Whiplash Reforms - Second Update

March 2021

Introduction

The MOJ publishes long awaited, and detailed rules, on whiplash reforms but glosses over rehabilitation claims.

The MOJ has now published the Pre-Action Protocol (PAP) and Practice Direction (PD) for Claims that will be brought in the new Official Injury Claim Portal (OICP) and made amendments the RTA Protocol, the PAP for claims in the current MOJ Portal (MOJP).

The RTA Small Claims Protocol

Scope

The PAP applies to claims arising from road traffic accidents which occurred on or after 31 May 2021 where the injuries are valued at not more than £5000 and the overall value is not more than £10,000.

There are 9 exclusions, the ones that will most commonly apply are that the claimant is a child, protected party (lacks capacity to conduct proceedings) or a “vulnerable” road user which includes motor and pedal cyclists and pedestrians.

Claims for “protocol vehicle costs”, damage, recovery, storage and hire that are payable to the claimant personally are in scope. Subrogated or credit claims, “non-protocol vehicle costs”, are excluded.

It is noteworthy that whilst the MOJP excludes all vehicle related damages from the overall value of the claim, protocol vehicle costs are included in the OICP valuation. So, the inclusion of say, a £5000 PAV claim and £4000 loss of earnings with a 10 month whiplash would exclude the claim from the OICP.

It was previously indicated that the same approach to vehicle damages would be applied to rehabilitation – so rehab provided through medical agencies on credit would be excluded but, save for a reference in the initial claim, the PAP is surprisingly silent on the subject.

Exit

The Protocol will no longer apply if:

- A revaluation means the claim exceeds the financial limits.
- Either party becomes a protected party.
- The insurer notifies the claimant that there are complex issues of fact or law (in contrast to the MOJP where the claimant also had this option).
- The insurer makes an allegation of fraud or fundamental dishonesty.
- The insurer continues to deny causation of any injury after disclosure of the medical report.
- The court orders in other proceedings that the injury claim must exit and be added to those proceedings. For example, proceedings could be issued for a credit hire claim and the court then becomes aware of the injury claim.

A claim that exits through value will proceed under the RTA Protocol, if it is within that PAP's scope, with the claimant required to submit a CNF, provided that liability (other than failure to wear a seatbelt) has not been disputed.

Claims that exit through denial of injury after disclosure of the medical report will not be subject to any PAP.

In all other cases, the Personal Injury PAP will apply to claims that exit.

Making a claim

The claimant (or their representative) completes a Small Claims Notification Form (SCNF) on-line. An unrepresented claimant can request assistance from the Portal Support Centre to enter the claim.

The claimant will be asked to state whether they consider their whiplash injury was exceptionally severe or whether they have exceptional circumstances that have had an impact on their PSLA (for the purposes of any claim for the tariff uplift).

The SCNF must be signed with a statement of truth (SOT) or the representative must certify that they hold a SCNF signed by the claimant (as in the MOJP).

The Portal will carry out a MID search and send the claim to the compensator - insurer or the MIB if no insurer is identified.

Liability

An insurer has 6 weeks (the MIB has 8 weeks) to provide their response on liability which must be one of the following:

- Admission of liability in full.
- Admission of liability in part.
- Deny liability.
- Admit fault in full or in part but dispute the accident caused any injury to the claimant.

If the insurer does not provide a response within time then they are deemed to have admitted liability in full.

Whilst there is twice as much time to respond than there is under the MOJP, unless liability is admitted in full, the insurers response must include the evidence that they rely upon. This must include the defendant's version of events that is signed with a SOT.

The insurer can provide a witness summary (with a SOT from the insurer) if there is a good reason why they were unable to obtain a signed version of events in time. We doubt that lack of co-operation will be accepted as a good reason.

Good reasons may include the defendant being out of the country with no means to sign the statement, in hospital or otherwise incapacitated. It will be interesting to see whether an inability to read English and the requirement of a translator will be considered a good reason.

If the insurer admits liability in part this must be expressed as a percentage. It is important to note that an "offer" of split liability is not an offer but an admission. An admission in part is stated to be equally as binding as a full admission in full, it can only be withdrawn with agreement of the claimant or the courts permission. An application to withdraw an admission will result in the claim leaving the Protocol.

It seems to us that this could discourage attempts to compromise and it may have been better to allow an insurer to accompany a denial of liability with an offer to agree a split. Insurers may wish to make offers on liability outside of the portal rather than be bound by an admission, although the PAP states all proposals should be made on the Portal. Alternatively, only 1% liability could be admitted to allow further without prejudice proposals (see below).

An admission of liability is only binding on the Portal claim if settlement is agreed but is binding on all claims if proceedings are issued.

As in the MOJP, the admission of causation within a full admission may be withdrawn on service of the medical report by notifying the claimant within 4 weeks.

If the claimant rejects a partial admission, a counter proposal may be made and each party may make up to 3 proposals on liability. These proposals are without prejudice and are not binding, unless of course there is acceptance of a proposal.

If liability is denied the claimant may start proceedings for a determination of liability only. The insurer may upload further evidence on liability at any time up to the point where they respond to the court pack generated for the proceedings. Both parties will require the courts permission to rely upon any evidence that was not uploaded to the Portal.

The claimant may proceed to obtain a medical report where there is a full or part admission or the court has determined liability, in full or part, in the claimant's favour.

Medical Reports

A medical report must be obtained for a whiplash injury and the ban on pre-medial offers for these claims is re-stated although it is also stated that pre-medical offers may be made for other injuries including the non-whiplash element of any claim. Such offers are to be made outside the Portal. This offers a potential tactic to deal with tariff-plus claims.

As with the MOJP, the first medical report must be a fixed cost medical report obtained through MedCo. A further medical report may only be allowed where:

- It is recommended in the first expert's report.
- The first report does not provide a prognosis.
- The claimant is receiving continuing treatment.
- The claimant has not recovered within the prognosis.

The continuing treatment exception seems unnecessary as this would likely lead to a lack of prognosis or delayed recovery. If there is a prognosis and the claimant does recover in line with that following the treatment, then there should be no need for a further report. There is a risk that this could be exploited to obtain further reports.

Where the claimant is unrepresented, the instructions to the expert are generated by the Portal (unless the claimant is being examined outside of jurisdiction). The insurer is responsible to pay the experts fees. If a further report is justified the insurer must arrange (send instructions within 2 weeks) and pay for it.

If the defendant disputes that the accident caused any injury to the claimant, the defendant's version is included in the expert's instructions which will ask the expert to provide separate opinions if the claimant or defendants accounts were found to be true.

If the claimant seeks the tariff uplift the instructions will request an opinion on whether there is any support for it.

The factual accuracy of the report must be checked by the claimant and (unless challenged by the claimant) the facts will be deemed to be agreed once the report is sent to insurer. This does not bind the claimant to the prognosis (unless the claimant reported a full recovery), which is an opinion.

Offers to settle

The claimant indicates on the Portal that they are ready to disclose the medical report and completes or updates the “List of Losses” which includes any fees/disbursements. The List must be verified with a SOT, which is a welcome additional requirement over the MOJP process.

The claimant is unable to add any further losses in the Portal once they indicate that they are ready to settle. If the claimant is seeking the tariff uplift, they must include their explanation to justify that claim, confirm how the medical report supports it and any other evidence relied upon. The claimant is to state what percentage uplift is claimed up to the 20% maximum (it seems unlikely that anyone would claim less than the 20%). Claims for a whiplash injury over 18 months, tariff amount £4215, would exceed the £5000 financial limit if the 20% uplift was applied.

Once the claimant has complied with the steps for settlement, unless they value the claim above the financial limits, the insurer must make an offer, or confirm that they continue to dispute that the accident caused any injury, within 4 weeks. In the latter case the insurer may make an offer to settle the non-injury heads of loss which the claimant may accept in full and final settlement of the claim, effectively withdrawing the injury claim.

The insurers offer must be a single offer but set out the tariff sum, any sum offered for non-whiplash injury and the sums offered for each other head of claim with an explanation why any item is disputed.

The offer must also state the total value of the offer, the amount of any deductions for contributory negligence and repayable benefits and be verified by a SOT.

As in the MOJP, the overall offer may be higher than the total of the amounts offered for the individual heads of claim.

At the same time, the insurer must make a separate offer for any fees together with the reasons for disputing any item. The claimant is unable to accept or reject the fees offer until the damages have been agreed.

If the insurer’s offer is not accepted the claimant may simply reject the offer (and start the proceedings process), make a counter-offer or put the claim “on hold”. In contrast to the MOJP, there is no requirement for the claimant to make an offer.

The insurer may increase their offer at any time during this stage but may not lower it. Likewise, the claimant may lower their offer but not increase it. The insurers highest and the claimant’s lowest offers therefore remain on the portal and may be accepted at any time, unless withdrawn.

Each party may make up to 3 offers or counter-offers (see below). All offers must contain a SOT.

Offers must remain open for acceptance for 2 weeks but may be withdrawn at any time afterwards. A party may then make a new offer. If the new offer is made before the other party has made their next offer, the new offer counts as the same number towards the 3 offer limit. If afterwards, then the new offer counts as the next offer.

If, however, the insurer withdraws their offer after the claimant has made their third offer, the insurer may not make a new offer on the Portal. The effect of this is to also remove any comments from the insurer on the heads of claim and these comments will not then be available to rely upon in any proceedings.

The process seems needlessly complex, particularly for an unrepresented claimant, for example:

The insurer (D) offers £2000 – D offer 1

The claimant (C) counters at £5000 – C offer 1

D increases to £2200 – D offer 2

D withdraws offer 2

D makes "new" offer of £3000 – This is still offer 2

C makes offer £4700 – C offer 2

D withdraws offer 2

Claimant makes offer £4500 – C offer 3

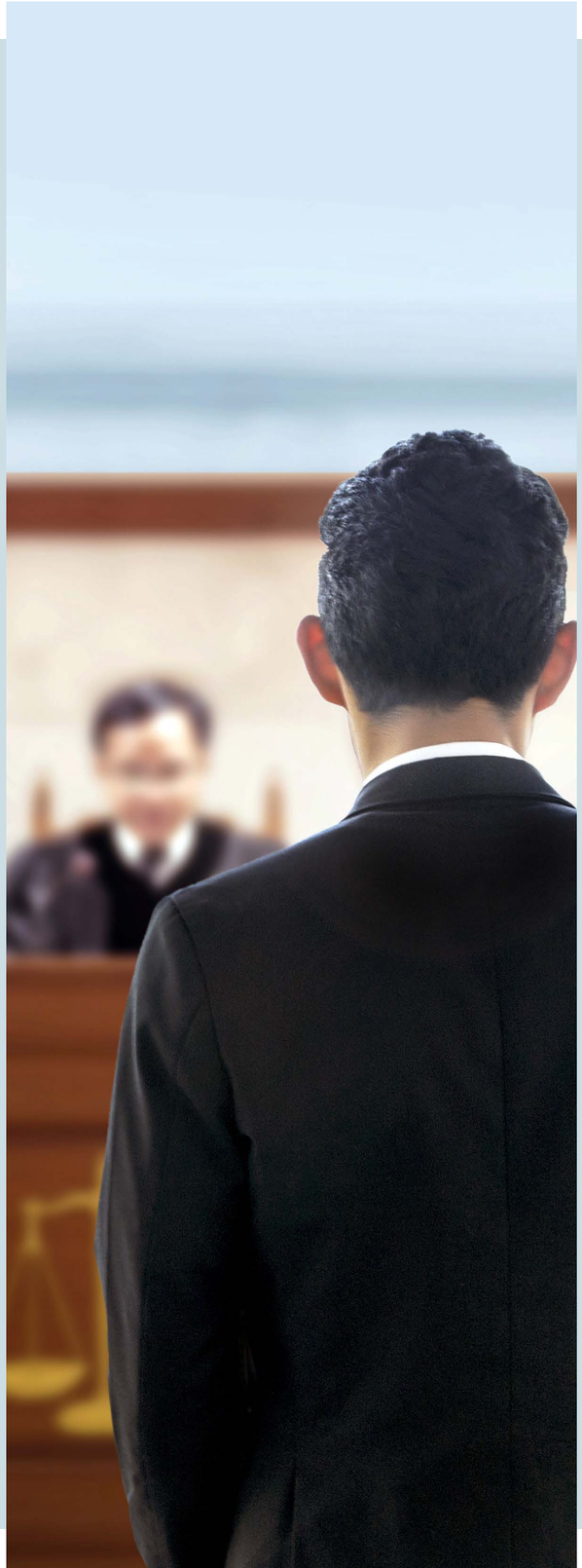
D makes new offer £3200 – D Offer 3

If the insurer were to withdraw their last offer, they would be unable to make a new offer as it would be after the claimant's third offer. Had the claimant not made the additional offer then the insurer would have been able to withdraw and make a new offer and effectively have made 5 offers in the claim.

Settlement

Where settlement is agreed the insurer must pay the agreed damages within 2 weeks. If the insurer fails to pay on time the claimant may start proceedings for an order for payment (judgment). However, the claimant will on settlement be asked to update any claim for fees or add a claim if none was made previously. The claimant may then conclude the claim if there are no fees, no further fees and the insurers offer for fees was to pay in full or the claimant accepts any deductions in the insurers offer for fees.

If the fees are in dispute the claimant may then reject the offer for fees or make a counter-offer. On receipt of a counter-offer, the insurer, if not accepting, may make a further offer. If the fees are agreed the insurer must pay in 2 weeks and in default the claimant may start proceedings for payment. If fees are not agreed the claimant may start proceedings for them to be assessed by the court.



Non-Protocol Vehicle Costs

Settlement of the claim does not prevent the claimant from pursuing any claim for non-protocol vehicle costs (NVC) outside of the Portal.

If settlement cannot be agreed and the claimant is the vehicle driver/owner they will be asked to complete questions to establish if there are any outstanding NVC that need to be included in proceedings.

If the inclusion of the NVC would put the value of the claim over £10,000, the claim will leave the Protocol. It is not clear if the claimant would then be expected to submit the claim in the MOJP (should it be in scope) and effectively start again or commence proceedings. There is a presentation of the Portal by the MIB on 2nd March and we will be seeking clarification on this point then.

If the claim remains at or under £10,000, the claimant must complete a NVC claim document, which also requires a SOT, and upload to the Portal. The insurer has 3 weeks to provide a response document which, you guessed it, also must have a SOT.

Once the insurer has provided the response, or on the expiry of the 3 week period, the claimant may proceed to generate the court pack.

As this step only occurs when the claimant is issuing proceedings to assess damages, the claimant could, for example, have a credit hire claim of £20,000 but still proceed to issue proceedings for a liability determination under the protocol.

Court Proceedings

Proceedings may be started any of the following circumstances:

Type of case	Section of Practice Direction which applies	Paragraph of this Protocol	Table for documents	Court form
Liability dispute only – liability denied in full	Section 2	12.9	A	RTASC L
Claim value dispute: no liability dispute, no NVC claim or **uplift** request	Section 3	12.11	C	RTASC Q
Claim value dispute: liability part disputed; may include NVC claim or **uplift** request	Section 4	12.10	A, B (1) and B (2) where applicable	RTASC D
Claim value dispute: liability not disputed; NVC claim; may include **uplift** request	Section 5	12.10	B (1) and B (2)	RTASC D
Claim value dispute: liability not disputed; no NVC claim; includes **uplift** request	Section 6	12.10	B (1)	RTASC D
Application for interim payment	Section 7	12.12	E	RTASC O
Non-payment of agreed interim payment	Section 8	12.12	G (1)	RTASC O
Starting due to limitation	Section 9	12.12	D	RTASC O
Dispute over **fees**	Section 10	12.12	F	RTASC O
Non-payment of agreed settlement sum	Section 11	12.12	G (2)	RTASC O

Each of these 10 scenarios is dealt with separately within the new Practice Direction, resulting in a 78 page document that we will cover in a separate release.

When the claimant wishes to start proceedings, the Portal will automatically provide the insurer with notice for the purposes of section 152 of the road Traffic Act 1988.

The claimant will select the documents to be included within the Court Pack from those that are made available on the Portal on the basis of the claimant's selection of the reason for the proceedings. This will then generate the Court Pack List which is to be sent to the insurer at least 5 working days before starting proceedings. The insurer has 5 working days to review the list, add (but not remove) any documents and input solicitors' details should they wish to nominate. Failure to respond will deem the list agreed.

The claimant will then respond to questions for the completion of the court form which will then be generated by the Portal. The Claimant must print the court form and sign the SOT. The claimant must also print the list and all the documents to be sent to the court. It is surprising that proceedings seem to be commenced by post and not electronically. Whilst the majority of people will have internet access, many will not own a printer.

Final Comments

The rules are certainly detailed and comprehensive, the PAP runs to 88 pages. Indeed, in seeking to keep this release to a digestible size, there are several sections, interim payments, limitation and contributory negligence for failure to wear a seat belt, that we have not covered.

We are pleased to see that the concerns that we raised as to the treatment of causation disputes (low speed impacts, farmed “late” claims etc) have been taken on board and, rightly, given specific treatment that will allow insurers to continue to defend such unmeritorious claims.

The overall lack of any coverage of rehabilitation claims is surprising but this is perhaps a result of the previous intention that rehabilitation arranged by legal representatives through medical agencies would be excluded from the Protocol. It seems likely that there could be further development on this subject.

For reading by claims professionals, the rules are commendably well written (save for the overly complicated offers process) but will likely be daunting to many outside of the profession. We anticipate that the Portal Support Centre could be very busy. That said, we do wonder how many people will seek to navigate this process without professional assistance and, if most solicitors do vacate the whiplash space, it seems likely that the CMC’s will move in. Only time will tell how that will unfold.

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