The first act of a costs saga

If cost budgeting for clinical negligence is abandoned, what is then the proposed alternative, asks **Sanja Strkljevic**

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In May, Sir Rupert Jackson remarked: 'It has always been known that cost management in clinical negligence would pose particular problems. In my final report I proposed that a different method of costs managing clinical negligence cases (including pre-issue and cost management) be piloted. Unfortunately, that pilot never got off the ground... I recommended that an extra [Queen's Bench Division] master be appointed in order to facilitate the costs management of clinical negligence cases. Contrary to that recommendation no extra master was appointed. Instead the number... has been reduced to two.'

The original costs management rules in Civil Procedure Rule (CPR) 3, and the accompanying practice direction (PD), provided the court with discretion as to whether it should costs manage cases. This was effectively removed by the amendment to CPR 3.15, which provides that the court will make a costs management order where the parties have exchanged costs budgets, unless it is satisfied that 'the litigation can be conducted justly and at proportionate cost in accordance with the overriding objective without such an order being made'. However, under PD 3E the court will generally make a costs management order under CPR 3.15 where budgets have been filed and exchanged.

False start

Clinical negligence costs budgeting did not get off to a good start following its introduction on 1 April 2013, from when all cases issued in the High Court needed to be costs managed by High Court masters, two in this instance. Each costs case management conference (CCMC) is listed for at least one hour, if not two. This has caused an unavoidable backlog in the QBD.

Until recently, the wait for the first CCMC in London has been in the order of half a year. The listing is usually issued of the court's own motion after the defence has been filed, or if the parties have been able to agree limited directions until the case management conference (CMC). In any event, the waiting time for the first CCMC has been at least six months, sometimes up to nine. This does not comply with the CPR's overriding objective to ensure cases are dealt with expeditiously and is detrimental to our clients, who wish to see an end to their case as soon as possible.

To address this delay, in the same lecture, Sir Rupert announced a one-off release of cost budgeting. All London clinical negligence cases with CCMCs already listed between October 2015 and January 2016 have been released from costs management. The court has already started issuing orders listing 'old style' CMCs, directing that the case is not cost managed but that the parties have to file and exchange cost estimates. Already, the waiting time now for CMCs is down to about three months.

Sir Rupert has also proposed that parts of CPR 3.15 and PD 3E be repealed by suggesting: 'The court should not manage costs in any case if it lacks the resources to do so without causing significant delay and disruption to that or other cases.' Whether or not it is accepted remains to be seen, as is what will happen once the backlog in the QBD has been cleared.

Temporary fix

It is evident that if ever a pilot was required it would have been so in clinical negligence. The three-month moratorium on budgeting is a temporary solution, but is it a measure that many practitioners will look forward to becoming permanent? While the process of preparing the budget focuses the mind on the conduct of the litigation and the steps necessary to reach a conclusion to the case, the exercise is costly and time-consuming.

Clinical negligence costs budgets are never agreed. Defendant budgets are often unrealistic and artificially low. The NHS Litigation Authority challenges almost everything in the claimants' budgets. Attempts to narrow the issues before the CCMC can be futile. One also must not forget that once the budget has been approved, a party might need to revert to the court to revise it should it be necessary, incurring further costs. The experience has not been positive.

If cost budgeting for clinical negligence is abandoned, what is then the proposed alternative? There has been much talk of introducing fixed fees in clinical negligence cases valued up to £100,000. No consultation has yet been issued and no detail has been provided on the level of fees.

Sir Rupert has called for a fixed costs regime 'perhaps cover[ing] the claims up to £250,000', a principle supported by Lord. While what is proposed remains unclear, it is impossible to comment, but suffice to say, watch this space. **SJ**