings must be issued urgently for limitation purposes; or other court intervention is urgent and necessary (but ADR should be considered thereafter);
 - (e) the claim includes future care costs and further key information is needed on quantum before settlement discussions can proceed;
 - (f) the case is a test case requiring the court to lay down a precedent for future claims;
 - (g) ADR would not be a cost-effective option in the circumstances of the case, because there is reason to believe that the case will be resolved more quickly or cheaply without it e.g. because the claim either cannot be pursued further or is likely to settle imminently. If so, ADR should be reconsidered if those circumstances change. In each case it is a question of weighing the costs of mediation, which can be substantial, against the benefits and potential savings of promoting fair and early settlement.
15. In addition there are many cases which are inherently suitable for ADR but where the timing is not right because further essential disclosure or information gathering is necessary before a just and fair settlement can be achieved. This does not mean that ADR should wait until every possible piece of information has been obtained and every expert report exchanged. Such an approach would confine ADR to the stage shortly before trial which would have little benefit. Therefore a decision should be made in each case whether the further information sought is really needed before settlement can occur, whether it might become available at or before mediation, or whether it is simply something which is desirable or might strengthen the case. As a general rule in many cases it will be desirable to exchange key expert reports on liability and/or causation before ADR takes place, but it would not usually be necessary for experts to have attended a Part 35 meeting beforehand. Exceptionally a Part 35 meeting can take place simultaneously with mediation.
16. If mediation is rejected in circumstances where there are major disputes on liability or causation, the alternative of early neutral evaluation should be considered. Early neutral evaluation can be particularly helpful if there are one or more key issues of expert evidence or law which appear to be irreconcilable between the parties and make settlement by negotiation difficult.

The Commission's Approach

17. The Commission wishes to encourage the wider use of ADR in clinical negligence disputes but does not wish to force parties to try ADR if it is likely to be futile or increase costs. The Regional Office reserves the right to limit a certificate so that it covers only participation in ADR but will only impose such a condition having considered all the circumstances of the case and representations received. In particular the Regional Office will consider imposing such a condition on receipt of;
- (a) a report under Rule 43.2(vi)(c), (d) or (e) of the Code procedures (refusals to accept offer of ADR);
 - (b) representations from an opponent or the NHS Litigation Authority suggesting that ADR has been unreasonably refused;

- (c) an application to extend the scope of a clinical negligence certificate, in particular an application to amend the certificate from Investigative Help to Full Representation, or to extend scope to cover trial.
18. The Regional Office in each case will consider the strength of the reasons given for not pursuing ADR. The examples given at paragraphs 14 and 15 above are illustrations of what might be good reasons for not pursuing ADR. On the other hand the following would generally not be considered good reasons for refusing ADR;
- (a) the client simply refuses to consider ADR and wants to have his or her day in court (bear in mind that a litigation day in court cannot be guaranteed, whereas a mediation day can);
 - (b) the fact that there are still important outstanding factual or legal issues between the parties – this will almost always be the case;
 - (c) the fact that in negotiating the parties are so far apart they cannot imagine settling – early neutral evaluation will sometimes be the way forward in such cases;
 - (d) further information or exchange of evidence is required, but that information is not really central to the client’s case.
19. The Commission will give due weight to the views of the other side. The fact that the opponent actively wishes to attempt ADR is an encouraging sign, so particularly strong reasons would be needed to justify not pursuing that route.
20. If the Commission does limit a certificate for ADR to take place the Regional Office is unlikely to prescribe the specific form of ADR and will leave this for the parties to consider according to the nature of the case. In complex cases a combination of ADR techniques may be appropriate. The Commission will lift any restrictions on a certificate if appropriate if ADR, having been pursued by the client in good faith, breaks down at any stage.
21. Even if ADR does not result in immediate settlement of the case it will often improve the understanding of each side of the other’s position. In cases which do not settle the Commission would expect both sides to put forward their best realistic Part 36 offers. As with any other case future funding decisions will take into account the likelihood of improving on any offers which have been made.

Setting up Mediation

22. If it is decided to mediate in a clinical negligence dispute a suitably qualified and experienced mediator must be chosen. See the guidance at Section 7.6 in relation to choosing a mediator and the National Mediation Helpline (0845 60 30 809).
23. There are many different approaches to mediation. Some parties prefer the mediators to give an opinion of the legal status of the case. Others prefer the mediator to allow them to reach (or not reach) their own agreement without access to the mediator’s legal or expert opinion. Parties might want to explore the type of mediation they would prefer and ensure that the mediator for their case can provide this.

Setting up Early Neutral Evaluation

24. If parties decide to put an issue or a case as a whole to early neutral evaluation the first step is to agree as precisely as possible what issue or issues will be put forward to the person providing the evaluation. This may well be done by reference to the pleadings or the expert evidence. Secondly a mutually acceptable person must be chosen to provide the advice. This will usually be either a senior lawyer, sometimes Queen’s Counsel, or a medical expert with expertise in the issues in question. Any of the bodies mentioned above may be able to assist in this process. In due course the Commission may wish to maintain an informal list of senior lawyers likely to be

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acceptable to both claimants and defendants who may be prepared to provide early neutral evaluation in clinical negligence cases.

25. Thirdly agreement must be reached as to the documentation that will go into the early neutral evaluation. It is important that both sides have an equal say in the way the case is put forward.