Neutral Citation Number: [2019] EWCA Civ 1220

Case No: A2/2017/0928
A2/2017/0930

**IN THE COURT OF APPEAL (CIVIL DIVISION)**
**ON APPEAL FROM THE MANCHESTER COUNTY COURT**
**HHJ Smith**
**M16X154**
**M16X151**

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 17/07/2019

**Before :**

**THE MASTER OF THE ROLLS**
**LORD JUSTICE IRWIN**
and
**LORD JUSTICE COULSON**

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**Between :**

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| **Suzanne WEST** | **Appellant** |
| **- and -** | |
| **STOCKPORT NHS FOUNDATION TRUST** | **Respondent** |

**And between :**

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|---|---|
| **Lee Thomas DEMOUILPIED** | **Appellant** |
| **-and-** | |
| **STOCKPORT NHS FOUNDATION TRUST** | **Respondent** |

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**Nicholas Bacon QC** and **Rupert Cohen** (instructed by **Kain Knight Costs Lawyers, as agents for Slater and Gordon (UK) Ltd and Forster Dean Solicitors**) for the **Appellants**
**Roger Mallalieu** (instructed by **Acumension Ltd**) for the **NHS Trust**

Hearing dates : 18 & 19 June 2019

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# Approved Judgment

**Sir Terence Etherton MR, Lord Justice Irwin and Lord Justice Coulson :**

## 1) Introduction

1. These appeals raise a number of specific issues arising out of the respondent's successful challenge to the amount of the ATE insurance premium recoverable by the appellants. By common consent, however, the issues also raise a number of wider points relating to reasonableness and proportionality and the proper approach to the assessment of costs.

2. The potential significance of these appeals led to this court's order that there be a fact-finding hearing, before two assessors, which resulted in a detailed report ("the Assessors' Report") being provided to the court for the purposes of the appeals. Details of that exercise are set out in Section 6 below. As a consequence of that report, this court has been able to reach a number of conclusions which were not previously open to first instance judges grappling with these and related issues.

3. We begin by setting out the unique position of ATE insurance premiums in clinical negligence cases (**Section 2**). Then, having set out the factual backgrounds to the appeals of Ms West and Mr Demouilpied (**Sections 3 and 4**), we identify in **Section 5** some of the wider concerns that have arisen on costs assessments relating to such premiums.

4. In **Section 6** we deal with the Assessors' Report, which is attached in its entirety at **Annex 1**. At **Section 7** we identify what seem to us to be the substantive issues that arise on these appeals. We then deal with questions of reasonableness at **Section 8** and issues concerned with proportionality at **Section 9**. At **Section 10** we set out what we consider to be the right approach to costs assessments generally. At Sections **11 and 12** we set out our conclusions on the two appeals before us. At **Section 13** we outline what we consider to be a realistic way forward for the future in disputes about ATE insurance premiums. We are very grateful to both counsel for their assistance in arriving at these conclusions.

## 2) The ATE Insurance Premium

5. ATE insurance became popular following the severe restrictions on the availability of legal aid introduced some 20 years ago. Concerns were expressed, however, about the recovery of ATE premiums from unsuccessful defendants. In his *Review of Civil Litigation Costs* Sir Rupert Jackson recommended that ATE insurance premiums should cease to be recoverable from unsuccessful defendants. This recommendation related to all civil litigation. Although that recommendation was generally accepted by the Government, an exception was made for clinical negligence cases. The explanation for that stance can be found in paragraph 6 of the Government's formal response to Sir Rupert's recommendations (*Reforming Civil Litigation Funding and Costs in England and Wales (Cmnd 8041) (2011)*), which said:

> "**Refinement to the proposals for public policy reasons**
>
> The Government is aware of specific concerns in relation to the funding of expert reports in clinical negligence cases. These expert reports can be expensive and we need to provide a

> means of funding them to ensure that meritorious claims can be brought by those who cannot afford to pay for these reports upfront. To address this, the Government is making one change to Jackson LJ's key recommendation. The Government intends to have a tightly drawn power to allow recoverability of the ATE insurance premiums to cover the costs of expert reports only in clinical negligence cases. The details would be set out in Regulations."

6. We also note that, in paragraph 24 of the same document, there was express reference to the difficulties involved in pursuing a clinical negligence claim without an expert's report. Again, the response concluded that ATE insurance premiums, limited to the cost of such reports, would "remain recoverable".

7. Section 46 of the Legal Aid, Sentencing and Punishment of Offenders Act 2012 repealed Section 29 of the Access to Justice Act 1999 and inserted a new Section 58C into the Courts and Legal Services Act 1990 which took effect on 1 April 2013. That provides:

> "58C Recovery of insurance premiums by way of costs
>
> (1) A costs order made in favour of a party to proceedings who has taken out a costs insurance policy may not include provision requiring the payment of an amount in respect of all or part of the premium of the policy, unless such provision is permitted by regulations under subsection (2).
>
> (2) The Lord Chancellor may by regulations provide that a costs order may include provision requiring the payment of such an amount where—
>
> (a) the order is made in favour of a party to clinical negligence proceedings of a prescribed description,
>
> (b) the party has taken out a costs insurance policy insuring against the risk of incurring a liability to pay for one or more expert reports in respect of clinical negligence in connection with the proceedings (or against that risk and other risks),
>
> (c) the policy is of a prescribed description,
>
> (d) the policy states how much of the premium relates to the liability to pay for an expert report or reports in respect of clinical negligence ("the relevant part of the premium"), and
>
> (e) the amount is to be paid in respect of the relevant part of the premium.
>
> …

> (5) In this section—
>
> "clinical negligence" means breach of a 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);
>
> "clinical negligence proceedings" means proceedings which include a claim for damages in respect of clinical negligence;
>
> "costs insurance policy", in relation to a party to proceedings, means a policy insuring against the risk of the party incurring a liability in those proceedings;
>
> "expert report" means a report by a person qualified to give expert advice on all or most of the matters that are the subject of the report;
>
> "proceedings" includes any sort of proceedings for resolving disputes (and not just proceedings in court), whether commenced or contemplated."

8. Following one false start, the relevant Regulations were introduced by SI 2013/739. They were entitled the Recovery of Costs Insurance Premiums in Clinical Negligence Proceedings (Number 2) Regulations ("the Regulations"). Regulation 3 provides:

> "(1) A costs order made in favour of a party to clinical negligence proceedings who has taken out a costs insurance policy may include provision requiring the payment of an amount in respect of all or part of the premium of that policy if –
>
> (a) The financial value of the claim for damages in respect of clinical negligence is more than £1,000; and
>
> (b) The costs insurance policy insures against the risk of incurring a liability to pay for an expert report or reports relating to liability or causation in respect of clinical negligence (or against that risk and other risks).
>
> (2) The amount of the premium that may be required to be paid under the costs order shall not exceed that part of the premium which relates to the risk of incurring liability to pay for an expert report or reports relating to liability or causation in respect of clinical negligence in connection with the proceedings."

9. As Lewison LJ noted in *McMenemy v Peterborough and Stamford Hospitals NHS Trust* [2017] EWCA Civ 1941, [2018] 1WLR 2685, at paragraph 40, the Regulations effected three particular changes, namely the removal of the absolute bar against recovery of ATE insurance premiums in the event that the expert's report was not in fact obtained; the introduction of a minimum financial value of the claim before an

ATE insurance premium was capable of being recovered; and the removal of the contemplation that the cost of the report may not be allowed under the costs order.

10. The Explanatory Memorandum which accompanied the Regulations said at paragraph 7.3:

> "However, the Government has allowed for a permanent limited exception for clinical negligence cases, where ATE insurance premiums covering the cost of expert reports will still be recoverable. This is because expert reports are often necessary to establish whether there is a case for bringing proceedings, but can be expensive. Currently ATE insurance can insure against the risk of incurring liability to pay the costs of such reports, but with the substantial withdrawal of legal aid in personal injury (including clinical negligence) cases, a funding mechanism available to claimants to purchase those reports is required. As a result, the practical effect of this exception is it will allow claimants to purchase expert reports for clinical negligence claims and the premium in respect of incurring the costs of those reports will remain recoverable from defendants."

11. Paragraph 7.4 of the same Memorandum dealt with the need to control costs. It stressed that the Regulations restricted the recoverability of the insurance premium "to the risk of incurring liability to pay for an expert report or reports determining liability and causation only". This was contrasted with, for example, reports dealing with quantum. In this way, it was said that "claimants will still be able to progress their claim, whilst ensuring that the costs paid by defendants to cover claimants' ATE insurance premiums are reasonable and proportionate."

12. There is no doubt, therefore, that the availability of ATE insurance, and the recoverability of the relevant premium, is an important means by which access to justice continues to be provided in clinical negligence cases. That was stressed by Brooke LJ, giving the judgment of the Court of Appeal, in *Rogers v Merthyr Tydfil County Borough Council* [2006] EWCA Civ 1134; [2007] 1WLR 808, at paragraph 105, and Lewison LJ in *McMenemy* at paragraph 74. Access to justice must therefore be the starting point for any debate about the recoverability of ATE insurance premiums in any dispute about costs.

## 3) The Factual Background/*West*

13. Ms West sought damages against the respondent for clinical negligence. Her claim was settled for £10,000. In order to obtain the necessary expert's report required for that claim she took out ATE insurance. The recoverable element of the premium was £5,088. Her overall bill of costs was in the sum of £31,714.44.

14. The ATE insurance policy was with ARAG. It was a block-rated policy. The particular features of such a policy are set out in greater detail in **Section 6** below. For present purposes, it is sufficient to say that such a policy is not a bespoke policy; instead, it has a fixed premium set by reference to a wide "basket" of cases rather than

individually assessed by reference to the risk of the particular case. It is a policy which, at least contractually, a solicitor with a contract with ARAG is obliged to use.

15. The draft bill of costs was the subject of lengthy Points of Dispute served by the respondent. A similar document was served in the *Demouilpied* case. It is clear that these documents are generic and repetitive, with numerous references to authorities and requests for further information. We set out our observations on the utility of such documents in **Section 8** below, when dealing with the question of reasonableness.

16. In relation to the ATE insurance premium, the amount was challenged by the respondent by way of a separate set of written submissions which contained further references to authority. This separate document referred to a number of what were called "wider factors involved in the proceedings" including this:

> "4(b) It is a matter of public importance that the court ensures that ATE premiums, if held to be recoverable in principle, are assessed in proportionate and reasonable sums. Save for a relatively small number of claims brought against other organisations/persons defending clinical negligence claims, ATE premiums will be charged inter partes to the NHS LA acting on behalf of NHS trusts in England and Wales. The NHS LA paid damages and costs in circa 10,000 cases per annum. Post-Jackson, all of those claims continue to have claims for ATE premiums brought against the public body. This is a very substantial impact on the public purse, should the court fail to allow proportionate and reasonable premiums."

17. The respondent's submissions then suggested that Ms West's prospects of losing the case were very low (which obviously raised the question of why the claim had not been admitted from the outset) and calculated what it described as an appropriate premium in the sum of £834.75. In the alternative, the respondent put forward what it said was a comparable policy obtained from LAMP Services Limited ("the LAMP policy") with a premium of between £1,802 and £1,982.20. Although the submissions made plain that the respondent "does not endorse the LAMP ATE insurance product", they asserted that the policy "clearly demonstrates" that an alternative available insurance product should have been chosen.

18. A copy of the LAMP insurance policy was attached to the submissions. It appears that LAMP was a company registered in Gibraltar. It is now insolvent, although it was apparently still trading at the time of the cost assessments in these cases.

19. Ms West's costs bill was the subject of a provisional assessment by District Judge Iyer. He disallowed the premium in full "because C does not allege that any inquiries were made about availability of litigation insurance and letter of retainer recommended ATE without any reference to this". In addition, he reduced the base solicitor and own client costs to £10,000 on grounds of proportionality.

20. Ms West's solicitors applied for a review of the provisional assessment. At the review, the only point in issue was the recoverability of the ATE insurance premium. On that topic, DJ Iyer said:

> "Even if I had not seen any evidence about what the premiums might be, I would have thought that the premium really should not have exceeded £2,500. I do have evidence here. There is a question about whether the evidence indicates an alternative policy but I think that given the information that there is here, that the evidence is sufficient, and according to these, it does rather look as if the claimant could have found insurance policies available to cover a figure that was no more than what the likely expert report costs would be, ranging from £2,120 to £2,332… My instinct would have been a figure of about £2,500 and that is the figure that I consider would have been a reasonable premium to have paid."

21. Ms West appealed to His Honour Judge Smith. In his judgment dated 4 November 2016 Judge Smith dismissed the appeal. He rightly said that the DJ Iyer's judgment was concerned solely with the question of reasonableness. He said that, in so far as that judgment was based on an "instinctive" view that the premium was unreasonable, the District Judge had been wrong to proceed on that basis. Judge Smith said, however, that the respondent had discharged the necessary evidential burden in view of the existence of the LAMP policies. He noted that the appellant had not relied upon any material in response. He concluded:

> "The District Judge was therefore entitled, as a matter of law, to rely upon the evidence before him. At that stage, he was also entitled to rely upon his experience, which in fact led him to award a higher figure than that given in the LAMP documents. He was entitled to do so in the exercise of his discretion to allow a reasonable figure, having resolved the doubt as to reasonableness in favour of the paying party, as he was required to do by CPR 44.3 (2) (b). I therefore dismiss the appeal."

## 4) The Factual Background/Demouilpied

22. Mr Demouilpied also sought damages against the respondent for clinical negligence. His claim was settled for £4,500. His bill of costs was in the total sum of £18,376.36. That included the recoverable element of the ATE insurance premium of £5,088. The policy was a similar block-rated ARAG policy to that taken out by Ms West.

23. The respondent produced Points of Dispute of a similar length and nature to that produced in Ms West's case. Again, the challenge to the ATE insurance premium was made by way of a separate set of submissions, which included lengthy citation of authority, together with the same passage about the public purse noted at paragraph 16 above. There was again a reference to the same LAMP policies. In the separate document the respondent stated that it calculated that a reasonable and proportionate premium was £175. This was significantly less than the premium payable on the LAMP policies.

24. The costs were the subject of a provisional assessment by Deputy District Judge Beard. As to reasonableness, he concluded that it was reasonable to incur the ATE premium. As to proportionality, however, he had regard to the LAMP policies and

noted: "Comparable premium approach adopted in satisfaction of achieving overriding objective and proportionality. Defendants' comparable premium of £1982.20 adopted."

25. There was an application by the appellant for a review which was carried out by Deputy District Judge Buckley. In an eleven page judgment dated 11 May 2016 he concluded that "the amount of the premium was disproportionate in the light of the compensation targeted, and the limited amount of the risk to which the insurer was exposed". He also considered, however, that the cost of the LAMP policies was disproportionate and undertook his own calculation, taking a starting figure of £1,100 (which was unexplained) and then reducing that by fifty per cent to reflect the prospects of success. Accordingly, he calculated the appropriate premium at £650. He concluded:

> "34. While I appreciate that [a] block rate scheme, with its 'one size fits all' approach, makes good commercial sense, I fear that that approach is not reconcilable, in small claims such as this, with the requirement of proportionality."

26. The appellant appealed. On the appeal Judge Smith correctly noted that DDJ Buckley had reached his decision on the basis of proportionality. Judge Smith thought that the Deputy District Judge's freestanding calculation of a premium of £650 was "both inappropriate … and potentially inadmissible". He said, however, that the Deputy District Judge was entitled to consider proportionality, and in view of his conclusion that the figure of £650 was proportionate:

> "… I am satisfied that it was within the generous ambit of his discretion to reach that conclusion. The fact that he used an inappropriate calculation to support that figure does not mean that his conclusion was wrong. Accordingly, the appeal is dismissed."

## 5) Wider Concerns

27. These appeals raise specific points about the assessment of ATE insurance premiums, but they also highlight wider concerns about the costs assessment process, including those noted below.

28. First, there is a clear risk that an issue (such as the recoverability of a fixed premium), which ought to be the subject of clear guidance with minimal room for debate, is being decided on an ad hoc, case-by-case basis. So, in the present appeals, involving as they do the same fixed premium of £5,088, the respondent put forward its own calculations of £834.75 and £175, or alternatively the higher figures derived from the LAMP policies of between £1,802 and £1,982. Further, there have been a wide range of answers from the judges, running from disallowance of the premium altogether (paragraph 19 above), increasing to the freestanding figure of £650 (paragraph 25 above), and up to the £1,982 referable to the LAMP policies (paragraph 24 above) and the calculation of £2,500 said to be based upon those same policies (paragraph 20 above). In this way, four different assessments of the same figure by three different district judges produced four different results.

29. Secondly, linked to that first point, some of those assessments appear to have been the result of the instinctive or subjective reaction of the judge undertaking the costs assessment without reference to objectively ascertained comparable policies and premiums. As Judge Smith correctly observed, that is impermissible. Not only does that approach increase the risk of inconsistent results which are unclear and unexplained but, even more important, it has a direct impact on the claimant's access to justice noted in paragraphs 10-12 above. If a claimant's right to recover the ATE insurance premium in clinical negligence cases is the subject of a capricious system of cost assessment, then a claimant may be denied the very access to justice which the exception at s.58C and the Regulations were designed to protect.

30. Thirdly, there are concerns about the respondent's repeated reliance on the burden of proof. This can be seen in their Points of Dispute documents and other written submissions, and it was noted unfavourably in the Assessors' Report (see paragraphs 42 and 45 below). The respondent's strategy appears to be to offer something minimal to put the reasonableness or proportionality of the ATE premium in issue, and then assert that the burden of proof falls upon the individual claimant, who will usually be unable to deal with the wider questions that might be raised concerning the insurance market. On this aspect of the case at least, the respondent has access to much more information than an individual claimant, so that the respondent's reliance on the burden of proof has potentially a distorting effect on the costs assessment.

31. Fourthly, and related to the previous point, we note the respondent's use of so-called comparables. We consider that, when dealing with reasonableness, detailed evidence about unarguably comparable insurance policies and premiums would be admissible. What is not permissible is reliance on the production of a few photocopied pages of another policy which, taken as a whole, is not in fact comparable.

32. In the present cases (which are doubtless mirrored in many other clinical negligence cases) the insurers behind the appellants, on the one hand, and the respondent, on the other, are advancing two extreme positions. The effect of the appellants' submissions is that an ATE insurance premium, certainly if it is a block-rated policy, is essentially inviolable and should always be regarded as reasonable and proportionate. On the other hand, the respondent says that each case is different and that each district judge or costs judge should be left to work out the answer to the questions of reasonableness and proportionality in each case, producing a range of different results.

33. The Assessors' Report has enabled us to steer a course between those two extremes. The report has resolved various issues of fact concerning block-rated ATE insurance premiums which allows us to formulate guidance in a way that was not open to the first instance judges in the present cases.

## 6) The Assessors' Report

### 6.1 Background

34. Permission to appeal was granted by Lewison LJ on 13 July 2017.

35. Irwin LJ gave directions on 24 August 2018, followed by a hearing on 9 October 2018. It was accepted by the parties that it would be necessary to adduce new evidence to enable the issues to be properly determined on the appeals. Pursuant to

CPR 35.15 and CPR 52.20, and in the light of the procedure adopted in *Rogers and Callery v Gray (No 2)* [2001] EWCA Civ 1246, [2001] 1 WLR 2142, Irwin LJ ordered that there be prepared by assessors a report to assist the determination of the appeals The assessors were to be a High Court Judge sitting with a costs judge.

36. Irwin LJ ordered that the issues to be addressed in the report were:

i) the origin and characteristics of the policies and premiums in issue in these appeals;

ii) the approach to setting the premiums which fall within the scope of the Regulations;

iii) the approach to setting the 'non-recoverable' element payable out of the insured's damages;

iv) an analysis of the operation and features of the ATE market offering policies of a form described in section 58C of the Courts and Legal Services Act 1990 including the approach to the assessment of risk, and the consequences for premium setting and insurance;

v) the likely effect of a reduction in the recoverable level of premiums on the availability of such policies in the market; and

vi) such consequential factual matters as the assessors considered appropriate.

37. Kerr J and Master Leonard were the assessors. They sat and heard submissions and evidence for five days between 1 and 8 April 2019. They recorded their conclusions in the Assessors' Report, which was a detailed and meticulous report of some 70 pages and was handed down on 24 May 2019. The Assessors Report is appended to this Judgment as **Annex 1**. We express our considerable thanks to them.

### 6.2 The Key Findings

38. The following paragraphs in the Assessors' Report are of particular relevance and importance in the disposal of these appeals.

39. Paragraphs 38-48 deal with the terms of the contracts between ARAG and its panel solicitors. The assessors note that those terms provide that the panel solicitor must use the ARAG scheme as the insurance provider for ATE insurance in respect of all cases in agreed classes. At paragraph 44 they note that "the solicitor must recommend the relevant ARAG scheme policy to any eligible client when entering into the funding agreement."

40. There is an extensive description of the single-stage block-rated policy and premium at paragraphs 49-57, followed by a lengthy section of the report dealing with the approach to setting the premiums and the non-recoverable element payable out of the insured's damages, starting at paragraph 58 and running on to paragraph 113. The assessors conclude at paragraphs 94 and 95 that, in the absence of expert evidence as to the methodology in setting premiums, the evidence before them (including evidence from the respondent) indicated that the ATE premiums in these appeals are "fairly typical".

41. Between paragraphs 114 and 155 there is a detailed comparison of the different policies provided by some of the principal insurers in this market. This notes the different experience of different insurers, which obviously informs the terms of their policies and the premiums payable. At paragraph 125 the assessors refer to the LAMP policies, which are regularly used as comparables, and say:

> "He [Mr Cousins, then the CEO of LAMP] described the policies with a £9,000 indemnity limit, memorably, as a 'pregnant albatross', referring to the fact that schedules from those policies are regularly produced, out of context and without reference to availability or scheme specifics, to challenge on detailed assessment insurer's clinical negligence ATE premiums. That includes, ironically, LAMP's own premiums under other schemes, which can be significantly higher …"

The assessors also note in the next paragraph that the LAMP policies relied on by the respondent in these appeals would not have been available to these appellants (because one was not available at all in the market at the relevant dates and, as regards the other, Mr Demouilpied's solicitors were signed up to another scheme).

42. The Assessors' Report compares policy premiums between paragraphs 156 and 160. At paragraph 158 they note that Mr Haynes, who was the underwriting and marketing director of ARAG, had concluded that ARAG's insurance came at more less the same cost as that of its competitors, or as a little less expensive, which they say at paragraph 159 was broadly supported by Mr Cousin's evidence, and was also supported, to a degree, by the respondent's own evidence. In dealing with that evidence at paragraph 160, the assessors noted that the respondent's approach before them was to produce a body of evidence "largely designed to put the appellants to proof of what they say, rather than advancing any positive case on behalf of the respondent." As we have already said, this reliance on the burden of proof is a feature of the respondent's general approach.

43. In their conclusions as to cover, starting at paragraph 191, the assessors are clear that the limit of the indemnity plays a marginal role in the setting of recoverable clinical negligence ATE insurance premiums. The premium was primarily a function of the average cost risk. At paragraph 198 the assessors note that there is little incentive for solicitors to undertake any thorough or detailed ongoing review of the market, "at least where recoverable premiums are concerned". They explain that, provided that a solicitor and an ATE insurer have a good working relationship, clients are not burdened with unattractively high irrecoverable premiums and difficulties are not experienced in recovering from an opponent the recoverable element of the premiums for the client, there is little incentive to review the market. At paragraph 199 they note that the extent to which a solicitor's contractual obligation to recommend a particular insurer's product has any bearing on market choices "seems limited".

44. At paragraphs 239 onwards the assessors express their concern about the approach adopted by the respondent in these terms:

> "239. The difficulty with submissions based upon what will happen if premiums are reduced to a 'reasonable and

> proportionate' level is that they beg the question what a reasonable and proportionate level is. The position of the insurers, understandably, is that their premium levels are already reasonable, proportionate and (across the board, taking into account the variations in risk modelling and policy cover) competitive. It would be difficult for them to advance a positive case founded on a hypothetical adjustment to those premiums; they would have first to decide what degree of hypothetical adjustment to make and it is understandable that they have not sought to do so.
>
> 240. The proposition that reducing insurance premiums will lead to a better managed market seems to rest largely upon what we have concluded are unrealistic expectations of the management and monitoring of legal costs by insurers."

45. Finally, as to the amount of the premiums themselves, we note the following conclusions both as to the respondent's attitude to the burden of proof and the "reasonably competitive" rate of the premiums:

> "246. As Mr Clegg [a costs consultant employed by Acumension, the respondent's representatives] has explained, the respondent did not think it appropriate or necessary, in giving evidence for the purpose of this report, to disclose what would appear to be a large body of comparable evidence tending to support ARAG's case to the effect that its premiums, across the market, are reasonably competitive. Mr Clegg's answer to this was that it was not incumbent upon the respondent, which does no more than seek to raise a legitimate element of doubt about the choice made by the appellants, to do so...
>
> 248. The assessment of recoverable clinical negligence ATE premiums, particularly in small cases, will typically take place within a short time frame at county court level, in the course of which a judge may be required to exercise a broad discretion. Even in the larger cases, for example at the Senior Courts Costs Office (SCCO), detailed assessment proceedings do not generally entail lengthy investigations into complex financial and actuarial calculations, the cross-examination of witnesses on such matters, or the weighing of large bodies of evidence. Orders for disclosure are exceptional.
>
> 249. Normally there will be no evidence from the insurer to assist the assessing judge. Nor is the paying party under any obligation to do more than produce documents which suit its case.
>
> 250. We appreciate that one of the issues in this appeal is whether it is appropriate, when judging the proportionality of an ATE insurance premium, to take into account the workings

> and nature of the ATE market. If and to the extent that it is, the assessing judge in the situation we have described is effectively 'flying blind'. Making an informed decision may be impossible. The judge may have to choose between a broad-brush uninformed decision and taking the view that the evidence produced by the paying party is insufficient to raise any real element of doubt..."

The Report goes on to say, at paragraph 251, that perhaps both insurers and NHS Resolutions "could do better". That is a point to which we return at the end of this judgment.

### 6.3 Matters Outside The Scope Of This Appeal

46. During the course of his oral submissions Mr Roger Mallalieu, counsel for the respondent, said that the points which we should decide arising out of the Assessors' Report included the following: the self-insurance of premiums; the failure rate; and the effect, in setting the amount of the premium, of agency fees, commission, profits and overheads. None of those were matters identified by Irwin LJ at the outset of this process (see paragraph 36 above).

47. We do not propose to deal with those issues. The Assessors' Report addressed directly the issues identified in the Order of 28 October 2018 set out in paragraph 36 above. In describing the efficient operation of the market, however, the Assessors' conclusions were reached allowing for the setting of premiums in the light of agency fees, overheads and profits.

## 7) The Issues

48. The following issues arise for our determination:

    i) How should a reasonableness challenge to an ATE premium be made and resolved?

    ii) Is a proportionality challenge limited to a consideration of the circumstances of the case in question pursuant to CPR 44.3(5), or can it go wider and deal with "all the circumstances" in accordance with CPR 44.4?

    iii) If the ATE insurance premium is reasonable, should it also be subjected to a proportionality assessment?

    iv) Taking account of the answers to (a) - (c), what is the proper approach to a costs assessment as regards reasonableness and proportionality?

    v) Applying the answers to issues (a) - (d), should the appeals in either *West* or *Demouilpied* (or both) be allowed?

    vi) What is the way forward for future challenges to the reasonableness of ATE insurance premiums?

49. We now turn to consider those issues in sequence.

## 8) Issue (a): The Reasonableness Of The ATE Insurance Premium

### 8.1 The Principal Authorities

50. We have already referred to Rogers. Part of the judgment of the Court of Appeal was concerned with the decision of this court in *Lownds v Home Office (Practice Note)* [2002] EWCA Civ 365, [2002] 1 WLR 2450, in which Lord Woolf said at paragraphs 28-31 that, if an item of cost was both necessary and reasonable, then it was automatically proportionate. In his report at paragraphs 5.11 and 5.12 Sir Rupert Jackson recommended that the effect of *Lownds* should be reversed and that an item of cost could be disproportionate even if it is necessary. The consequent changes to the CPR are addressed in Section 9 below. For the reasons noted there, we make clear that *Lownds* must no longer be regarded as good law.

51. *Rogers* remains, however, an important and useful authority. That is because the Court of Appeal considered carefully the limits of any challenge to an ATE insurance premium. Brooke LJ said:

> "105. … Necessity here is, we think, not some absolute litmus test. It may be demonstrated by the application of strategic considerations which travel beyond the dictates of the particular case. Thus it may include, as we are persuaded it does, the unavoidable characteristics of the market in insurance of this kind. It does so because this very market is integral to the means of providing access to justice in civil disputes in what may be called the post-legal aid world.
>
> 106. It is important to recognise that this conclusion runs with, not across, the grain of the procedural reforms expressed in the CPR. The very recognition that justice requires a use of resources that is proportionate to what is at stake implies the rightness of a strategic approach. There can be no touchstone of a proportionate use of resources so understood, without an eye to the context in which any such resources are expended. Once it is concluded that the ATE staged premium here was necessarily incurred, principle and pragmatism together compel the conclusion that it was a proportionate expense. We turn therefore to the question whether the ATE staged premium was necessarily incurred.
>
> …
>
> 117. If an issue arises about the size of a second or third stage premium, it will ordinarily be sufficient for a claimant's solicitor to write a brief note for the purposes of the costs assessment explaining how he came to choose the particular ATE product for his client, and the basis on which the premium is rated – whether block rated or individually rated. District judges and costs judges do not, as Lord Hoffmann observed in *Callery v Gray (Nos 1 and 2)* [2002] 1 WLR 2000, para 44, have the expertise to judge the reasonableness of a premium

> except in very broad brush terms, and the viability of the ATE market will be imperilled if they regard themselves (without the assistance of expert evidence) as better qualified than the underwriter to rate the financial risk the insurer faces. Although the claimant very often does not have to pay the premium himself, this does not mean that there are no competitive or other pressures at all in the market. As the evidence before this court shows, it is not in an insurer's interest to fix a premium at a level which will attract frequent challenges."

52. It is accepted that the particular comments as to necessity need to be disregarded following the change in the law and the over-ruling of Lownds, but the Court of Appeal's observations as to the inability of judges, without the assistance of expert evidence, sensibly to address the reasonableness of the premium (except in very broad brush terms), and the risk to the whole market if they do, remain entirely relevant and appropriate.

53. In *Kris Motor Spares Limited v Fox Williams LLP* [2010] EWHC 1008 (QB), [2010] 4 Costs LR 620, Simon J (as he then was), sitting with assessors, said:

> "44. I have concluded that in a case where the issue is raised as to the size of the premium there is an evidential burden on the paying party to advance at least some material in support of the contention that the premium is unreasonable. I have reached this conclusion in the light of the cases which I have cited, and in particular Rogers v. Merthyr. Despite the doubts about the operation of the Market, the Court of Appeal was satisfied that it was not in the insurer's interest to fix a premium at a level which would attract frequent challenges; and that a Master was not in a better position than the underwriter to rate the financial risk that the insurer faced. Where a real issue was raised the court envisaged the hearing of expert evidence as to the reasonableness of the charge. If an issue arises, it must be raised by the paying party. This is not to reverse the burden of proof. If, having heard the evidence and the argument, there is still a doubt about the reasonableness of the charge that doubt must be resolved in favour of the paying party, see (for example) Lord Scott of Foscote in Callery v. Gray (Nos 1 & 2) at [126]. In the present case, no evidence was deployed by KMS which might have assisted the Master; and Fox Williams received no further requests for information. On the material he had it cannot be said that Master Rogers's conclusion on the level of premium was wrong.
>
> …
>
> 46. The recoverability of ATE premiums under a costs order is the subject of vigorous debate (see Lord Justice Jackson's Final Report at §4.4); and this judgment should not be seen as discouraging challenges to ATE premiums on the basis of unreasonableness, for so long as such premiums may be

> recoverable in principle. However such challenges must be resolved on the basis of evidence and analysis, rather than by assertion and counter-assertion. The issue should be identified promptly and, where necessary, there should be directions for the proper determination of specific issues. This may involve the costs judge looking at the Proposal; and in the Receiving Party providing a note for a one-off ATE premium and not just for a staged premium."

54. We agree with that analysis.

55. Although the decision of this court in *McMenemy*, referred to above, addressed proportionality, Lewison LJ, with whom the other judges agreed, summarised the courts' approach to the recovery of ATE insurance premiums and reasonableness by reference to *Callery v Gray (Nos 1 & 2)* [2002] UKHL 28, [2002] 1 WLR 2000, as follows:

> "26. It is, however, clear that the departure from the usual case-by-case assessment of costs was deliberate on the part of this court and upheld by the House of Lords, despite serious reservations by Lord Hoffmann and a powerful dissent by Lord Scott. In effect, therefore, the question was settled at a macro level by reference to the general run of cases and the macro economics of the ATE insurance market, and not by reference to the facts of any specific case."

56. We derive the following principles from these authorities:

i) Disputes about the reasonableness and recoverability of the ATE insurance premium are not to be decided on the usual case-by-case basis. Questions of reasonableness are settled at a macro level by reference to the general run of cases and the macro-economics of the ATE insurance market, and not by reference to the facts in any specific case [*McMenemy*].

ii) Issues of reasonableness go beyond the dictates of a particular case and include the unavoidable characteristics of the ATE insurance market [*Rogers*].

iii) District judges and cost judges do not have the expertise to judge the reasonableness of a premium except in very broad-brush terms, and the viability of the ATE market will be imperilled if they regard themselves (without the assistance of expert evidence) as better qualified than the underwriter to rate the financial risk the insurer faces [*Rogers*].

iv) It is for the paying party to raise a substantive issue as to the reasonableness of the premium which will generally only be capable of being resolved by way of expert evidence [*Kris*].

57. Those are the relevant principles applicable to any consideration of the reasonableness of an ATE insurance policy. They must be applied in every case because the ATE insurance market "is integral to the means of providing access to justice in civil

disputes [now limited to clinical negligence cases] in what may be called the post-legal aid world": see paragraph 105 of *Rogers*.

58. In the course of argument, we were referred to a number of first instance decisions. We mention some of them below. To the extent that they depart from the principles that we have set out at paragraph 56 above, they should not be followed.

59. In particular, we do not agree with the suggestion of Foskett J in *Surrey v Barnet and Chase Farm Hospitals NHS Trust* [2016] EWHC 1598 (QB), [2018] 1WLR 499, at paragraph 116, that *Rogers* is in some way out of date, and that costs judges can consider ATE insurance premiums by engaging in a robust analysis and entering the arena (paragraph 118). That significantly overstates the legitimate role of the costs judge in dealing with such premiums, and is contrary to the principles that we have identified in paragraph 56. To that extent, therefore, we endorse the observations of Langstaff J in *Pollard v University Hospitals of North Midlands NHS Trust* [2017] 1 Costs LR 45, where, at paragraph 40, he expressed reservations about Foskett J's approach and said, at paragraph 41, that, when dealing with a block-rated policy, "a judge should be very hesitant before concluding that the premium is in error, and should have good reasons for doing so".

60. In addition, we note that Martin Spencer J in *Percy v Anderson-Young* [2017] EWHC 2712 (QB), [2018] 1WLR 1583, and Stewart J in *Murray v Oxford University Hospitals NHS Trust* [2019] EWHC 539 (QB), [2019] 1 Costs LR 177, found various ways to distinguish the approach taken by Foskett J in *Surrey*.

### 8.2 The Assessors' Findings

61. We consider that the principles set out in paragraph 56 above are supported by the Assessors' Report in **Annex 1**. In particular, the effect of their report is that:

    i) Expert evidence would be required in order to reach a view that a particular premium was unreasonable;

    ii) for a block-rated policy, the premium is unconnected both to the risk of success and the level of cover in any particular case; and

    iii) the workings of the ATE market are complex, with a number of inter-locking elements which make it unsuitable for broad-brush or generalised submissions.

### 8.3 The Correct Approach

62. None of this is to say that a paying party (which in clinical negligence cases will usually be the respondent) is automatically bound to accept the reasonableness of whatever premium has been paid. The fact that ATE insurance provides access to justice does not mean that the relevant premium must automatically be regarded as reasonable.

63. The practical issue is how and in what sorts of cases can the reasonableness of the premium be challenged. We set out our guidance below.

64. The first point to make is that, if the ATE policy is a bespoke policy, then the grounds of challenge of the amount of the premium are relatively wide. For example, it would

be open to the respondent to challenge the bespoke policy premium on the basis that the risk had been wrongly assessed.

65. As regards a block-rated policy, such as the policies in the present appeals, the ability of the paying party to mount a sustainable challenge will be much more restricted. The majority of challenges to block-rated premiums must relate back to the market in one way or another, and would therefore require expert evidence to resolve. In particular, it will not usually be enough for the paying party simply to give evidence that another policy was cheaper. It is not for district judges or costs judges to have to plough through the detail of allegedly comparable policies, still less to be required to assess the effect of any differences in content. An expert's report would be required to the effect that the other policy was directly comparable to the policy under review.

66. Moreover, by reason of the contract terms commonly agreed between insurers and solicitors, an alternative block-rated policy may not in fact have been available to the receiving party in any event. That may not of itself rule out consideration of that policy as a comparable, but the challenge would involve difficult issues as to reasonableness to be resolved on the facts of the particular case.

67. Finally, a simple comparison between the value of the claim (either the claim made or the settlement sum) and the amount of the premium paid is not a reliable measure of the reasonableness of the ATE insurance premium. That would ignore the way in which the premium payable for a block-rated policy is fixed taking into account a basket of a wide range of cases. It is similar to the "swings and roundabouts" comments associated with fixed costs. In *Sharp v Leeds City Council* [2017] EWCA Civ 33, [2017] 4 WLR 98, for example, Briggs LJ (as he then was) said:

> "41. … The fixed costs regime inevitably contains swings and roundabouts, and lawyers who assist claimants by participating in it are accustomed to taking the rough with the smooth, in pursuing legal business which is profitable overall."

68. If the district judge or costs judge decides that there is substantive evidence which genuinely puts in issue the reasonableness of a premium, then he or she can require the claimant to address that evidence and decide the resulting debate on the evidence in the usual way. We stress, however, that that should only happen if the judge considers that a genuine point of substance, usually requiring expert evidence, has been raised by the paying party and not otherwise.

69. On the basis of the Assessors' Report in this case, we consider that the issue of the reasonableness of ATE insurance premiums has, at least for the foreseeable future, been settled. That ought, therefore, to resolve the issue of their reasonableness in all or almost all of the other cases apparently waiting for the outcome of these appeals. We appreciate, of course, that in the future things may change. We offer a way forward in **Section 13** below.

## 9) Proportionality

### 9.1 The Civil Procedure Rules

70. There was a threshold debate between the parties as to whether a proportionality challenge was limited to the circumstances of the particular case ("the narrower interpretation"), or whether it was to be assessed by reference to all the circumstances, and so encompass matters which were not necessarily related to the case in question ("the wider interpretation").

71. CPR 44.3 (2) is in the following terms:

> "2) Where the amount of costs is to be assessed on the standard basis, the court will –
>
> (a) only allow costs which are proportionate to the matters in issue. Costs which are disproportionate in amount may be disallowed or reduced even if they were reasonably or necessarily incurred; and
>
> (b) resolve any doubt which it may have as to whether costs were reasonably and proportionately incurred or were reasonable and proportionate in amount in favour of the paying party.
>
> (Factors which the court may take into account are set out in rule 44.4.)…"
>
> "5) Costs incurred are proportionate if they bear a reasonable relationship to –
>
> (a) the sums in issue in the proceedings;
>
> (b) the value of any non-monetary relief in issue in the proceedings;
>
> (c) the complexity of the litigation;
>
> (d) any additional work generated by the conduct of the paying party; and
>
> (e) any wider factors involved in the proceedings, such as reputation or public importance."

72. Part 44.4 (which is expressly signposted in r44.3(2)) is in the following terms:

> "1) The court will have regard to all the circumstances in deciding whether costs were –

(a) if it is assessing costs on the standard basis –

(i) proportionately and reasonably incurred; or

(ii) proportionate and reasonable in amount, or

(b) if it is assessing costs on the indemnity basis –

(i) unreasonably incurred; or

(ii) unreasonable in amount.

2) In particular, the court will give effect to any orders which have already been made.

3) The court will also have regard to –

(a) the conduct of all the parties, including in particular –

(i) conduct before, as well as during, the proceedings; and

(ii) the efforts made, if any, before and during the proceedings in order to try to resolve the dispute;

(b) the amount or value of any money or property involved;

(c) the importance of the matter to all the parties;

(d) the particular complexity of the matter or the difficulty or novelty of the questions raised;

(e) the skill, effort, specialised knowledge and responsibility involved;

(f) the time spent on the case;

(g) the place where and the circumstances in which work or any part of it was done; and

(h) the receiving party's last approved or agreed budget."

73. We consider it is clear that, on the basis of these rules, questions of proportionality are to be considered by reference to the specific matters noted in 44.3(5) and, if relevant, any wider circumstances identified under r.44.4(1). Accordingly, the wider interpretation is correct. There are several reasons for that conclusion.

74. First, r.44.4 is expressly signposted in r.44.3(2).

75. Secondly, r.44.4(1) expressly states that it is dealing with assessments of both proportionality and reasonableness.

76. Thirdly, r.44.3(5) is easily reconciled with the signposting in r.44.3(2) to r.44.4 on the basis that proportionality is sufficiently established by satisfaction of r.44.3(5) but failure to satisfy r.44.3(5) does not preclude establishing proportionality by reference to other circumstances under r.44.4.

77. Fourthly, as Mr Mallalieu accepted in an answer to a question from the Master of the Rolls during argument, his interpretation was to the effect that r.44.3(5) should be read as saying "costs incurred are proportionate if and only if they bear a reasonable relationship to …". Not only is that not what the rule says, but those words comprised the original formulation proposed by Sir Rupert Jackson, which was not adopted by the Civil Procedure Rule Committe.

78. Finally, in this context, it is clear that r.44.3(2)(a) was intended to give effect to the recommendation of Sir Rupert Jackson in his Review that Lownds should be overturned by rule change.

### 9.2 Is Proportionality Applicable At All?

79. We consider, first, proportionality and the recoverable part of a block-rated ATE insurance premium which has been assessed as reasonable, either because there was no challenge to it or, where there has been a challenge, the paying party has not demonstrated a sustainable challenge in view of the nature of the threshold addressed at **Section 8.3** above.

80. Such a premium cannot, in our judgment, then be assessed as disproportionate. Any attack on proportionality would be, as it was in the *Demouilpied* appeal, based on the difference between the amount recovered and the amount of the recoverable element of the premium, when considered as part of the overall costs. There are two reasons why a discount for proportionality is inappropriate. Firstly, being a block-rated policy, the amount of the reasonable premium bears no relationship to the value of the claim, much less the amount for which the claim was settled. Secondly, ATE insurance is critical to access to justice in clinical negligence claims, as was made clear by the Court of Appeal in *Rogers* and by the Government both in its formal response to Sir Rupert Jacksons's recommendations and in the Explanatory Memorandum accompanying the Regulations (see paragraphs 5 and 10 above).

81. This last point raises the wider issue as to whether, when considering proportionality, the judge needs to have regard to every item of cost, or whether there are some costs which ought to be removed from that part of the assessment. We consider that, when the judge comes to consider proportionality, there are some elements of costs which should be left out of account.

82. The exceptions are those items of cost which are fixed and unavoidable, or which have an irreducible minimum, without which the litigation could not have been progressed. Court fees are perhaps the best example.

83. We note that this approach is commonly adopted in costs assessments. So, in *May v Wavell Group Limted* [2017] 12 WLUK 679, a decision of HHJ Dight CBE and Master Whalan, at paragraph 72, when considering proportionality, the court left out of the exercise court fees and the costs of drawing the bill itself. Similarly, in *Malmsten v Bohinc* [2019] EWHC 1386 (Ch), Marcus Smith J, sitting with Master

Rowley, left out of account both VAT and the costs of drawing the bill when considering the question of proportionality. The judge explained this at paragraphs 60-61, as follows:

> "60. In my judgment, the Master was entirely right to leave both VAT and the costs of drawing the bill out of account when considering the question of proportionality. These are no more than distorting factors, when considering the overall proportionality of costs. The fact is that, when considering proportionality, one is seeking to determine whether there is a proper – a proportionate – relationship between the overall costs and the action or the application giving rise to those costs. Self-evidently, the costs of any detailed assessment – which are costs entirely unrelated to the nature of the action or application whose costs are being assessed – must be left out of account. I do not consider the contrary to be seriously arguable, given the definition of "proportionality" in CPR 44.3(5).
>
> 61. Equally, the inclusion of VAT confuses rather than assists. The fact is that VAT is – when payable – not an option, but an inevitable cost to the receiving party..."

84. This ought not to disadvantage the paying party. Take as an example a claim that was settled for £10,000 but where the costs were £50,000, of which £5,000 was made up of the recoverable element of the ATE insurance premium. In those circumstances, when working through the various categories of cost to assess proportionality, the judge may have some overall figure in mind that would be proportionate. That figure will remain unchanged: the reductions to achieve it will simply be by reference to other elements of cost, not the ATE insurance premium. Plainly, a different approach may well apply to a bespoke insurance arrangement.

85. We recognise that this means that, when undertaking the proportionality exercise, it is those elements of cost which are not inevitable or which are not subject to an irreducible minimum which will be vulnerable to reduction on proportionality grounds in order that the final figure is proportionate. Such costs are, however, likely to be costs which have been incurred as a result of the exercise of judgement by the solicitor or counsel. Those are precisely the sorts of costs which the new rules as to proportionality were designed to control.

86. As should be apparent, leaving particular items out of account when considering proportionality because they are both reasonable and an unavoidable expenditure does not re-introduce the *Lownds* test, by which necessity always trumped proportionality. Most costs will still be subject to the proportionality requirement.

## 10) The Right Approach To Costs Assessment

87. We are anxious not to restrict judges or force them, when assessing a bill of costs, to follow inflexible or overly-complex rules. One of the matters, however, which is apparent from the many cases cited to us, and from the submissions of counsel on the hearing of these appeals, is that there is an absence of consistency in the way in which

costs bills are assessed. Taking the various points made above and drawing them together, we give the following guidance on an appropriate approach.

88. First, the judge should go through the bill line-by-line, assessing the reasonableness of each item of cost. If the judge considers it possible, appropriate and convenient when undertaking that exercise, he or she may also address the proportionality of any particular item at the same time. That is because, although reasonableness and proportionality are conceptually distinct, there can be an overlap between them, not least because reasonableness may be a necessary condition of proportionality: see Rogers at paragraph 104. This will be a matter for the judge. It will apply, for example, when the judge considers an item to be clearly disproportionate, irrespective of the final figures.

89. At the conclusion of the line-by-line exercise, there will be a total figure which the judge considers to be reasonable (and which may, as indicated, also take into account at least some aspects of proportionality). That total figure will have involved an assessment of every item of cost, including court fees, the ATE premium and the like.

90. The proportionality of that total figure must be assessed by reference to both r.44.3(5) and r.44.4(1). If that total figure is found to be proportionate, then no further assessment is required. If the judge regards the overall figure as disproportionate, then a further assessment is required. That should not be line-by-line, but should instead consider various categories of cost, such as disclosure or expert's reports, or specific periods where particular costs were incurred, or particular parts of the profit costs.

91. At that stage, however, any reductions for proportionality should exclude those elements of costs which are properly regarded as unavoidable, such as court fees, the reasonable element of the ATE premium in clinical negligence cases, and the like. Specifically, therefore, if the ATE premium is assessed as reasonable, it will not fall to be reduced by any further assessment of proportionality.

92. The judge will undertake the proportionality assessment by looking at the different categories of costs (excluding the unavoidable items noted above) and considering, in respect of each such category, whether the costs incurred were disproportionate. If yes, then the judge will make such reduction as is appropriate. In that way, reductions for proportionality will be clear and transparent for both sides.

93. Once any further reductions have been made, the resulting figure will be the final amount of the costs assessment. There would be no further stage of standing back and, if necessary, undertaking a yet further review by reference to proportionality. That would introduce the risk of double-counting.

## 11) The Appeal in *West*

94. Applying the principles set out above to the facts in the *West* appeal, we conclude that the appeal must be allowed. The evidence in the Assessors' Report is that the ATE insurance premium paid by Ms West was "fairly typical" and "reasonably competitive". The evidence therefore demonstrated that it was a reasonable figure; there was no evidence, and nothing in the Assessors' Report, to suggest that it was unreasonable.

95. The LAMP policies, which comprised the only justification for the reduction of the premium in the *West* case, were the "pregnant albatross" as noted by the assessors and mentioned at paragraph 41 above. For the reasons given in the Assessors' Report it is highly doubtful that such policies could properly be described as fully comparable. Moreover, they were contractually unavailable to Ms West because of the arrangement between her solicitors and ARAG. That last point may be relevant to any assessment of reasonableness. Our decision to allow the appeal does not turn, however, on that issue.

96. As in *Demouilpied*, the district judge in *West* undertook his own calculation based on his own figures. That was wrong in principle. There was nothing to support the figure of £2,500.

## 12) The Appeal in Demouilpied

97. Applying the principles set out above, the appeal in *Demouilpied* must also be allowed. First, there should not have been any reduction to the amount of the premium on the grounds of proportionality. It was not suggested that the premium was unreasonable, and it was an unavoidable cost of the litigation.

98. Further, and in any event, the district judge embarked on a freestanding calculation process. That was, as Judge Smith rightly described, both inappropriate and impermissible.

## 13) The Way Forward

99. Subject to any points which do not arise from the Assessment, or are not addressed in this judgment, the position in respect of the recoverability of block-rated ATE insurance policy premiums is settled, at least until there are identifiable changes affecting the matters considered.

100. We recognise, of course, that in the future points may arise as to the reasonableness of such premiums as they and the market change. If and when they do, they ought to be addressed by way of a group of test cases. This imposes no burden on the respondent, since it is usually the paying party in clinical negligence cases. There can be a cost-sharing agreement organised between the relevant claimants so as to ease the burden on them. In that way, there will be a control mechanism exercisable by the court in respect of the ongoing amounts of such premiums, but any future debate will not be dealt with in an uncontrolled and unmanageable way.

101. This will also allow the court to deal with and resolve real disputes. Experience shows that this is more helpful to the court user than rules or guidance given in the abstract. As we understand it, it was precisely for that reason that the Civil Procedure Rule Committee declined to set up a regulatory mechanism to monitor and review the amount of ATE insurance premiums.

**ANNEX 1**

**REPORT OF MR JUSTICE KERR AND MASTER LEONARD**

**SITTING AS ASSESSORS TO THE COURT OF APPEAL**

**DATED 24 MAY 2019**

## BACKGROUND AND INTRODUCTION

1. This report has been prepared for the purposes of two appeals from decisions of His Honour Judge Smith, sitting in the Manchester County Court, on 4 November 2016. HHJ Smith's judgment addressed appeals by Ms Suzanne West and Mr Lee Demouilpied from decisions of, respectively, District Judge Iyer and Deputy District Judge Buckley.

2. Both appeals concerned the recovery by the Appellants from the Respondent of the cost of "after the event" ("ATE") insurance premiums paid by each of the Appellants for the purposes of claims for damages against the Respondent based upon allegations of clinical negligence. Each claim settled, without the issue of proceedings, on the acceptance of a Part 36 offer.

3. On the assessment of the costs payable to the Appellants following the acceptance of those Part 36 offers each of the Appellants sought, under section 58C of the Courts and Legal Services Act 1990 and Regulation 3 of the Recovery of Costs Insurance Premiums in Clinical Negligence Proceedings (No 2) Regulations 2013 ("the 2013 Regulations"), to recover from the Respondent the cost of that part of the ATE premium which related to the risk of incurring liability to pay for an expert report or reports relating to liability or causation.

4. Ms West had, in October 2013, instructed Fentons Solicitors ("Fentons") for the purposes of pursuing her claim. On 6 December 2013 she took out a "Recourse" ATE policy with ARAG plc ("ARAG") for a total premium of £5,700 plus Insurance Premium Tax ("IPT") of which £4,800 (excluding IPT) was identified as the part recoverable under the 2013 Regulations **[1811 – 1818]**. Expert reports on liability and causation were obtained at a total cost of £4,165 **[1786 – 1787]**. On 11 February 2014 a Letter of Claim was sent to the Defendant accompanied by a Part 36 offer in the sum of £10,000. The offer was accepted on 7 July 2015.

5. On the assessment of Ms West's costs, recoverable following acceptance of the Part 36 offer, the Respondent argued that the premium paid by Ms West was unreasonable in amount and/or disproportionate, and in support of that argument produced policy schedules **[1856 – 1859]** ("the LAMP Comparables") from LAMP, another ATE insurance provider, which appeared to show lower premiums for (the Respondent argued) the same sort of cover. DJ Iyer took account of that evidence in coming to the conclusion that a recoverable ATE premium in excess of £2,500 was unreasonable and in consequence irrecoverable from the Respondent.

6. Mr Demouilpied, in March 2014, instructed Forster Dean Solicitors ("FD") to pursue his claim. On 16 April 2014 he took out an ARAG "Recourse" policy on the same terms as Ms West, paying the same premium **[1627 – 1634]**.

7. A Letter of Claim was sent to the Defendant on 1 April 2014. The Defendant responded admitting liability in June 2014 and made a Part 36 offer in the sum of £3,500. Following the receipt and disclosure of medical evidence obtained by FD on behalf of Mr Demouilpied

the Defendant made a further Part 36 offer in the sum of £4500 on 16 December 2014. Mr Demouilpied accepted that offer on 5 January 2015. Expert reports on liability and causation were obtained at a total cost of £837.50 plus VAT [**1621**].

8. The assessment of Mr Demouilpied's costs was undertaken by DDJ Buckley, who concluded that the recoverable part of the premium paid by Mr Demouilpied was reasonably incurred and reasonable in amount but disproportionate. He allowed the recovery of £650 as a proportionate sum **[1598 paragraph 33]**.

9. Both decisions were upheld by HHJ Smith. The Appellants obtained permission to appeal to the Court of Appeal. Directions were given for the introduction of fresh evidence and on 16 October 2018 Lord Justice Irwin, acknowledging that the appeals are unusual and exceptional, made an order pursuant to the provisions of CPR 35.15, 35PD10, CPR 52.20(2)(b) and in the exercise of the court's case management powers, for the commission of this report for the purposes of assisting in the resolution of the issues arising in the appeals. On the evidence before us **[150, paragraph 6e]** at least 60 cost assessments have been stayed to await the outcome of these appeals.

10. The issues to be addressed by this report are:

    a. The origin and characteristics of the Policies and Premiums in issue in these Appeals ("**Issue 1**").
    b. The approach to setting the premiums which fall within the scope of the 2013 regulations ("**Issue 2**").
    c. The approach to setting the 'non-recoverable' element payable out of the insured's damages ("**Issue 3**").
    d. An analysis of the operation and features of the ATE market offering policies of a form described in section 58C of the Courts and Legal Services Act 1990 including

the approach to the assessment of risk, and the consequences for premium setting and insurance ("**Issue 4**").

e. The likely effect of a reduction in the recoverable level of premiums on the availability of such policies in the market ("**Issue 5**").

f. Such consequential factual matters as the assessors consider appropriate ("**Issue 6**") .

11. The purpose of this report is to address only those factual issues. To that end, evidence and submissions were heard from each party between 1 and 4 April and on 8 April 2019. These are our conclusions.

## ISSUE 1: THE ORIGIN AND CHARACTERISTICS OF THE POLICIES AND PREMIUMS IN ISSUE IN THESE APPEALS

### Background

12. ARAG entered the ATE insurance market in 2006, having obtained Financial Conduct Authority ("FCA") authorisation on 27 August 2006 **[Agreed Chronology]**. On 21 December 2009, Sir Rupert Jackson completed his Final Report on Civil Litigation Costs, in which he made a number of recommendations for reform. They included putting an end to the recovery of Conditional Fee Agreement ("CFA") success fees and ATE premiums under orders for the payment of costs, with personal injury claimants to receive a different form of protection through Qualified One-Way Costs Shifting ("QOCS"). A 10% increase in general damages awards, together with provisions capping success fees payable by them, would compensate them for the loss of recoverable success fees.

13. On 1 March 2011, the Ministry of Justice published a response ("Reforming Civil Litigation Funding and Costs in England and Wales") which confirmed that this

recommendation (and others) would be implemented, but also, with regard to clinical negligence cases, that

> "for those meritorious claims where claimants have no alternative option for funding expert reports, the premium for ATE insurance limited to the costs of expert reports will remain recoverable*".* **[Agreed Chronology]**

14. The Legal Aid, Sentencing and Punishment of Offenders Act 2012 ("LASPO") put an end to the recovery, under orders for costs, of ATE premiums from 1 April 2013. A number of exceptions were made, including clinical negligence ATE premiums recoverable under the 2013 Regulations. ARAG's current "Recourse" clinical negligence policy is designed for such cases.

15. In *Simmons v Castle* [2012] EWCA Civ 1039 (26 July 2012) and [2012] EWCA Civ 1288 (10 October 2012) the Court of Appeal confirmed, with effect from 1 April 2013, a 10% increase in general damages for personal injury claimants other than those who could recover a success fee under a pre-LASPO CFA.

**ARAG's pre-LASPO "Recourse" Policy and Relationship with its Panel Solicitors**

16. The key evidence in relation to the origins and the evolution of ARAG's current "Recourse" policy was given by Mr David Haynes, an underwriting and marketing director of ARAG. Mr Haynes has over 33 years' experience in the legal expenses market, the last 18 of which have been in a senior underwriting position. He has been employed by ARAG since its formation in 2006 **[148, paragraphs 3-4]**.

17. ARAG is a "Managing General Agent" (MGA), providing legal expenses and assistance insurance products nationwide. In that capacity, ARAG issues and administers "Recourse" policies under delegated underwriting and claims handling authority from

Brit Syndicate 2987 at Lloyds (an AA-security rated insurer by Fitch). Under an agreement entered into on 15 September 2006 **[Agreed Chronology]** ARAG is authorised to handle the design and sale of policies; the management of relationships with solicitors; risk assessment; the issue of policies; and the handling of all claims **[148, paragraph 4]**.

18. ARAG's pre-LASPO "Recourse" policy offered a two-stage premium. The first stage premium applied if the case settled prior to the issue of proceedings. It was entirely "block-rated", meaning that it was a fixed premium set by reference to a wide "basket" of cases rather than individually assessed by reference to the risks of the particular case. The second stage premium applied from the issue of proceedings. It was individually priced to the extent that a pre-determined rate was applied to the insurer's estimated maximum loss (own disbursements, excluding counsel's fees, and the opponent's estimated total costs) in each individual case, to produce a total premium. The second-stage premium was the total premium minus the first stage premium **[393]**.

19. ARAG does not have the necessary authorisation from the FCA to sell ATE insurance products directly to consumers. Obtaining and maintaining FCA authorisation would, says Mr Haynes, come at a significant cost, which would inevitably lead to an increase in the cost of its premiums. At present, the regulatory and compliance costs are reduced, he says, by the products being sold through firms of solicitors who act as intermediaries and upon whom ARAG relies to recommend its product **[396, paragraph 21]**.

20. It is, and was before 1 April 2013, a feature of ARAG's relationship with the panel solicitors who use its block-rated clinical negligence ATE policies that the solicitors are

contractually obliged to use ARAG as their exclusive clinical negligence ATE insurance provider and agree to recommend ARAG's policy to all eligible clients. This, according to the unchallenged evidence of Mr Haynes, **[395 paragraphs 19-20]** is common to all insurers offering clinical negligence ATE cover. The underlying logic of this contractual requirement is that, block-rated policies being calculated by reference to the level of risk across a "basket" of cases, the insurer needs to eliminate the possibility of "adverse selection" through which the panel solicitor would insure only riskier cases**.**

21. Mr Daniel Lee, former head of clinical negligence at Fentons (Ms West's solicitors), gave evidence in relation to Fentons' decision to join ARAG's panel of solicitors, which according to his witness statement was made in August 2010. Fentons was acquired by Slater & Gordon Lawyers in 2013 and Mr Lee left the firm in about October 2016, so he was unable to produce any documentary records of the selection process and was evidently giving evidence from memory. Between October 2016 and October 2018, Mr Lee was head of clinical negligence at FDR Law. At his instigation, FDR Law joined ARAG's panel and he has expressed his satisfaction with the service and cover offered by ARAG as FDR Law's exclusive clinical negligence ATE provider **[480 paragraphs 7-8]**.

22. Mr Lee says that in 2010, Fentons chose ARAG as its exclusive ATE provider following research of the ATE market and consideration of insurance product appropriate for its personal injury and clinical negligence clients' needs. Fentons considered a proposal from ARAG and concluded that it was suitable to fulfil that role. Mr Lee says that the factors taken into account in coming to this conclusion included ARAG's financial stability and an excellent reputation for claims service and payment;

ease of use and certainty as to the scheme terms; that ARAG's block-rated premiums were competitively priced; that its standard limit of indemnity (£100,000) was sufficient for the majority of Fentons' claims; and that its premiums were deferred and contingent upon a successful conclusion for payment.

23. This list of ARAG's merits appears, in very similar words, in the written statements of other witnesses for the Appellants, namely Mr Haynes **[152]**; Mr Thompson of FD **[487]**; and Ms La Pietra of QLD Ltd, brokers who introduced FD to ARAG **[492]**. In Mr Thompson's case the wording is identical. Mr Lee insisted that the list was put together from his own knowledge and recollection. If the same wording appears in Mr Thompson's statement in identical terms, then presumably, Mr Lee says, his words were copied into it. The dates of the witness statements support what he says **[Lee 16 April 2018; Haynes 20 April 2018; Thompson 20 April 2018; La Pietra 2 November 2018]**.

24. Mr Lee says that ARAG was Fentons' exclusive clinical negligence ATE provider until Slater & Gordon took over in 2013, following which, after a period of transition of about a year, all cases moved to Slater & Gordon's chosen insurer, Allianz. His recollection is that Allianz's premium price was similar to ARAG's but possibly slightly lower given that Slater & Gordon, by virtue of its size and large caseload, was able to negotiate favourable terms**.**

25. The Respondent has produced a number of policy schedules which indicate that Fentons may have been arranging insurance for its clinical negligence clients with other insurers up to about 2012. Mr Lee was unsure of the explanation for this. He suggested a number

of possibilities, for example (with regard, at least, to the earlier examples) that he might have misremembered the date upon which Fentons joined ARAG's panel; that Fentons may have been working through some pre-existing arrangements; or that there might have been some joint insuring arrangement which he could not recall **[Appellant's closing submissions paragraph 28]**. He was however quite clear (and it is not in issue) that Fentons had a contractual obligation to recommend ARAG's policy to all clinical negligence clients who had, in Fentons' view, a need for such insurance.

26. Mr Lee confirmed in his oral evidence that neither Fentons nor its clients received any benefit, (other than insurance cover) from arranging insurance with ARAG, and that every client would have been advised of Fentons' obligation to recommend ARAG's policy. Any shortfall in recovery of the premium from a litigation opponent would, he believes, have been borne by Fentons' clients.

27. Mr Daniel Thompson gave evidence in relation to the decision of FD (Mr Demouilpied's solicitors) to join ARAG's panel. The decision, he says, was made in or around February 2010. Mr Thompson is not himself (and never has been) a clinical negligence practitioner. Nor was he involved in the decision-making process, although he was aware of it. That would have been Mr Hunter, a partner in FD who left the firm over six years ago. Nor was Mr Thompson, following a change in FD's document management systems, able to unearth any internal records relating to the original choice. He says that there would have been no need for FD, which remains on ARAG's panel and is still satisfied with its service, to revisit those documents**.**

28. Mr Thompson's evidence was that FD's decision to join ARAG's panel was made on the advice of QLP, an insurance broker. He has produced a copy of QLP's recommendation of 25 February 2010, which appears to have been countersigned by Mr Hunter on 13 April 2010. He has, like Mr Lee, offered a list of the merits that would have made ARAG suitable from FD's point of view, but he accepted in oral evidence that this list was supplied to him by the Appellant's solicitors rather than representing his own recollection. The QLP document recommended a minimum prospect of success for clinical negligence cases of 65% **[499]**, failing which the case must be "referred", and Mr Thompson's recollection was that that remained the minimum threshold for clinical negligence cases.

29. FD's 2010 agreement with ARAG covered a number of types of claim, including clinical negligence, and required FD to refer to ARAG at least 75 cases per year. Mr Thompson's recollection was that FD, which ceased to undertake clinical negligence work in December 2018, was never tied to any exclusive relationship with ARAG, although it was FD's primary ATE provider. Under cross-examination he stated that FD have had, and continue to have, regular review meetings with QLP. This was not referred to in his evidence in chief, and we have little evidence about the content and purpose of those meetings, which would seem to have been ancillary to FD's continuing working relationship with ARAG **[Appellant's closing submissions paragraph 30; Respondent's closing submissions paragraphs 166, 171, 182**.

30. Mr Thompson confirmed under cross-examination that FD and its clients do not receive any benefit (other than ATE insurance cover) from insurance arrangements with ARAG.

Nor, he said, has he known ARAG to waive, or FD to bear, any shortfall in a recovered ATE premium **[Appellant's closing submissions paragraph 30].**

31. Ms Andrea La Pietra has been a director of QLP since 1999. Together with Mr Tom Davey, she prepared QLP's February 2010 recommendation to FD. In her written witness statement, she summarises the merits that led QLP to recommend ARAG to FD. Notwithstanding its similarity to the list of merits given by other witnesses, she says that it is a representative distillation of the reasoning set out in QLP's February 2010 recommendation.

32. QLP, says Ms La Pietra, is regularly approached by solicitors like FD who require ATE insurance for their clients: in the last year, QLP would probably have made around 20 such recommendations. QLP works with a number of insurers on a non-exclusive basis and, on behalf of the solicitor, will approach a number of them with a view to obtaining terms, whether on a "bespoke" (individually rated) or "scheme" (block-rated) basis. For solicitors with high claim volumes, such as FD, a scheme can, she says, provide a cost-efficient and administratively straightforward method of insuring their clients. QLP will receive payment from the selected insurer by way of a share of paid premiums.

33. Ms La Pietra confirms that, following a performance review in September/October 2012, FD's relationship with ARAG changed with effect from 15 October 2012. Thereafter, she says, FD insured all appropriate claims with ARAG (subject to ARAG's scheme underwriting criteria, client consent and insurance checks). It is QLP's practice to undertake (and initiate, if appropriate) regular reviews with solicitors, as the market changes, to monitor the running of schemes and client satisfaction.

**Submissions and Conclusions**

34. The SRA (Solicitors Regulation authority) Financial Services (Conduct of Business) Rules 2001 govern the conduct of solicitors undertaking certain activities which would otherwise be regulated by the FCA. "Insurance mediation activities" includes the recommendation of contracts of insurance (other than life policies) to a client. The rules require that the solicitor must inform the client whether the advice is being given on an analysis of the market, and if not, advise the client whether the firm is contractually obliged to make the recommendation.

35. Mr Mallalieu, for the Respondent, accepts that it is quite sufficient, to comply with the rules, to notify the client of the solicitor's contractual obligation to make the recommendation. Mr Lee has confirmed that that is Fentons' practice, but Mr Thompson insisted that FD did not have any contractual obligation to recommend the ARAG policy.

36. Mr Mallalieu has invited us to find that there is some cause for concern as to whether the rules, generally, are always being complied with. That is based upon the evidence of Mr Thompson and one piece of documentary evidence; a copy CFA from an ARAG panel solicitor **[660]** which appears, according to investigations undertaken by Mr Haynes and incorporated in his witness evidence, to have been incorrectly drafted in some respects **[401-402]**.

37. We do not think that the wrongly drafted document provides any firm foundation for reaching any such conclusion. As for Mr Thompson, it is clear that his knowledge and recollection of his firm's clinical negligence practice was limited and, through no doubt

he did his best, not necessarily particularly reliable. In so far as one can draw any conclusions from it, it would be that FD did not, in practice, adhere to a contractual obligation to recommend ARAG's products in every case. In this it would seem that they were not alone, as the policy schedules put to Mr Lee indicate. We do not consider that the evidence justifies the conclusion suggested by Mr Mallalieu.

**ARAG's Post-LASPO "Recourse" ATE Policy: The Panel Solicitor's Agreement**

38. The management of ARAG's post-LASPO "Recourse" ATE policy, the policy taken out by the Appellants, rests upon two contracts. The first is the agreement between ARAG and its panel solicitor. The second is the contract of insurance between ARAG and its insured.

39. To join ARAG's panel, solicitors have to complete an application form, following which ARAG will consider the firm's success rates, experience and record **[Appellant's closing submissions paragraphs 35-36]**. The assessment process is not inflexible; although the application form provides for the solicitors to supply information over the preceding five years, where the firm is too new to do so ARAG will consider, for example, the experience of the firm's partners.

40. Panel solicitors' procedures are audited by three full time ARAG auditors **[Appellant's closing submissions paragraph 35]** who, according to Mr Haynes, expect to audit every firm annually by taking a sample of files [**Appellant's closing submissions paragraph 35**]. Claims are handled, as they come in, by a separate claims team. Mr Haynes was not in a position to give evidence as to the approach of the claims team, other than commenting that he would not expect them to pay claims unless satisfied that they are reasonable.

41. The terms of ARAG's agreement with panel solicitors **[179–201]**, as applicable at the time that Ms West's and Mr Demouilpied's policies were taken out, are in all material respects the same as those in effect now. The solicitor or ARAG may terminate the agreement at any time by notice in writing **[clause 4.6 at 193]**.

42. The terms provided that the panel solicitor must use ARAG's scheme as the insurance provider for ATE insurance in respect of all cases in agreed classes. It is a prerequisite of cover that the solicitor has entered into a funding agreement with the client. The funding agreement will be a Conditional Fee Agreement ("CFA") or Damages-based Agreement ("DBA"), although other funding arrangements can be agreed in writing. In practice, the funding agreement will be a CFA, to the extent that it is routinely referred to as such in the parties' evidence and submissions and even in policy schedules **[e.g. 136, paragraph 9, 1811, 1819, 1627]**. We shall do the same.

43. The intention behind requiring a CFA to be signed before insurance is issued is to ensure that the panel solicitor, based upon specialist experience, identifies prospects of success of at least 51%, the premise being that the solicitor will not otherwise incur the risk of working on the new case without payment.

44. The solicitor must recommend the relevant ARAG scheme policy to any eligible client when entering into the funding agreement, and the insurance policy must be issued within three months of that agreement **[183]**. (Mr Haynes' evidence is that the policy is normally issued within a few weeks of signing the funding agreement) **[Appellant's**

**closing submissions, paragraph 37b].** The solicitor has delegated authority to issue policies **[204, 208, paragraph 1.9]**.

45. Mr Haynes says in his witness statement **[137, paragraph 14]** that the "Recourse" policy must be taken out before obtaining medical records and/or experts' reports, again for the purposes of avoiding adverse selection. In oral evidence he accepted that although that is the intention of the policy, there is no bar to obtaining a medical report before insurance is taken out. In that event, he said, ARAG would wish to see it, but having a report would not in itself disqualify the client from obtaining cover. He also accepted that there is no obligation upon the client to take out ARAG's policy, once recommended by the panel solicitor. The solicitor could still act for the client: how to proceed would be a matter for the solicitor and the client **[Appellant's closing submissions paragraph 37a].**

46. ARAG will not automatically issue an ATE insurance policy where proceedings have commenced or another existing, suitable legal expenses or other insurance policy exists **[clauses 1.8.1 and 1.8.3 at 184].** ARAG will indemnify reasonable disbursements after the commencement of the policy **[clause 2.3 at 187**]. Mr Haynes, in evidence, expressed the view that "reasonable" would represent the standard applicable on detailed assessment and that "disbursements" would, so far as his knowledge goes, include the fees of medical agencies incurred for the purposes of obtaining expert reports **[Appellant's closing submissions paragraph 37d]**.

47. There are other relevant terms of the agreement. The panel solicitor must comply with the Client Care provisions of the SRA code of conduct 2011 **[1.7.3, 183]**. The solicitor

is required to report to ARAG within five working days if the prospect of success in a claim falls beneath 51%; where the limit of indemnity on the policy is thought to be likely to be exceeded; on all cases that have been successful or unsuccessful; on all cases which have been abandoned; and on all cases where there is a claim against the Insurance Policy **[clause 2.9, 190 - 191]**.

48. Mr Haynes, in oral evidence, stated that ARAG would itself wish to review any new case with a prospect of success of less 65% before approving issue of a policy, something not mentioned in his written witness statements. Mr Mallalieu comments that this late evidence seems hard to reconcile with ARAG's stated logic of block-rating, which is to obtain a wide spread of cases with prospects of 51% or better without "cherry-picking" **[Respondent's closing submissions paragraph 92d]**. But it is not in itself inconsistent with ARAG's stated need to avoid "adverse selection": quite the contrary, if anything.

**ARAG's Post-LASPO "Recourse" ATE Policy Terms**

49. The ARAG "Recourse" policy, taken out by the Appellants, was designed to meet the ATE insurance requirements of solicitors' clinical negligence clients in the new regime introduced by LASPO from 1 April 2013. It incorporates a standard single-stage, block-rated premium comprising an amount recoverable from an opponent pursuant to section 58C of the Courts and Legal Services Act 1990 and a non-recoverable amount to be deducted from damages. This, says Mr Haynes, has the benefit of ensuring the policyholder knows, from the outset of the claim, how much the total premium is and what part of the premium will be deducted from their damages. In the event of the claim being discontinued or lost, the policyholder will not have to pay the premium, which is effectively self-insured **[136, paragraph 10]**.

50. In the past five years, says Mr Haynes, the recoverable premium has increased by less than 7%, whereas the consumer price index has increased by just under 8%, so that in real terms, the "Recourse" policy premiums have reduced **[140, paragraph 20]**.

51. The policy documentation comprises a "Recourse Policy Schedule" ("the Schedule") and "Recourse Complete Policy Document" ("the Policy Document").

52. The Schedule incorporates the relevant client-specific data and sets out the policy start date; the identity of the opponent; the limit of indemnity (£100,000); the date of the CFA between the policyholder and the relevant solicitor; the total premium; that part of the premium which is recoverable from the opponent pursuant to section 58C; and that part of the premium which is recoverable from the policyholder's damages **[135; Demouilpied Schedule 1627; West Schedule 1811 and 1819 (later version, different IPT)]**.

53. The "date of issue" shown on the Schedule is the date on which it was last generated. That might be, for example, the date on which the policy was first issued; when a panel solicitor requests a copy of the certificate; or when the IPT rate changes **[394 paragraph 13]**.

54. The Policy Document sets out the detailed terms and conditions of ARAG's agreement with the insured. These are its key provisions.

55. The Policy will only provide cover provided that (i) the policyholder has entered into a CFA ("funding agreement") with the relevant ARAG panel solicitor; (ii) the policyholder agrees to pay the premium when due; and (iii) ARAG believes the claim is more likely than not to succeed. This, says Mr Haynes, is based on the solicitor's assessment **[136, paragraph 9**, **[1631]**.

56. Cover extends to the opponent's legal costs and disbursements and the policyholder's own solicitor's ("reasonably, proportionately and properly incurred") disbursements (excluding counsel's fees) in the event of a judgment against the policyholder, the discontinuance of the claim (by written agreement between ARAG, the policyholder and their solicitor) or, where the claim has been successful, the policyholder failing to beat a Part 36 offer made by the opponent which has reasonably been rejected **[1631- "What is Insured"]**. Cover is retrospective, starting at the date of the CFA.

57. The policy also covers the policyholder's own disbursements (including counsel's fees where counsel is acting on a CFA or DBA) and the insurance premium, where the claim succeeds but the court makes no order as to costs or the opponent cannot pay **[1631 - "What is Insured"]**.

**ISSUE 2: THE APPROACH TO SETTING THE PREMIUMS WHICH FALL WITHIN THE SCOPE OF THE 2013 REGULATIONS**

**ISSUE 3: THE APPROACH TO SETTING THE 'NON-RECOVERABLE' ELEMENT PAYABLE OUT OF THE INSURED'S DAMAGES**

58. These issues fall to be considered together, as the recoverable and non-recoverable elements of the post-LASPO "recourse" policy premium have been calculated as part of a single exercise, as explained by Mr Haynes.

59. ARAG was faced with a tight timetable for preparing its post-LASPO clinical negligence ATE policy: Mr Haynes described the process of fixing a premium price as a "scramble". Regulations governing recovery of qualifying ATE premiums in clinical negligence cases were not published until 21 January 2013, and those regulations were revoked in their entirety by the Clinical Negligence Proceedings (No 2) Regulations 2013, made on 26 March 2013 (to take effect on 1 April 2013).

60. ARAG, in common with all other ATE insurance providers, restructured its insurance products, including their coverage and pricing models, to work within the new post-LASPO regime. Mr Haynes says **[164, paragraph 10]** that this led to a very diverse post-LASPO range of premium structures from various ATE insurance providers, pricing their products in different ways, based upon their individual claims experience and future forecasts. The evidence before us bears this out **[Haynes at page 404, paragraph 61b]**.

61. ARAG began its review of data, for the purpose of creating a policy for the post-LASPO regime, during the fourth quarter of 2012, using data held as at the end of the third quarter (30 September 2012). The review was conducted in the UK in conjunction with group underwriters and actuaries in the Düsseldorf headquarters of ARAG's ultimate parent company ARAG SE, along with Brit Syndicate 2987 at Lloyds. **[Haynes 165-166 and 382-383]**.

**The Calculation of the Total Post-LASPO Clinical Negligence Premium**

62. From its records of all "earned" (paid) premiums, and claims paid and reserved both pre-and post-issue of proceedings, in all clinical negligence policies written up to 30 September 2012, ARAG analysed the "won", "lost", "abandoned at cost" and "abandoned at no cost" ratios to identify a "burning cost" (the cost of paying claims) for each of the pre-issue and post-issue stages. We set out below the calculations from that data first prepared by Mr Haynes on 13 December 2012 and updated, after actuarial input from Düsseldorf, between February and March 2013 **[Agreed Chronology]**.

63. The burning cost for each stage was derived first by dividing ARAG's record of "Total Claims Incurred" by "Earned Risks". The "Total Claims Incurred" figure is the sum of amounts paid, outstanding reserves, URR ("unexpired risk reserve", an additional reserve to reflect the fact that longer-running, unsuccessful cases are likely to be costlier **[302, 321]**) and a safety margin **[agreed note premium calculation, paragraph 5]** (to reflect the uncertainties of the post-LASPO regime) **[342, final paragraph]**. "Earned Risks" represents the number of successful cases in which a premium has been paid in full or in part.

64. From this exercise ARAG derived a burning cost of £2,999 for cases that concluded pre-issue and £7,604 where proceedings had been issued.

65. The next stage was to make an adjustment to take account of the fact that in the new, post-LASPO regime the risk of paying an opponent's costs would be substantially mitigated by QOCS. For cases that concluded pre-issue, there was no adjustment to be made: the risk level was unaffected. For cases that had been issued, ARAG identified

the percentage of expenditure on own costs (32%) and added to it the percentage of successful cases in which a claim was paid due to a failure to beat a Part 36 offer (4%). The burning cost for cases in which proceedings had been issued was, accordingly, multiplied by 36% to derive a figure of £2,763.

66. The resulting figures were then increased to account for inflation (estimated at 10% over an average policy lifetime of 3 ½ years **[379, paragraph 14 (d)]** and the underwriter's (Brit's) profit margin of 20%. The resulting figures (£4,165 and £3,838 respectively) were weighted, according to the proportion of cases that concluded before and after issue (58% and 42% respectively) to give a single composite figure of £4,028. That figure was increased to allow for ARAG's expenses, commission and profit at 30% and adjusted to reach a final figure of £5,700.

67. The figures are summarised in the following table, put together by ARAG **[379]** to assist its legal representatives in understanding how the premium was calculated and reproduced in a most helpful summary of premium calculation agreed by the parties and appended to this report:

| | **Burning/claims cost (a)** | **Disb Risk + QOCS % (b)** | **New Burning Cost ©** | **Plus inflation (d)** | **U/W Cost Inc. Profit (e)** | **% Split of Risks (f)** | **Average U/W Premium (g)** | **Premium inc. ARAG expenses, comm'n & profit (h)** |
|---|---|---|---|---|---|---|---|---|
| **Pre Issue** | £2,999 | 100% | £2,999 | £3,332 | £4,165 | 58% | £4,028 | £5,754 (*Adjusted to £5,700*) |
| **Pre & Post Issue** | £7,604 | 36% | £2,763 | £3,070 | £3,838 | 42% | | |

68. All of the additions to the burning cost representing profit, inflation, overheads etc were calculated as a percentage of the gross resulting figure rather than the net figure from which they were derived. So, for example, the 10% adjustment for inflation for the pre-issue burning cost is not made by adding 10% to £2,999. It is made by dividing £2,999 x 0.9, so that it represents 90% of the resulting figure of £3,332. Mr Haynes said this is standard insurance industry practice, and that was the approach taken by an ATE insurer who provided Sir Rupert Jackson with a breakdown (reproduced at paragraph 3.16, page 86 of his final report) **[Mr Mallalieu's submissions folder, tab 3]** of brokerage and administration and profit at between 30% and 40% of the total ATE premium.

69. Mr Mallalieu for the Respondent points out that, for example, the underwriter's 20% cost/profit figure can be expressed as 25% of the net figure from which it is derived, and ARAG's expenses, commission and profit figure as 42% of the net figure, and that the cumulative, "compounding" effect of the increases substantially adds to the premium cost.

70. ARAG had next to calculate the recoverable and irrecoverable elements of the new premium. In order to calculate a recoverable premium for experts' reports on liability and causation, ARAG first needed to calculate the proportion of ARAG's expenditure on disbursements represented by expert reports. The figures used by Mr Haynes for these purposes (as was his figure for opponents' costs **[Agreed note paragraph 17; figure extracted from DH 6, "Lost ATE Cases-1 Year"]**) were derived from a relatively limited, recent dataset of claims paid from the beginning of 2012: as he first prepared his figures on 3 December 2012 that represented a period of just over 11

months. The figures were finalised in late March 2013, following publication of the 2013 Regulations **[Agreed Chronology]**.

71. Of the total expenditure on paid claims over that period, Mr Haynes identified the ratio representing opponents' costs. That was 22%. The remaining 78% represented ARAG's expenditure on behalf of the insured ("own costs"). To that figure ARAG added the 4% risk of paying an opponent under the QOCS regime (derived, as mentioned above, from ARAG's records of payments against Part 36 offers in successful cases) to identify a "post-LASPO residual risk" of 82%. To identify the "own costs" risk post-LASPO, ARAG divided the "own costs" ratio already identified, by the post-LASPO residual risk: (78%/82%) = 95% **[agreed note on premium calculations, paragraphs 17 (i)-(iii)].**

72. The next step was to identify the percentage of "own costs" represented by experts' fees. ARAG, anticipating the changes to be brought about by LASPO, had at the start of 2012 started to collect data differentiating between the cost of experts and other disbursements. Using that information, Mr Haynes identified total "own costs" and the percentage of that figure recorded as expenditure on medical reports or experts' fees, which he found to be 96%. (In doing so he left out 3% of the total "own costs" figure representing unidentified "general disbursements"**[DH 6, "Lost ATE cases-1 year Incur", cell E2 as a percentage of cell N2: £10,308 = £337,455 x 3%]**.

73. ARAG then needed to calculate the percentage of expenditure on experts that related to establishing liability and causation. ARAG held no data in this respect, and so ARAG's head of claims oversaw a manual review of 50 files, randomly selected from cases

which had concluded within the previous 12 months **[382]**. In his written evidence **[165]** Mr Haynes described this as a review of solicitors' files: in oral evidence he corrected this to say that the review was of ARAG's own files, cross-referring to solicitors' files as necessary.

74. The proportion of experts' costs attributable to reports on liability and causation was, from that exercise, calculated at 92%. The recoverable premium was, accordingly, calculated at (95% x 96% x 92%] = 84%: £4,788 net of IPT.

**Submissions: ARAG's Methodology**

75. Mr Mallalieu points out that the Appellant's stated position, when filing the notice of appeal, was that the post-LASPO ARAG premium had been set by reference to a data sample of over 15,000 cases **[6, 60]**. In fact, the relevant spreadsheet ("exhibit DH4" to Mr Haynes' second witness statement) shows that the historical data was extracted from a total of 3,531 recorded cases in ARAG's block-rated schemes from 2006. (Other records, for example in relation to "one-off" policies, would have been irrelevant for the purposes of the calculation of a new block-rated premium).

76. He submits that ARAG's calculation of the new post-LASPO clinical negligence ATE premium was unreliable, for these reasons.

77. ARAG entered the ATE market in 2006. The volume of policies written in the early years was low and volume of policies in later years much higher. The average lifespan of a clinical negligence claim at that time, in ARAG's experience, was 42 months. It is not disputed that failure rates are much higher with cases that conclude early and that in consequence, there are more claims on policies in such cases.

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78. Costs of expert reports on liability and causation are an "early cost". The ratio of such costs to other costs will also be higher in cases that conclude early. That was accepted by witnesses under cross-examination and is borne out for example by a review of the figures for pre-issue cases in the spreadsheet exhibited to Mr Haynes' statement as "DH4", in which "earned premiums" (premiums paid or part-paid in successful cases) are attributed to the year in which the relevant policy was written.

79. In "DH4", the ratio for pre-issue cases (the "burning cost" of which was not subject to adjustment for reduced QOCS risk, making them predominant in the calculation of the new premium) of "earned premiums" to total policies written, which shows a reducing ratio of success for each year, drops from 33.7% in 2009 (when larger numbers of policies started to be written) to 0.2% in 2012 **["DH 4", Post-Fast Scheme"]**. Further, in 2012 43% of the policies being analysed and almost 74% of all the policies being considered were written within at most 21 months of the analysis undertaken in the last quarter of 2012. For insured claims that have been issued, the success rate in the mature cases (those taken out in the earlier years) is higher still.

80. The inevitable consequence, argues Mr Mallalieu, is that an analysis of data based on a low historic volume of older cases but a high volume of recent cases – particularly where the average policy lifespan is as long as 42 months - will show a high failure rate, including a high level of expert's costs. That is unlikely to reflect the position over the longer term, once that large volume of later cases has been allowed to play out across their lifetime. The success rate over time would, over that period, improve and the ratio of expert to other costs would decrease.

81. The limitations of working with data over such a short period, and with so many recently written policies, was recognised in ARAG's January 2013 presentation, although it was not mentioned in the presentation that data were heavily skewed towards recently written policies which would necessarily incorporate an artificially high failure rate. That is a factor crucial to the identification of the burning cost.

82. It is also, Mr Mallalieu argues, crucial to the cost to a paying party where the premium is self-insured. In conventional insurance, the premium cost is simply spread across all policies. In self-insured policies the cost is only paid by the winners. The lower the success rate and the higher the failure rate, then the greater the cost of the premium.

83. The underlying calculation is relatively straightforward. It is inherent in the evidence of Mr Brown from DAS (reviewed in more detail below) and was considered in *Rogers v Merthyr Tydfil CBC* [2006] EWCA Civ 1134. Where premiums are self-insured, the basic "burning cost" of the premium for cases with a 50% prospect of success will be 100% of the likely cost (as the winning cases must pay for the losers). After profit, expenses, commission etc are added, an unsuccessful Defendant pays more by way of premium than the sum insured (based, on the undisputed evidence of Mr Haynes, on risk rather than level of cover).

84. If the insurer insures cases with a less than 50/50 win ratio, the cost will be yet higher. So, if the failure rate is 70%, the basic premium would be 233% (2.33 times) the likely cost. Unreliable or skewed data as to failure rates is therefore, submits Mr Mallalieu, a major concern.

85. Under cross-examination Mr Haynes accepted the limitations of the data used in 2012, but explained that there had been actuarial adjustments in February or March 2013 to address it. These adjustments were reflected in the URR and safety margin built into the calculation of "Total Claims Incurred" and are made either by adding in or subtracting a given sum. An addition reflects an anticipation that premium income versus claims paid will worsen. A deduction reflects an anticipation that premium income versus claims paid will increase. So, for example, the higher loss ratio for immature years is counterbalanced by a negative URR for pre-issue cases.

86. The function of these adjustments was explained by Mr Haynes under cross-examination, but he could not assist with any of the actuarial detail. There is no evidence as to how the URR and Safety Margin adjustments were arrived at. The figures in "DH 4", however, show that the URR and Safety Margin adjustments (save for a relatively modest negative URR figure for cases pre-issue) add to the "Total Claims Incurred" figure rather than reducing it. In fact, of the "Total Claims Incurred" figure from which the post-LASPO burning cost was calculated, some 28.5% is URR and 25.6% safety margin-more than half the total **[Respondent's closing submissions paragraph 77]**.

87. As to ARAG's calculation of the "recoverable" element of its post-LASPO clinical negligence premium, the split between the recoverable and irrecoverable elements of the premium was based on an 'random' data set of 50 files. The basis of data sampling is unknown. No records of the methodology of that data sampling exercise have been kept by ARAG and Mr Haynes was not able to give any evidence in that respect. There

is, Mr Mallalieu argues, no evidence of any attempt to ensure that that selection of files properly reflected the likely spread of cases across their 42-month lifespan, or that it was adjusted to reflect the large volume of premiums written in the period just before the review was conducted.

88. Further, he argues, the distortions created by using immature data will be magnified through the use of a small and entirely random data sample, only related to cases concluding in 2012 and so likely to be larger cases, where more costs are incurred. In a sizeable clinical negligence claim liability and causation report costs can be substantial, but the largest number of experts by far tend to be quantum experts. The sampling data was not kept and cannot be subject to any kind of analysis or verification. It is not even known if the data was taken from concluded pre-issue or post-issues cases or, if both, the mix. This is crucially important both because of the tendency of late-concluding cases to carry higher costs and because the pre-issue data sample in DH4 is predominant in the figures.

89. The process was based on ARAG's files – which would typically contain invoices or purchase ledgers – and not on a detailed review of solicitors' files; there was no evidence that such costs were scrutinised as to their reasonableness and proportionality, as opposed to whether they were said to be relating to liability and causation; and they will have included agency fees.

**Conclusions on ARAG's Methodology**

90. There is much force and logic in Mr Mallalieu's submissions about the calculation of the post-LASPO premium, and we do not disagree with his figures. We do not however

think it appropriate to come to the conclusion that ARAG's method of calculating the new premium was as deficient as he submitted.

91. Mr Haynes and his colleagues were working, within a very limited timeframe, with the limited data that they had. If there was a better method of analysing and interpreting it, it was not put to Mr Haynes nor identified to us.

92. We do not have any reliable analysis of the normal ratio of experts' costs to other costs in the early or late stages of a claim, and nor, at the time, did Mr Haynes. Solicitors can spend a great deal of time at the early stages of the claim investigating, obtaining medical records, instructing experts and critically considering their reports: we do not think it right to make the broad assumption urged upon us by Mr Mallalieu.

93. Nor would it be right to assume, because they are not fully understood, that the URR and safety margin figures were in any way arbitrary. Evidently they were not, given that a negative URR was applied to pre-issue cases and no URR adjustment was made to the QOCS risk, as Mr Haynes confirmed in re-examination.

94. In the absence of expert evidence, we are not in a position to say that ARAG should have applied a different method or that the burning cost calculated by ARAG was distorted. In fact, evidence heard from Mr Haynes, his competitors and even from the Respondent (discussed below) indicates that ARAG's clinical negligence ATE premium is, for a market-wide product, fairly typical.

95. Mr Bacon **[Respondent's closing submissions paragraph 75]** invites us to draw the inference that if there was a serious case to answer as to ARAG's methodology in setting premiums, the Respondent would have produced expert evidence to demonstrate what it was. Whilst we would not think it fair to draw that specific inference, we do agree that to form any firm conclusion on the merits of ARAG's methodology expert evidence would be needed, and we have none.

96. The sample data used to calculate the proportion of recoverable premiums was undoubtedly small, but Mr Haynes made a fair point when he said that a randomly chosen sample of cases closed in 2012 could reasonably be taken to represent a variety of claims of varying ages issued over the previous 5-6 years. Much of the criticism aimed at the exercise seems to be speculative. While we accept that there is no positive evidence to show that the cases selected did represent an average spread, equally there is no good reason to suppose that they did not.

97. The suggestion that ARAG should, in calculating the cost of experts, have scrutinised them for "reasonableness and proportionality" does not seem to us to be realistic. As Mr Haynes said, ARAG has a claims department, and part of its job is to ensure that claims are properly made. Any data gathering exercise will have started from the premise, reasonably enough, that claims paid were justified. It is correct to point out that medical agents' fees have not been stripped out from the data, but whether they should have been is not a matter for us.

98. We should add that Mr Mallalieu invited us to find, in the absence of detailed evidence, that ARAG did not, after April 2013, conduct any adequate review, in the sort of detail

undertaken in the last quarter of 2012 and the first quarter of 2013, to take advantage of maturing data. We do not think that such a conclusion would be justified. ARAG has, through a response to Part 18 requests, confirmed that it monitors the profitability and ratios on won, lost and abandoned (at costs and at nil) outcomes quarterly, and that a full review was carried out in mid-2014, in consequence of which recoverable premiums were increased by 6.75%, and in late 2015, following which the non-recoverable element was increased from January 2016 **[reply to request 6)]**

**January 2013: Presentation to Underwriters and ARAG's Board**

99. In January 2013, ARAG completed an Underwriting Notification **[165, paragraph 16 and 299-322: unredacted version, quoted below, 386]** which was sent to ARAG Group Underwriting in January 2013, as well as to the Class Underwriter at Brit. The document summarised ARAG's pre-LASPO performance and forecasted the impact of the post-LASPO regime on future premiums. As to ARAG's response, the document said:

> "As a result of the changes we need to change the structure of our ATE policy and adjust the pricing to reflect the change in risk. Currently the premiums are set by the market as they are recoverable from the opponent in successful cases. As such premiums must be within range of those charged by owning competitors although we aim to charge upper quartile. In future premiums will be payable from damages (although than a few exceptions) we expect fierce competition especially in the profitable case types…"

100. Mr Haynes explained that the reference to the "upper quartile" referred to the fact that the premium price would reflect the strength and standing of the AA-rated Lloyds underwriter.

101. The document also foresaw that clinical negligence would become the "dominant case type, representing 50% of ARAG's future ATE business" **[300, last few paragraphs]**. It estimated a reduction in business as a result of claimants having to pay the premiums

from damages, assuming that they would only do so if the new ATE premium did not exceed 10% of the damages recovered, taking account of the fact that damages awarded would be increased by 10% **[303, 3rd paragraph from the bottom].**

102. The notification explained that the policy would convert to a flat premium, covering pre- and post-issue: "As we project 91% of the premium will be recoverable (this element relates to the premium to ensure Experts' Reports) we believe that there will be less sensitivity over the level of the premium" **[306, paragraph 1.2]**. It anticipated that demand for the ATE product would reduce by 11%, on the assumption that claimants would only be prepared to buy ATE cover if the premium was less than 10% of the likely damages **[308, paragraph 3.1.2]**.

103. ARAG presented the findings of its analysis to the ARAG SE main board on 29 January 2013. The presentation was prepared jointly by Mr Haynes and ARAG's Düsseldorf-based actuarial and group risk management **[339]** departments. The presentation confirmed that the implementation of LASPO would be extremely damaging to the ATE insurance market, which was likely to reduce from 65% of all UK business to 35% by 2015.

104. It also reported that the data which Mr Haynes and his colleagues had to work with was immature. ARAG had entered the market in 2006, and the lack of historical data meant that "for long tailed cases", historical trends would be difficult to extrapolate into the future. The UK business had grown very rapidly: 93% since 2007 and 31% in the previous 3 years. Data from 2007 represented only 1% of the total portfolio, whereas 2011-2012 data representing approximately two thirds of it, had not yet fully settled. The

portfolio composition had also changed over time. These factors impeded a statistically valid assessment of reserve requirements and, overall, a valid and stable actuarial analysis **[340-342]**. The presentation further recorded that, as a result, the board was presented with a "best estimate figure" and a "range in which the actuarial reserve and future earned premiums for the ATE business should probably fall" **[339]**'. It noted that "Techniques such as the use of comparable figures from other business units thus could not be applied for the reserve assessment" **[340]**.

105. The presentation repeated some of the information incorporated in ARAG's Underwriting Notification, including the likelihood that clinical negligence would become the dominant case type in ATE insurance, making up in excess of 50% of ARAG's future ATE business, and that competition would drive down premiums and success fees once they were no longer recoverable from a losing party **[365]**. One stated objective was to keep premiums within "the target uplift of general damages of 10%. Allowances must also be made for lawyers' success fee within the uplift". **[362]**

106. ARAG **[368]** sought the approval of ARAG SE's main board to the new post-LASPO clinical negligence scheme, to be followed by agreement with Brit, on the understanding that matters would be reconsidered if the new regulations, when finalised, were materially different from what was expected. Approval was duly given.

**Respondent's Submissions: The Düsseldorf Presentation**

107. This presentation, says Mr Mallalieu, evidences ARAG's early 2013 thought process and was probably never intended for external review. It shows that the main "damage" caused to the ATE market and main reason why ATE insurers were considering leaving

the market was not any risk of court assessment of the recoverable element, but the general effect of LASPO and the general loss of recoverability.

108. ARAG's own approach to compensate for this was to shift more heavily into the clinical negligence market. Part of the reason for that was because of continued recoverability: the premiums would continue to be paid by the opponent and would be less open to challenge and scrutiny.

109. ARAG's view, at the time of the review, was that the 10% increase to general damages was to compensate for loss of recoverability of both the success fee and ATE premium. ARAG's aim was to keep any premium not merely within this 10%, but to try and do so whilst also allowing for the solicitor's success fee. ARAG recognised that one of the key changes post-LASPO was that the loss of recoverability would introduce competition and would drive down only the non-recoverable part of the premium.

110. The Underwriting Notification of January 2013 also recorded ARAG's perception that there was less sensitivity over the level of the premium where the premium was recoverable from the opponent and that ARAG had assumed that the client would only be prepared to buy ATE cover where the recoverable element of the premium was less than 10% of the likely damages. It also mentioned **[387]** the 10% "safety margin", which increased the burning cost of the future premium calculation.

**Conclusions**

111. We would not disagree with any of these observations, but the context was that ARAG in the UK was presenting to its parent board, in a foreign jurisdiction, the realities of the drastic changes to the ATE market brought about by LASPO. ARAG cannot be criticised for recognising that it is easier to sell an insurance premium to a client who will never have to pay for it, nor for recognising that in consequence a greater share of future business was likely to come from recoverable clinical negligence premiums (which were, given the advent of QOCS, going to be larger).

112. It was also appropriate to explain to ARAG's board the 10% increase in general damages intended to compensate for the loss of success fees, and its importance in relation to the pricing of premiums. Mr Haynes and his colleagues would have been remiss if they had not done so. The presentation did not distinguish between recoverable and irrecoverable premiums in this respect: it appears to have been a general observation about the post-LASPO market **[362]**.

113. It is another matter to conclude either that ARAG took the view that it had a free hand in setting the level of the recoverable part of the clinical negligence ATE premium, or that that view influenced its rating methodology. Neither proposition was put to Mr Haynes. The methodology explained by him appears, on the evidence before us, to be a reasonable attempt to set a realistic premium, albeit based on limited information.

**ISSUE 4: AN ANALYSIS OF THE OPERATION AND FEATURES OF THE ATE MARKET OFFERING POLICIES OF A FORM DESCRIBED IN SECTION 58C OF THE COURTS AND LEGAL SERVICES ACT 1990 INCLUDING THE APPROACH**

**TO THE ASSESSMENT OF RISK, AND THE CONSEQUENCES FOR PREMIUM SETTING AND INSURANCE**

114. It is common ground that the clinical negligence ATE insurance market is dominated by five insurers: ARAG, LAMP, DAS, Allianz and Temple. We have heard evidence from representatives of three of them: ARAG, LAMP, and DAS.

**LAMP Policies**

115. Mr Alan Cousins, Chief Executive Officer at LAMP Services Ltd and LAMP Group Ltd until 11 March 2019, explains that LAMP Services Ltd is an FCA authorised and regulated intermediary which, among other things, introduces business to and supports LAMP Insurance Company Ltd, a subsidiary of LAMP Group Ltd. LAMP Insurance Company Ltd is a regulated insurance company authorised by the FCA to write insurance business in the UK. Mr Cousins is a Fellow of the Chartered Insurance Institute and has worked for three different insurance groups for over 30 years.

116. Mr Cousins confirms that LAMP is the ATE insurance provider which issued the "comparable" premiums relied upon by the Respondent in seeking a reduction of the ARAG insurance premiums claimed by the Appellants **[413, paragraph 5)**.

117. Like ARAG's, LAMP's clinical negligence policy premiums are block-rated, based on a basket of cases. LAMP however does not operate a single, market-wide policy like that taken out by the Appellants. Its underwriting book is, rather, separated into schemes. A scheme can apply to a single firm of solicitors or to a group of firms. The requirements (such as reporting requirements) and terms for each scheme vary and are particular to LAMP's agreement with the individual firm of solicitors. The agreement will delegate

authority to the solicitor to decide whether the client is eligible for the cover offered under LAMP's scheme, failing which the solicitor will have to refer the case to underwriters for consideration on a bespoke basis **[415-416, paragraph 19-20]**.

118. The calculation of the premium is based not upon the level of cover but upon the average cost risk to LAMP of cases discontinuing. Mr Cousins says that a review of the data and personal experience shows that LAMP experiences a failure frequency in clinical negligence cases of over 60%, mostly before claims are seen by the defendant **[415, paragraph 17]**. The premium calculation might also, he said, incorporate an element of "fluctuation loading", similar to the "safety margin" used by ARAG.

119. Account is then taken of overheads, expenses and a small margin of profit to set the level of premium to be charged. In oral evidence Mr Cousins said that this could be calculated in various ways, but broadly speaking overheads would represent about 25% of the gross premium (net of commission payable to a broker), while the profit element would be about a further 15%, depending upon the division of work between LAMP and the solicitor within the particular scheme.

120. Mr Cousins put much emphasis upon the significance of a particular scheme being designed for use with a particular solicitor. If LAMP's policy was written for the whole market, he says, it would look like ARAG's. Solicitors' caseloads vary: they may deal, typically, with cases of varying degrees of size and/or complexity. The particular scheme will be designed for that caseload. The insurer will first analyse the market, then the solicitor's practice, before selecting its "basket" of cases upon which to base a block-rated premium from that solicitor's caseload. The insurer will have regard to how the

solicitor works, the risk assessment procedures and so forth. The characteristics of the solicitor's practice will be as important for the operation and terms of the scheme as will the history of a particular driver for the purposes of motor insurance. LAMP has had about 60 post-LASPO schemes with about 20 solicitors' firms **[428, paragraph 6]**.

121. Mr Cousins had much to say about the two LAMP policy schedules relied upon by the Respondent to support the proposition that the ARAG policy premium was unreasonable and/or disproportionate in amount.

122. The first of these, exhibited to his first witness statement as "AC1" **[421]** shows a policy inception date of 10 January 2014. The limit of indemnity is £9,000 plus premium, for adverse costs (excluding wasted costs orders) and own disbursements. The total premium is £2,000, of which the recoverable element is £1,700 (both figures net of IPT). This policy, says Mr Cousins, was available to the single firm of solicitors within the scheme between 17 December 2013 and March 2014, when a review was conducted and the scheme ended, following which cover was not available at that premium.

123. The second, exhibited to his first witness statement as "AC2", **[424-425]** shows an inception date of 9 April 2014. The premium, before IPT, totals £2,200 of which the recoverable element was £1,870. Again, the limit of cover is £9,000 plus premium for adverse costs (excluding wasted costs orders) and own disbursements. The relevant policy, says Mr Cousins, was incepted under a scheme which was available from March 2014 to October 2015. In October 2015 a review was conducted and the scheme ended, although a policy with the same price is still available under a different scheme.

124. LAMP, says Mr Cousins, has several schemes for post-LASPO clinical negligence claims with varying limits of indemnity. The most common level of indemnity offered is £100,000. The lower limit of indemnity of £9,000 would not have been available for the majority of clinical negligence cases. It was offered in only four schemes, of which the policy schedules relied upon by the Respondent comprise two examples. If additional cover was required, the solicitor would have to approach LAMP to make a bespoke application **[417 paragraph 26-30, Respondent's closing submissions paragraph 108]**.

125. He described the policies with a £9,000 indemnity limit, memorably, as a "pregnant albatross", referring to the fact that schedules from those policies are regularly produced, out of context and without reference to availability or scheme specifics, to challenge on detailed assessment insurers' clinical negligence ATE premiums. That includes, ironically, LAMP's own premiums under other schemes, which can be significantly higher: one example being a LAMP premium of £6,843.07 before IPT (with a recoverable element of £5,836.69) **[686]**.

126. Neither of the policies relied upon by the Respondent would, he says, have been available to either of the Appellants. The first was not available at all at the date each of them took out an ATE policy (Ms West on 6 December 2013 and Mr Demouilpied on 16 April 2014). The second existed when Mr Demouilpied took out his policy, but his solicitors were not panel solicitors within that particular scheme.

127. The firm participating in both of the relevant schemes was Neil Hudgell Solicitors ("NH"). Both schemes were designed for that firm (although Mr Cousins pointed out that

one could not be sure which other suitable solicitors may or may not have joined the later scheme) **[Appellant's closing submissions paragraph 53]** and the termination of the first of them, in March 2014, came about because NH wanted to change some case handling criteria.

128. Mr Cousins said that to the best of his knowledge, NH did not use any ATE provider at all between the end of March 2013 and the following September, when they accepted the LAMP scheme as the best for their needs **[Appellants' closing submissions paragraph 63d]**. Before LASPO, clinical negligence work represented about 13% of LAMP's business, which was largely focused on catastrophic personal injury; after LASPO, it rose to about 50%.

129. Mr Cousins has been able to disclose (for the purposes only of this appeal and redacted in relation to some scheme and solicitor-specific details) LAMP's solicitor agreement for those schemes **[442-451**], but has not been given permission by NH to disclose other commercially sensitive material that would explain the reasons for the parameters of the two relevant schemes, for example the relatively low limit of indemnity at £9,000.

130. The agreement, terminable on 30 days' written notice by either party **[clause 3.2(a), 445]** is expressed to be subject at all times to the solicitor's overriding duty to comply with the SRA code of conduct, in particular to act in the best interests of the policyholder. Like the ARAG agreement, it requires the solicitor to enter into a CFA or DBA with the client **[paragraph 6, 446, Appellant's closing, paragraph 52c]** and delegates authority to the solicitor to issue policies for pre-proceedings clinical negligence claims within one year

of the date of the CFA, at least a year before the limitation date **[appendix 1 at 451]**. It does not incorporate a specific obligation to recommend LAMP's policy.

131. The solicitor is to act as agent of the insurer in the issuing of the policy, but in all other respects as agent of the policyholder. Mr Cousins confirmed that, in requiring a case to have "reasonable" prospects of success, the terms required a prospect of success of 51% or better, in the solicitor's opinion. For proceedings to be issued, the prospects would have to be at least 60% **[444 paragraph dd]**: some schemes, he said, might require a 60% prospect from the outset. Any drop below the required level would have to be reported to LAMP **[443 s]** which would, having audited throughout, discuss what to do with the solicitor and, on a case-specific basis either terminate the policy or investigate further **[Appellant's closing submissions, paragraph 51]**.

132. When taken to copy correspondence suggesting that LAMP required a "screening" report from an expert before issuing insurance, Mr Cousins described that proposition as wrong. He stated categorically that for any block-rated scheme, LAMP, like ARAG, did not require preliminary reports. They would, he said, simply be redundant. We prefer his evidence to the second-hand correspondence produced by the Respondent **[528, 685-6]**.

133. Mr Cousins produced brief, "high-level" summaries of LAMP's clinical negligence book [**453**] and the failure rates of those policies within the "NH" scheme (he declined to produce the detailed figures, citing logistics, commercial sensitivity and data protection obligations **[427]**). Both summaries were prepared as at April 2018. The summary of LAMP's clinical negligence book **[453]** shows a total of 5,547 policies, of which 34% limit indemnity to £9,000, 2% offer the "AC1" premium and 29% the "AC 2" premium.

Cases falling within the NH scheme show a failure frequency of 61.59% within 1,281 cases in the NH scheme **[438]**, with an average burning cost of £5,333.12 which, says Mr Cousins, includes the self-insured element **[Appellant's closing submissions paragraph 55]**.

**DAS**

134. David Brown, an ATE underwriting manager of DAS legal expenses insurance Company Limited ("DAS") has given evidence in relation to the formulation of DAS's post-LASPO clinical negligence policies and premiums. He says that DAS delegates authority to issue policies to carefully selected solicitors who can demonstrate expertise in pursuing clinical negligence claims **[457, paragraph 9]**. In return, DAS expects cases to be insured without adverse selection against DAS **[457, paragraph 11]**.

135. Like the ARAG and LAMP premiums, DAS's premium is deferred and self-insured, including against the risk of non-payment by an unsuccessful opponent. It is also block-rated in the sense that it is based upon a "basket" of cases, but DAS applies a fixed multiplier to the specific cost risk in a given case. **[460, paragraph 29]**. Individual rating, says Mr Brown, would not be cost-effective or economically viable and would increase operating costs considerably, which would in turn increase premiums **[457, paragraph 10]**. The non-recoverable part of the premium (adjusted, as in ARAG's case, for QOCS) applies to the risk of paying an opponent's costs and disbursements other than expert reports relating to liability and causation **[456, paragraph 6]**.

136. DAS sets a two-stage recoverable premium. The first stage applies from the policy start date up to the issue of proceedings and the second from the date of issuing proceedings.

The recoverable element of the premium is initially based on an estimate provided by the claimant's solicitor of the likely cost of liability and causation reports.

137. The estimated first stage (pre-issue) premium is rated at 200% (net of IPT) of the estimated cost of liability and/or causation reports, to reflect the high risk of failure at the pre-issue stage. This was put by Mr Brown in his witness statements **[459, paragraph 20]** at 80% or higher **[465, paragraph 14]**, but clarified in oral evidence, when he explained that this rate applies to cases which fail before they reach the point of notification to the defendant, following which success rates increased **[Respondent's closing submissions paragraph 124]**

138. Mr Brown confirmed that the 200% figure is reached by dividing 60 by 40, on the basis that DAS expects to lose 60% of cases at the pre-issue stage. That, he explained, gives a risk factor of 1.5 (150% of cost), which is divided by 0.75 to accommodate a 25% allowance for, overheads and expenses. That brings the total up to 200%.

139. Where proceedings are issued, the second stage of the premium becomes payable in addition to the first. Again, the second stage is based on estimated costs, but the applicable rating for the second stage is 25% of any additional expert reports obtained in respect of liability and /or causation, reflecting a significantly higher prospect of success.

140. DAS finally re-calculates the premium based on the actual cost of the reports themselves. If no liability and or causation reports are obtained then no recoverable premium is charged **[458 – 459; 464]**.

141. Mr Brown gives an example **[464 paragraph 8]**. If a new case is reported to DAS, the claimant's solicitor will provide an estimate of the likely spend on liability and causation reports prior to the issuing of court proceedings. If the estimate is £10,000, the premium will be £20,000 plus IPT. If the actual cost of liability and causation reports is £5000, the recoverable premium will be reduced to £10,000 plus IPT.

142. Mr Brown has disclosed **[468-470]** extracts from DAS's specimen terms and conditions governing their relationship with their scheme solicitors. In order to fall within delegated authority the case must have prospects of success of at least 51% **[1.2, 468]** (in which case, said Mr Brown, it would be accepted without further scrutiny by DAS). The solicitor is expected to carry out a continuous risk assessment of each case to ensure that the prospects of success do not fall below 51% and, if they do, the terms say that indemnity will be withdrawn **[1.9, page 470]**. In fact, said Mr Brown in evidence, DAS may choose not to do so.

143. The document provided by Mr Brown is not quite complete, and it does not incorporate any obligation upon the solicitor to recommend a DAS policy to the client. Mr Brown, however, confirmed that there would be such a contractual obligation upon the solicitor. It would be up to the client whether to accept it.

144. In order to calculate the premium applicable, upon applying for insurance the firm must advise DAS of the estimated cost of expert reports addressing liability and causation during the investigation period, which will then be used by DAS to calculate the recoverable element of the premium **[2.1.1, 468];** and must give an estimate of the

remaining disbursements to be incurred during the investigation period, which will be used to calculate the non-recoverable element of the premium **[2.1.2, 468]**.

145. Upon the successful conclusion of the case, whether by settlement or otherwise, the firm must confirm the actual incurred cost of expert reports addressing liability and causation; which may result in a re-calculation of the "recoverable" premium. The specimen terms provided by Mr Brown **[2.1.3 – 2.1.,5, 468-469]** indicate that the irrecoverable element of the premium will also be recalculated, but Mr Brown's oral evidence was that this is an error. He said that it would be DAS's policy to ensure that a client knows the irrecoverable element of the premium from the outset.

146. Mr Brown confirmed that in paying for experts' fees DAS would not distinguish between experts' and medical agency fees. Some solicitors use agents, he said, and some do not because they already have contact with an expert. Solicitors are likely to leave insurers if they have difficulties in obtaining payment under policies.

**The ARAG Post-LASPO Damages-Based Scheme**

147. Mr Haynes explains that in 2013, ARAG developed a damages-linked "Recourse" scheme exclusively for ARAG's panel solicitors whose caseloads consisted of a high volume of low-value clinical negligence cases. Mr Haynes says this came about because ARAG's competitors were offering lower premiums for low-value damages cases and there was pressure from solicitors to provide a lower non-recoverable premium for claimants with smaller claims.

148. Following discussions with solicitors' firms who handled a higher volume of lower value cases, ARAG introduced split-rating based on damages level. To join the scheme, a

solicitor had to have in excess of 20% of their caseload estimated to be worth less than £7000. This comprised 39 of ARAG's 268 panel solicitors: less than 15%.

149. The Respondent has produced a number of policy schedules from the damages-based ARAG policy **[545-549]**. It shows total premium, net of IPT, of £2,000 with a recoverable element of £1,802, provided the claim concludes with damages of £7,000 or less. If the case concludes at £7,000 or more, the premium is significantly higher: all premiums, net of IPT, are above £6,000, with a recoverable element of over £5,000.

150. Neither FD nor Fentons qualified for the damages-linked scheme at the time the Appellants took out their ARAG policies. If they had, Mr Demouilpied would have had the opportunity to obtain a policy at a recoverable premium of £2,000 (as opposed to the £4,800 provided for by his non-damages linked "Recourse" policy), but according to Mr Haynes Ms West, who recovered £10,000 in damages, her premium, under the damages-based scheme, would not; her premium under the damages-linked scheme have been £5,300 plus IPT, more than she now seeks to recover **[398-399]**.

151. Mr Mallalieu points out that we have no evidence as to whether solicitors who were not members of this scheme, but who had an initial enquiry from a potential client with a low value case, either were themselves aware of this scheme or informed the potential client of the existence of this or similar schemes. It would seem unlikely, given that FD were unaware of the scheme until 2015. In the spring of 2015, ARAG was advised by QLP, acting as FD's broker, that FD required a solution for the low value cases. A review of their business mix indicated that they were suitable for the scheme and they joined it from 15 August 2015 **[400, paragraph 39].**

**Failure Rates**

152. In the last quarter of 2012, ARAG's projected win ratio (as incorporated into its premium calculations and based upon the outcomes of all completed cases) was 37%, with a "lost" and/or "abandoned at cost" frequency of 50% (the remaining 13% being accounted for by cases abandoned at no cost) **["DH 5", column M]**. This contrasts with an equal ratio of 44% for each, pre-LASPO **["DH 5", column M]**.

153. Mr Haynes says **[165, paragraph 14]** that a recent analysis, as at October 2018, indicates that the win ratio will be lower than projected in the last quarter of 2012 and the "abandoned at cost"/"lost" ratio higher: 35% and 54% respectively, over what he describes as a volatile, difficult and uncertain market since 1 April 2013**.**

154. ARAG, DAS and LAMP have all recorded high failure rates. Mr Haynes confirms that in five years of trading post-LASPO, ARAG has not made an underwriting profit in any given year to date **[paragraph 28, 142]**. The answer is not, he says, simply to put up the premium. It is, he says, a very competitive market and ARAG's market share has reduced to a degree: he put it at around 10-15% **[Appellant's closing submissions paragraph 62]**. Arbitrarily increasing premium prices will lose ARAG market share. Premium prices are as important as good risk assessment, picking firms with the right expertise, and quality control. Recorded loss ratios present a major challenge, and combined with the present uncertainty, mean that there may be no future in the market.

155. Mr Haynes states that in recent years several established ATE insurers have left the market; Alpha Insurance (in March 2018 following the liquidation of its reinsurer CBL Insurance); Elite Insurance (in July 2017); Enterprise Insurance Company (in October

2016); First Assist (also referred to as "Burford"), in July 2016; and AU Insurance, which went into administration in April 2016) **[134-135, paragraph 6d and Appellants' closing submissions paragraph 61]**. He readily conceded, in oral evidence, that he cannot connect any of those events with difficulties in the post-LASPO clinical negligence market. They appear to have left the market for a variety of reasons.

**Comparing Policy Premiums**

156. Mr Haynes contends that given the variety of policies and of pricing models on the market, it is impossible to compare policies without considering which firms and what type of cases can avail themselves of each policy; the limit of indemnity; whether the premium is self-insured; whether it is the same for all levels of damages, regardless of the stage at which the case concludes; the point at which the policy can be taken out, and what costs are covered; the definition of an insurable risk, for example covering all types of clinical negligence cases including high value and complex cases; and the terms and conditions that accompany the policy schedule **[143-145]**.

157. Mr Brown makes a similar point. He says that it is unrealistic to assume that the mere existence of other policies is a guarantee that alternative policies would have been available on the same terms. Choosing, for example, between DAS's two-stage, fixed multiplier model and a single staged model with a fixed level of premium does not "evidence an unreasonable or disproportionate choice", only that the ATE market has evolved and responded to the changes introduced by LASPO. **[460]**.

158. With regard to the competitiveness of ARAG's premium, Mr Haynes admitted that is difficult to say where ARAG sits within the range available, given the haste with which insurers assembled their pricing models between 2012 and 2013, and the varying

approaches they took. ARAG offers a flat premium which may compare unfavourably to others where the case is small and fails at an early stage. ARAG had however carried out an analysis, based on what they understood the average prices of their competitors is to be, and concluded that ARAG's insurance comes at more or less the same cost as that of its competitors, or is a little less expensive. **[Appellants' closing submissions paragraph 62]**.

159. This is broadly supported by Mr Cousins' observation that if DAS were producing a market-wide scheme, it would be similar to ARAG's. Mr Brown's evidence focused more on the difficulty of comparing premiums produced by different risk and pricing models **[460, paragraph 31]** but what Mr Haynes says is also supported, to a degree, by evidence from the Respondent.

160. Mr Clegg, a costs consultant employed by Acumension, the Respondent's representatives, has produced a body of evidence largely designed to put the Appellants to proof of what they say, rather than advancing any positive case on behalf of the Respondent. He has produced copy schedules from the ARAG damages-linked scheme, but no contemporaneous comparables from, for example, Temple or Allianz. Mr Clegg confirmed in oral evidence that he had many such comparables but had not produced them. Temple's, he said, costs about the same as ARAG's; the Allianz policy was damages-based, and so cheaper for smaller claims but, for larger claims, could be very expensive, as much as £25,000 **[Appellant's closing submissions paragraph 20].**

**The Market: The Appellants' Submissions**

161. Mr Bacon submits that the evidence of ARAG, LAMP and DAS show the variety and vibrancy of the post-LASPO ATE market. Solicitors can terminate their scheme

arrangements or terms of business at any time. The policies on offer vary in their methodology (single or staged premiums); in their input data (whilst the policies are all block-rated, the insurer's win/loss ratios show the degree to which the insurer's book of risk differs); in the pricing (fixed or a function of actual cost liability); and in their characteristics (limit of indemnity, risks insured).

162. Insurance providers are, he says, constantly developing products. Just as LAMP withdrew a number of its schemes providing for a limit of indemnity of £9,000, ARAG, as a result of competitive pressure, introduced a split-damages linked scheme for panel solicitors whose caseloads consisted of a high volume of low-value clinical negligence cases. In Mr Cousins' evidence he described how the schemes providing the LAMP Comparables was instituted for, and on the basis of, the demands of, NH following a competitive tender.

163. Mr Brown in his oral evidence confirmed that premiums, quality of service, and whether the insurer will pay claims are all important to solicitors and firms. They will leave an insurance provider if there is too much resistance from the insurer to claims made. Solicitors keep their insurance arrangements under review - QLP attended FD two or three times a year to review their insurance arrangements.

164. Clients are informed of the insurance arrangements between firms and insurance providers; and if a client rejects the recommended product there is nothing stopping the firm sourcing a different policy or provider for the client. Neither solicitors nor clients get any financial benefit from obtaining the recommended policy.

165. ARAG's prices are similar to those of other providers. They are below those of Temple, within the range of premiums offered by Allianz (being tied to damages), sometimes cheaper and sometimes more expensive than DAS (depending on the actual cost of reports) and, given the burning cost of LAMP's book similar to the average of LAMP's schemes.

166. Block-rating, says Mr Bacon, remains as central to access to justice now as it did when considered by the Court of Appeal in *Callery v Gray (No.1)* [2001] EWCA Civ 1117 and *Rogers v Merthyr Tydfil CBC* [2006] EWCA Civ 1134. As the witnesses for the Respondent have made clear, they do not take issue with the practice of block rating, and a feature of block rating is that winning cases pay for losing cases. In the context of clinical negligence it is often not practically possible to identify losing cases until receipt of expert reports. The presence of section 58C of the Courts and Legal Services Act 1990 is an express recognition of the fact that expert's reports on liability and causation are fundamental to a full assessment of the merits: *McMenemy v Peterborough and Stamford Hospitals NHS Trust* [2017] EWCA Civ 1941; [2018] 1 W.L.R. 2685) at paragraph 35.

167. Mr Clegg himself accepted, in oral evidence, that the practice of block-rating is not in itself unreasonable. **[Appellants' closing submissions paragraph 20].**

168. Referring to the evidence of Mr Haynes and Mr Brown, Mr Bacon argues that the variety within the market shows the futility of comparing policies in the absence of underwriting evidence. It is simply not acceptable to compare a set of policy schedules and conclude that the schedule showing the higher premium was disproportionate or unreasonable without knowing, for example, whether the receiving party's solicitor had access to the scheme providing the lower premium; without knowing about the nature of the policies giving rise to the premiums – i.e. whether they are block-rated and, if so, the methodology of the block-rating; without knowing the terms and conditions and limit of indemnity provided by the respective policies; and without knowing whether both policies were in existence at the same time.

**The Respondent's Submissions**

169. Mr Mallalieu's submissions for the Respondent fall into a number of categories.

**Submissions on Cover**

170. Mr Mallalieu contends that a limit of indemnity of £9,000, given the limited adverse costs risk under the QOCS regime, is sufficient to provide adequate cover for the general disbursement risk in clinical negligence claims, save where the claim is anticipated to be one of substantial value or involving a multiplicity of experts.

**Submissions on The Solicitors' Market**

171. The evidence in this case, submits Mr Mallalieu, indicates that any sort of "market review" by solicitors is notional at best. In the case of FD, for example, a review was conducted by a broker, QLP, in around February 2010. Since then, although FD has apparently had periodic meetings with QLP, there is no evidence that either FD or QLP on its behalf has conducted any further review of the market, as opposed to

meeting to discuss the workings of the chosen relationship with ARAG. There is no evidence that FD has undertaken any detailed or careful consideration, at any time in the almost nine years up to Mr Thompson's second witness statement, of whether ARAG remains a suitable provider, or how ARAG's rates compare to the market. FD does not even appear to have kept any documentation in relation to the review to help explain to a client (or indeed the court) the basis on which its recommendation is made.

172. In particular, there is no evidence of FD – or QLP on its behalf - having conducted a specific review of its ATE provider in the build up to April 2013. That month saw a seismic change. Not only did the basis of recoverability change, but the introduction of QOCS and the 2013 Regulations exemption for clinical negligence cases as well as other changes meant that insurers were entirely re-casting their approach to insuring and to premiums. The absence of any specific review of the insurance market in relation to these changes is stark.

173. The notion that solicitors provide any kind of market control is illusory. Claimants nearly always accept the solicitors' recommendation at least in relation to the recoverable element of the recommended insurance. While it is the firm that is tied and must recommend the policy, and the client can reject that recommendation, in practice this would mean the client changing solicitors and, according to both Mr Haynes and Mr Cousins, almost never happens.

174. The limited evidence of Ms. La Pietra did not take the matter much further. Her firm has a direct financial interest in the success of the ARAG product. Its interest lies in maximising premium recovery from the opponent since that is where the majority of the premium comes from. Her limited evidence related only to the February 2010 review. (She declined to provide evidence of a later 2012 review on the basis that she asserted that it was not relevant). The Fentons decision making process to determine its choice was very limited. There was no evidence of any proper or detailed subsequent market review before the firms already with ARAG simply 'rolled over' onto the post-LASPO model.

**Further submissions on the Düsseldorf Presentation**

175. Mr Mallalieu refers to his criticisms of the January 2013 presentation and Underwriting Notification in support of the following propositions.

176. There is very limited, if any, consumer interest in the market in ATE clinical negligence premiums given that the vast majority is self-insured, deferred and recoverable from the opponent. Such interest as exists is limited to the element recoverable from the client.

177. There are acknowledged downward pressures on that element which may mean that it is kept to a minimum. What precise influence that has on the irrecoverable element is unclear, but it is unlikely to serve to reduce it where the insurer expressly perceives a low level of scrutiny and a greater opportunity for recovery.

178. The solicitor's "market" is limited (for reasons discussed below) and, in any event, shares the same lack of interest in control of the element recoverable from the opponent. There is some evidence of insurers reviewing models (see the ARAG damages based premium). This appears to arise when solicitors perceive a threat or an undue level of challenge to the recoverable element. It suggests that court scrutiny of premiums is able to exert some influence, even if only modest to date, in light of *Rogers*, on the ATE market.

**Submissions on Policies, Losses and Payments**

179. ARAG, LAMP and DAS all impose on their solicitors a requirement that the cases they put into the scheme have a minimum prospect of success at the outset of 51%. ARAG, at least, have an application process that requires solicitors to show that they have achieved at least that rate of success in similar cases over recent years. The inherent assumption in ARAG's terms of business is that solicitors should not be putting cases into the scheme unless they have evaluated that they have at least a 51% prospect of success. A solicitor recommending the scheme to a client without first satisfying himself of this would be recommending insurance to the client which he would know may be avoided. ARAG, as Mr Haynes' very late evidence made clear, in fact do not guarantee insurance within the scheme unless the cases have at least a 65% prospect of success. Mr Thompson of FD said the same, and although his recollection was questionable it did support what Mr Haynes said.

180. Mr Mallalieu points out that despite these requirements, all the insurers based their premiums on historical data and actuarial adjustments which are based on

substantially worse success rates than they expect the solicitors to be able to establish before admission to the scheme, and to maintain during the scheme process.

181. It is not in itself surprising, or an indication of anything wrong, that an individual case with a 51% prospect of success or above at the outset fails at a later stage. That is in the nature of litigation. However, these policies are all based on large baskets of cases. These schemes are expressly intended to run on the basis that, whilst individual claims may fail, across the board a 51% rate should be both achievable and achieved.

182. In cross-examination Mr Mallalieu put it to Mr Haynes that, given the requirement for cases to have a 51% or better prospect of success at the outset, given the consistency of that expectation with the solicitor's expectation of payment under a CFA, given the specialist experience of clinical negligence firms and the insurers' reliance on that experience and expertise as demonstrated through the application process, if the process was working, then across the board insured cases should have a 51% or better outcome. If they did not – as the figures used to calculate the premiums suggested they did not - then the scheme was not working. Mr Haynes agreed with that proposition.

183. Unlike ARAG, LAMP accepts all cases within the scheme where the prospects of success are rated as 51% or better. Mr Cousins did, however, confirm that LAMP operates other clinical negligence schemes where the minimum requirement is a 60% prospect of success at inception. The use by LAMP of a higher prospect of success in other similar schemes illustrates the important point that threshold prospects of

success in clinical negligence ATE are meant to be adhered to. It would be pointless having one scheme with a 51% admission criterion and another with 60% if the solicitors could simply introduce schemes regardless or could proceed across a book of cases in such a way that their success rates were typically substantially below those levels.

184. The evidence in relation to LAMP policies was that there was a policy available based on a block-rated risk rating calculated against experience of historic cost outlay. No data were provided by LAMP in relation to the historic calculation, or details of how the burning cost was calculated, and so this could not be considered further. Whether that indicates data sampling difficulties similar to those experienced by ARAG is unknown. The same applies to DAS.

185. The consistent evidence from all three insurers was that they did not attempt to screen out agency costs from the invoices they paid for claims under the policies. Such evidence as there was before the court has been produced by Mr Clegg. That is an invoice for £5,070 plus VAT from 3 November 2015 comprising, according to the "Replies to Points of Dispute", an agency element in the region of 30% of the total cost **[528, para 29, 706-709]**.

186. Mr Mallalieu submitted that the evidence did not show adequate screening of whether the costs claimed by a solicitor for expert reports do or do not include items other than those relating to liability and causation (for example, whether a report may be inaccurately described). Where there is a single report, there is no adequate check; a

report could include not just liability and causation but also, for example, condition and prognosis. Similarly, the evidence of checks on whether the costs claimed are reasonable and proportionate on a standard basis was, at best, unsatisfactory. Mr Haynes was, for example, unable to say whether ARAG vetted invoices or purchase ledgers, for example, to screen out the cost of conferences with liability and causation experts, as distinct from production of written reports.

187. In the absence of any evidence that such costs are screened out, and given Mr Haynes' other evidence that the invoices for claims for disbursements are usually just paid, Mr Mallalieu invites us to conclude that it is probable that sums paid by ARAG – and therefore included in the calculation of the premium a defendant is to pay – do include matters such as claims for conferences with experts.

188. It is common to find on detailed assessment that invoices for an expert report may not specify what the report relates to, or alternatively may specify that the report relates to liability, causation, condition and prognosis and/or quantum. Such is the case in the bill of costs and supporting vouchers prepared for Ms West **[1786, 1801]**, which gave no breakdown by hours or otherwise of what is a report plainly concerning both condition and prognosis as well as liability and causation.

189. In the DAS model, there would need to be a robust process to filter this to ensure only the correct actual cost was being included in the premium calculation. In the ARAG and LAMP models, the issue is even more pressing, since what would be needed would be evidence that, when calculating the premiums based on historical data, there

had been a robust vetting of the historical data on the make-up of expert reports' invoices to ensure that the future burning cost and split of recoverable and non-recoverable elements was not based on a figure that included irrecoverable costs (non-liability and causation reports) in the recoverable element.

190. Expert report fees are reduced on assessment – not invariably, but on a reasonably regular basis. The policies generally limit their cover to reasonable and proportionate costs on the standard basis. In any event, as a matter of recovery between parties, it cannot be right that defendants might pay for the cost of insurance to cover unreasonable costs. However, there was no proper evidence of any scrutiny or vetting by the insurers in this regard. The evidence of Mr Brown, in particular, suggested that insurers would avoid proper scrutiny for fear of losing business.

**Conclusions: Cover**

191. The submission that indemnity cover limited to £9,000 for opponents' costs is sufficient for all but complex clinical negligence cases in the era of QOCS does not seem to have much bearing on the issues before us, given that the consistent evidence of the witnesses for ARAG, LAMP and DAS is that (as Mr Bacon submits) the limit of indemnity plays a marginal role in the setting of recoverable clinical negligence ATE insurance premiums. The premium is, primarily, a function of the average cost risk.

192. It seems likely (although we cannot know) that the DAS policies setting that level of cover were intended for smaller claims. Mr Cousins' evidence is that most policies

issued by LAMP had an indemnity limit of £100,000 **[449, paragraph 14: 453, total 5,547 policies: 438, 1281 NH policies]**.

193. In our view the proposition does not in any event bear examination. The purpose of insurance is to protect the insured against what might happen, not what is expected to happen. Given in particular that it does not have any real bearing upon the pricing of the premium, the general availability of a generous level of cover must be a positive feature of the market.

**Conclusions: The Solicitors' Market and the Düsseldorf Presentation**

194. With regard to the January 2013 presentation, as we have observed, ARAG recognised that it would be more difficult to sell ATE premiums to parties who would have to pay for them, then to parties who would not. The presentation does not seem to us to go beyond that, so as to justify a conclusion that ARAG anticipated lack of real control over recoverable ATE premiums. Their calculations indicate that they set the recoverable and irrecoverable levels by reference to risk and nothing else. The extent to which that methodology is open to criticism has already been addressed.

195. We have seen little evidence, if any, to support the proposition that competition between insurers vying for the business of solicitors exerts any real downward pressure on recoverable clinical negligence ATE premiums.

196. Evidently solicitors do exercise care, and may take professional advice, on the appropriate choice of ATE insurer or insurers. Although the evidence given by the

Appellants' witnesses as to their criteria, when choosing, was (with the exception of Mr Lee) rather formulaic, their list of criteria seems realistic enough.

197. We have seen no evidence in relation to a review by either Appellant's solicitor, in 2012 and 2013, of the new post-LASPO market, but it would be inappropriate to draw any firm conclusions from that as to the approach of solicitors generally. Evidently some firms, such as NH, did undertake a review.

198. Nonetheless, on the limited evidence before us, it seems that there is little incentive for solicitors to undertake any thorough or detailed ongoing review of the market, at least where recoverable premiums are concerned. Provided that a solicitor and an ATE insurer have a good working relationship, clients are not burdened with unattractively high irrecoverable premiums and difficulties are not experienced in recovering from an opponent the recoverable element of premiums for the client, there is little incentive to review the market. So, for example, FD maintained its relationship with the same insurer for nine years, through the LASPO changes, without any substantial review until 2015, when (some years after it was created) FD joined ARAG's damages-linked scheme.

199. The extent to which a solicitor's contractual obligation to recommend a particular insurer's product has any bearing on market choice seems limited. Professional standards accept that such an arrangement may properly satisfy the solicitor's obligation to act in the best interests of the client. Perhaps more to the point, the exclusivity requirement (on the evidence we have seen) would seem to be honoured more in the breach than the observance.

200. There is much force in the Appellant's submission (and the evidence of Mr Haynes and Mr Brown) to the effect that the post-LASPO clinical negligence ATE market, though still immature, offers a variety of ATE insurance products calculated in different ways: for example, specifically for low value claims, or for particular firms of solicitors, or for the entire market. It is, by definition, difficult to make comparisons.

**Conclusions: Policies, Losses and Payments**

201. We are invited to conclude that the apparent discrepancy between a requirement (in block-rated schemes) that a claimant must have a 51% prospect of success or better, and the actual levels of success under the schemes, indicates that there must be something wrong with the way in which those schemes work.

202. Whilst Mr Haynes appeared, in one brief answer, to have agreed with the proposition, he was asked for an opinion rather than to address any question of fact, and his answer was not explored. His evidence generally indicated that he thought it reasonable to rely upon specialist solicitors who would take a view on the matter pending the receipt of crucial expert evidence.

203. Litigation is notoriously unpredictable. The assessment of prospects of success must of necessity be a matter of judgment on the facts known at the time. At the early stages, particularly prior to receipt of expert evidence, that will be a judgment based on limited information. If, as required under the ARAG and LAMP schemes, the solicitor must act under a CFA, then the solicitor will potentially be investing a substantial amount of time and resources based upon that judgment.

204. It would take a wide-ranging, detailed review (and again, possibly, expert evidence) to come to any firm conclusion on the precise reasons for the failure rates experienced by ARAG, DAS and LAMP. There is, without it, no proper basis for drawing the conclusion suggested by Mr Mallalieu.

205. With regard to the payment of disbursements by insurers, experts' costs may well be reduced on detailed assessment, particularly on the standard basis where any element of doubt is resolved in favour of the paying party. That is a fact of life in litigation, which entails a substantial element of uncertainty at all times. It does not follow that the cost of insurance taken out against incurring the costs of experts, which will normally be incurred at the outset, is in itself unreasonable.

206. The proposition that an insurer should attempt to anticipate the outcome of a detailed assessment, or attempt to stand in the shoes of a court hearing (of necessity, hypothetical) objections from the paying party does not seem us to be realistic.

207. It is, as Mr Bacon has pointed out, unsurprising that insurers who insure all disbursements, recoverable or otherwise, will not make a practice of excluding medical agents' fees when they pay invoices. The fees of medical agencies are a routine feature of clinical negligence litigation (recently considered by the Court of Appeal in *British Airways Plc v Prosser* [2019] EWCA Civ 547).

208. Mr Brown's frank admission that an insurer must have regard to the fact that, if difficulties over payment are characteristic of their relationship, the insurer may lose

one of its panel firms, seems to us to be a reasonable observation, particularly in the context of a suggestion that medical agents' fees should be excluded. It was, notably, a feature of *Rogers* (Brooke LJ, giving the judgment of the court, at paragraph 17) that the claimant's solicitor had previously changed ATE insurers because of difficulties in getting the insurer to pay. Any insured party will expect an insurer to take a fair and reasonable approach to payment.

209. The real issue is whether ARAG or other insurers exclude medical agency fees from their calculations when working out the cost of recoverable clinical negligence ATE premiums. Evidently ARAG, in 2012-2013, did not. That level of detail was not available. The very limited evidence offered by the Respondent as to the degree to which such fees may make up the cost of expert reports clinical negligence cases offers no basis for any sound general conclusion on that point.

**Conclusions: Block-Rating**

210. The Respondent's position on block-rating is not entirely clear. In evidence, Mr Clegg said that the Respondent does not suggest that the practice of block-rating (where winning cases pay for losing cases) is itself unreasonable **[Appellants' closing submissions paragraph 20]** but many of Mr Mallalieu's criticisms of the way in which premium prices are set amount to criticisms of the block-rating system itself.

211. Mr Haynes says there is a noticeable difference between insuring a case where the Defendant has already denied liability and/or causation and the approach adopted in block-rated insurance policies taken out at the inception of a case. The latter approach ensures that the client has total costs protection from the outset, whatever

the Defendant's position subsequently turns out to be. In the former case, the premium is likely to be more expensive and the client is required to expend money on expert reports on causation and liability to ascertain the merits of the case; whereas in the latter case, the premium is likely to be cheaper and the cost of reports is insured **[145]**.

212. Mr Cousins says that it would be more complex and expensive to rate a premium individually, by reference to the facts of a single case: it would increase the premium **[414]**. Mr Brown's evidence is to the same effect. Individual rating would not be cost effective or economically viable. It would increase operating costs considerably, and so increase the premium **[457]**.

213. In *Peterborough & Stamford Hospitals NHS Trust v McMenemy & Ors*, Lewison LJ recognised (at paragraph 68) that the practice of block-rating keeps premiums lower than they might otherwise be, and that it was not appropriate (paragraph 74) to examine the reasonableness of taking out such insurance on a case-by-case basis. Even if it were open to us to disagree we would not, as the weight of evidence before us supports that view.

## ISSUE 5: THE LIKELY EFFECT OF A REDUCTION IN THE RECOVERABLE LEVEL OF PREMIUMS ON THE AVAILABILITY OF SUCH POLICIES IN THE MARKET

214. We have already recorded Mr Haynes' observations to the effect that ARAG may have no future in the clinical negligence ATE market, and his reasons for saying so. He also says that if premiums for low value damages cases are reduced within a

block-rated system, the logical consequence would be that premiums for higher damage cases may have to be increased to make up the shortfall, with the consequent cost to the NHS being, in effect, the same **[142, paragraph 27]**.

215. We have referred to the evidence of Mr Cousins to the effect that, on detailed assessment, LAMP's premiums are frequently challenged by defendants using LAMP "comparables". Despite LAMP being able to confirm categorically that those policies would not have been available to the claimant in the relevant action their premiums are, he says, still sometimes reduced. As a result LAMP is reviewing whether to withdraw their £9,000 indemnity limit schemes **[418]**.

216. Mr Brown says that because the DAS clinical negligence underwriting model is based on full recovery of the recoverable part of the premium, if it is not recovered in full that will in all likelihood result in premium increases which themselves may result in more frequent challenges by the paying party **[paragraph 12, 457-8**]. He also states that if defendants continue to bring challenges of the type raised in these claims, it will inevitably increase DAS's operating costs and in turn increase premiums overall **[paragraph 32, 461]**.

**The Appellants' submissions**

217. Mr Bacon submits that one likely effect of reducing the recoverable level of premiums on the availability of such policies in the market is that premiums will increase, for a number of reasons. As Mr Brown says, they are based on the proposition that they will be recovered in full. The risk of not recovering in full is that the premium increases and, as a consequence, so does the revenue required to

offset the costs of claims under the policies. Products will be withdrawn, as some will no longer be profitable.

218. If any shortfall is to be recovered from the policyholder the administration cost will substantially increase. It will be necessary, for example, for the insurer to consider the practicalities of recovery from the insured. It is akin to requiring the sort of information necessary for an individually rated premium, with the same consequences for premium prices.

219. There is, Mr Bacon submits, every chance that some of the current providers will follow on the heels of Alpha Insurance, Elite Insurance, Enterprise Insurance, First Assist ("Burford") and AU Insurance and leave the market. Insurers require certainty given the length of time between the inception of the policy and the point at which premiums are payable (at the end of the claim). That is not achievable where lower cost policies are being inappropriately deployed in assessments to undermine the quantum of the recoverable premium in respect of different, higher premium, policies.

**The Respondent's Submissions**

220. Mr Mallalieu takes a sceptical approach to the reported unprofitability of ARAG's clinical negligence insurance book over the last five years. Although Mr Haynes' evidence in this respect is not disputed, he points out that Mr Haynes does not say that ARAG has made a loss. The volume of policies written per year is not known, but the Appellants' reply to a Part 18 request [**1433, request 11**] confirms that premiums and claims are attributed to the year in which the particular policy was written. It follows, as established in evidence, that a given year is likely initially to

show a large volume of claims and very few paid premiums. As years pass, the pattern changes. There are more successes and more premiums paid. Accordingly, he submits, until the data is mature a lack of underwriting profit is hardly surprising. Mr Haynes' evidence was that the future was uncertain, not that ARAG anticipated never making a profit.

221. Given that even after five years some cases will still not have been concluded, the years of account are presumably not yet closed. What profit, or otherwise, they will show then is unknown. However, given the substantial underwriting margins and profit and overhead percentages charged, no doubt ARAG will be surprised and disappointed if a profit is not ultimately returned. In addition, as Mr Haynes has himself recorded in evidence, a large number of ARAG claims (and therefore the payment of premiums) are stayed pending the outcome of these appeals.

222. Mr Mallalieu submits that although each of Mr Haynes, Mr Cousins and Mr Brown briefly, and in very similar terms, raise the spectre of their respective employers considering its position if it achieves less than full recovery (at least, between parties, of the recoverable element) of whatever premium it chooses to set, no evidence is provided of any concrete plan to withdraw from the ATE insurance market and there is nothing more than mere assertion.

223. For example, there is no evidence of any consideration at senior management or board level by any of these insurers of their position in the market in light of these cases, which have now been underway for the best part of two years as significant appeals to the Court of Appeal, or of such consideration in light of the earlier case of

*McMenemy*, or of the same in light of the many challenges to post-LASPO ATE premiums which have been ongoing since April 2013.

224. The Respondent is not suggesting that these issues have not been considered at some level. Whether, however, that consideration has led to the view being taken that the insurers are confident in the market regardless, that their confidence is increasing or diminishing, that they are considering leaving the market or any one of a myriad number of other possibilities is a matter of speculation not evidence.

225. Similarly, there is no real evidence as to how an insurer might adjust to the recoverable element of the premium being limited to a reasonable and proportionate sum. As noted, there is no documentary evidence addressing operating costs over one particular model, for example block-rating, when compared with individually rated premiums or a "hybrid" model such as that adopted by DAS.

226. Insurers in that situation, Mr Mallalieu submits, might continue to offer the policy, but would exercise more robust control over insured costs. They might more strictly police the screening of claims by solicitors to ensure their actual success rates match the requirements of the policies, the insurers' Terms of Business and the MOJ's intention that ATE should be available for prima facie meritorious claims.

227. Similarly, any limitation on recoverable premiums by virtue of assessment as to their reasonableness and proportionality is likely to increase the scrutiny by solicitors and their clients of the premiums they are agreeing to pay and, in particular, to introduce into this arena a need for solicitors and clients to consider at the outset whether the

value, initial assessment of merits and other circumstances of the claim are able to justify a premium at the level which is being recommended and if not, what alternatives may be available either through that solicitor or others.

228. Perhaps the best evidence of changes that might occur, he suggests, relates to matters such as the ARAG damages limited premium. That appears to have been provided under some pressure from solicitors. That pressure appears to have come, not from a general market review or desire to reduce premiums generally, but from a need to address challenges on detailed assessment. It suggests that, even with the perceived *Rogers* limitations and ARAG's views about lack of scrutiny of recoverable premiums, where the courts do exercise scrutiny, insurers are able to respond, adapt and adjust accordingly.

229. As for insurers leaving the ATE market, Mr Haynes quickly and expressly accepted that the insurers concerned – Alpha, Enterprise, Elite, AU and Burford, had all left the market at different times for a variety of business-related reasons, including insolvency.

230. None of those decisions were related to challenges to recoverability of clinical negligence premiums or concerns about reductions on detailed assessment. None of those insurers, with the exception of Burford, were major players in the clinical negligence ATE market. Burford moved on to bigger prizes via its concentration on the litigation funding market following its underwriter, Munich Re, changing its own business model.

231. The main players in the clinical negligence market, i.e. ARAG, DAS, LAMP, Allianz and Temple, have been around since before LASPO, and are still here six years after LASPO, despite six years of what can, at best, be described as "flux". Whilst no doubt they would say that "if things change we will review our position", there is no clear evidence of any plan to exit from the market.

232. If the Appellants are to assert that the limitation of premiums to a reasonable and proportionate sum would have a materially detrimental effect on the market, it is for the Appellants to make good that proposition. They have not done so and it would be wrong for the Assessors to find anything other than that robust court scrutiny of premiums and reductions where appropriate would do anything other than ensure the Regulations and the market were working properly.

233. There is plenty of evidence that ATE insurers do not want the courts to scrutinise the premiums claimed at all; hence, presumably, the unsuccessful argument in *McMenemy* that they were outside the CPR and could not be subject to assessment. It is clear that such insurers would not welcome reductions to their premiums whether on grounds of reasonableness, proportionality or otherwise.

234. For those reasons, Mr Mallalieu invites us to reject the Appellants' proposition that the market would be adversely affected by frequent successful challenges to the level of recoverable premium on detailed assessment.

**Conclusions**

235. Mr Mallalieu's description of Mr Haynes' evidence in relation to profitability as "careful" seems to us unfair. Mr Haynes was frankly describing the position as

uncertain, rather than definitively loss-making. The stay of a number of assessments pending this appeal (we do not know how many of the 60 cases mentioned are ARAG's) seems unlikely to represent a large part of ARAG's business. Mr Haynes **[148, paragraph 3]** says that ARAG has written £8 million in post-LASPO premiums. Since policies have an average lifetime of 42 months we accept that ARAG has some legitimate cause for concern.

236. Equally it seems unfair to criticise the Appellants' witnesses for the broad-brush nature of their evidence on withdrawal from the market. By definition, the position is uncertain. The response of any insurer to a policy-based reduction in recoverable ATE premiums may well depend upon the extent of the reduction. If, to take an extreme example, the reasonableness and proportionality of insurance premiums were routinely to be judged without reference to the cost of providing cover, so that premiums were routinely recovered at a level below burning cost, we find credible the suggestion that insurers might come to regard the market is unworkable, and leave it.

237. It seems unlikely that any of ARAG, DAS or LAMP would have available, for example, board minutes discussing the myriad possibilities of reduction in premiums based upon legal principles that are still in issue.

238. Mr Mallalieu is right to observe that we have seen no documentary evidence addressing operating costs of one particular model when compared with another; but detailed consideration of such data and cross-examination in a depth similar to that

undergone by Mr Hazel on ARAG's figures would have extended the hearing before us well beyond the agreed five days and would have been disproportionate.

239. The difficulty with submissions based upon what will happen if premiums are reduced to a "reasonable and proportionate" level is that they beg the question what a reasonable and proportionate level is. The position of the insurers, understandably, is that their premium levels are already reasonable, proportionate and (across the board, taking into account the variations in risk modelling and policy cover) competitive. It would be difficult for them to advance a positive case founded on a hypothetical adjustment to those premiums; they would have first to decide what degree of hypothetical adjustment to make and it is understandable that they have not sought to do so.

240. The proposition that reducing insurance premiums will lead to a better managed market seems to rest largely upon what we have concluded are unrealistic expectations of the management and monitoring of legal costs by insurers.

241. Beyond that, it is impossible to be precise. Insurers cannot say with certainty what will happen if ATE premiums are reduced, because it depends upon the extent to which they are reduced, and the principles upon which the reduction is made. They can only say, reasonably enough, that the business has not been profitable to date and that the uncertainty of the current position means that they have to keep the position under review, including whether to stay in the market at all.

242. For the same reasons, we are unable to make a positive finding on what would or might happen if ATE premiums are reduced. All the suggestions mooted by Mr Bacon, Mr Haynes and Mr Brown seem possible. It may be, depending upon the degree to which premiums were reduced, that a practical way could be found to share the shortfall between insurers, solicitors and clients, but that must be a matter for speculation.

**ISSUE 6: SUCH CONSEQUENTIAL FACTUAL MATTERS AS THE ASSESSORS CONSIDER APPROPRIATE**

243. As we have mentioned, the approach of the Respondent for the purposes of this hearing has been, rather than advancing any positive case, to challenge the evidence of the Appellants and put their witnesses to proof. Positive evidence from the Respondent's witnesses has been limited.

244. Mr Stephen Davies, a costs lawyer employed as the Head of Costs at the Medical Protection Society ("MPS"), gave evidence to the effect that NHS spending on clinical negligence claims has almost doubled since 2010/11. Without wishing to minimise the concerns he raises, he was referring to all expenditure, including damages. He did not isolate expenditure on legal costs, still less expenditure on the cost of ATE insurance. In oral evidence he appeared to accept that the cost to the NHS of ATE insurance premiums has reduced but argued that the savings had been offset by the operation of QOCS. We are unable to judge whether this is so. We did not find his evidence of much assistance.

245. Mr Clegg produced a mass of anecdotal evidence of challenges to the recoverable element of ATE premiums in various detailed assessments up and down the country.

Since each assessment turned on its facts, the relevance of that evidence was questionable. It did not establish any pattern or provide a foundation for any propositions more widely applicable than in the individual cases he was discussing. His account does show that Mr Haynes was mistaken about certain details, but we did not find that Mr Clegg's narrative materially undermined the evidence of any of the Appellants' witnesses.

246. As Mr Clegg has explained, the Respondent did not think it appropriate or necessary, in giving evidence for the purposes of this report, to disclose what would appear to be a large body of comparable evidence tending to support ARAG's case to the effect that Its premiums, across the market, are reasonably competitive. Mr Clegg's answer to this was that it was not incumbent upon the Respondent, which does no more than seek to raise a legitimate element of doubt about the choice made by the Appellants, to do so.

247. We record that the Respondent made a late application, ultimately not pursued, to strike out certain parts of the Appellants' evidence, based on alleged failure properly to answer a Part 18 request. At the hearing, Mr Mallalieu invited us instead to draw appropriate adverse inferences from the paucity of certain responses from the Appellants. We do not think it appropriate to do so, in the light of the findings we have made, as set out above.

248. The assessment of recoverable clinical negligence ATE premiums, particularly in small cases, will typically take place within a short time frame at county court level, in the course of which a judge may be required to exercise a broad discretion. Even

in the larger cases, for example at the Senior Courts Costs Office (SCCO), detailed assessment proceedings do not generally entail lengthy investigations into complex financial and actuarial calculations, the cross-examination of witnesses on such matters, or the weighing of large bodies of evidence. Orders for disclosure are exceptional.

249. Normally, there will be no evidence from the insurer to assist the assessing judge. Nor is the paying party under any obligation to do more than produce documents which suit its case.

250. We appreciate that one of the issues in this appeal is whether it is appropriate, when judging the proportionality of an ATE insurance premium, to take into account the workings and nature of the ATE market. If and to the extent that it is, the assessing judge in the situation we have described is effectively "flying blind". Making an informed decision may be impossible. The judge may have to choose between a broad-brush, uninformed decision and taking the view that the evidence produced by the paying party is insufficient to raise any real element of doubt (citing the judgment of Simon J in *Kris Motor Spares Ltd v Fox Williams LLP* [2010 EWHC 1008 (QB))

251. This need not necessarily be the position. Perhaps both insurers and NHS Resolutions could do better. They have to strike the balance between keeping challenges on detailed assessment within the compass of proportionality, on the one hand, and, on the other, producing a sufficient evidential foundation for a challenge to or defence of the level of premium recoverable from a defendant. There is no formulaic right or wrong way of approaching this task, but we hope these appeals

and, to a more modest extent, this report, may help resolve some of the current difficulties for costs judges having to deal with such challenges.