Neutral Citation Number [2015] EWHC B6 (Costs)

Case No: A00MY496
SCCO Ref: CL 1404886

IN THE HIGH COURT OF JUSTICE
SENIOR COURTS COSTS OFFICE

Thomas More Building,
Royal Courts of Justice, Strand,
London, WC2A 2LL

Date: 29/05/2015

Before :

MASTER LEONARD

Sitting as a Judge of the County Court (Mayor's and City)

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Between :

MS EMILY NOKES	**Claimant**
- and -	
HEART OF ENGLAND FOUNDATION NHS TRUST	**Defendant**

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- -

Mr James Laughland (instructed by **Bolt Burdon Kemp**) for the **Claimant**
Robert Marven (instructed by **Acumension**) for the **Defendant**

Hearing date: 10 March 2015

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Judgment

Master Leonard:

1. This is the assessment, on the standard basis, of the costs of the Claimant as payable by the Defendant under an order of 25 July 2014. The claim was for clinical negligence. The Claimant seeks to recover the cost of an ATE insurance policy in accordance with Section 58C of the Courts and Legal Services Act 1990 (as amended from 1 April 2013) and Regulation 3 of the Recovery of Costs Insurance Premiums in Clinical Negligence Proceedings (No 2) Regulations 2013 ("the 2013 Regulations").

2. Section 58C reads, insofar as material, as follows:

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.

3. Regulation 3 of the 2013 Regulations says:

Costs order may require payment of an amount of the relevant part of the premium

> (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.

The Policy

4. The ATE policy is a Temple Litigation Advantage policy dated 8 November 2013. The certificate of insurance describes the premium in this way:

	Premium	Insurance Premium Tax (IPT)	Limit of indemnity (in addition to the premium)
a	£5,680.00	£340.80	£10,000.00
b	3.00% of Damages	Inclusive	£100,000.00

5. Underneath this, the certificate states "please note the above premium amounts and/or representative values are cumulative" and "a full description of the premium stages is contained in the definition of premium".

6. The policy terms, under the heading "The risks that you are insured against", describe the premium and includes these definitions:

"Premium (a)

> (1) Against the risk of incurring a liability to pay for one or more expert reports (for liability or causation) in respect of

Clinical Negligence in connection with the proceedings whether commenced or contemplated if the Insured becomes liable to pay Opponent's Costs by Order of the Court or because the Legal Action has been abandoned, discontinued or settled with the prior approval of Temple, which should not be unreasonably withheld.

Premium (b)

(1) For Opponent's Costs in the Legal Action in the event that the Insured becomes liable to pay such costs either by Order of the Court or because the Legal Action has been abandoned, discontinued or settled, subject to the prior approval of Temple, which shall not be unreasonably withheld; and

(2) For the Insured's other disbursements in the Legal Action if the Insured becomes liable to pay Opponent's Costs by Order of the Court or because the Legal Action has been abandoned, discontinued or settled with the prior approval of Temple, which shall not be unreasonably withheld.

The meaning of words used in this Insurance

Where the following words appear in this Certificate they shall mean…

Disbursements

Fees and expenses, including the Premium, that have been reasonably incurred on behalf of the Insured ..."

Definition of Premiums

The amount specified in the Schedule which is payable by the Insured at the determination of the Legal Action.

The amount specified in (a) shall be payable upon determination of the Legal Action and following recovery of costs from the Opponent and to be paid within 28 days of receipt of the Premium by the Appointed Legal Representative; the amount specified in (b) shall be payable upon determination of the Legal Action from the damages received by the Insured or the Appointed Legal Representative on their behalf and paid within 28 days of receipt of damages.

If, in any process of assessment, the Opponent is successful in any challenge to the cost of the Premium (a) then it is agreed that the Premium which was payable at the conclusion of the Legal Action shall be reduced to the amount which was approved and allowed on assessment. Any such challenge must be immediately notified by the Insured to the Insurer. It is

> agreed by the Insured that the Insurer shall have the right to make any representations to the Court or the Opponent as may be necessary in this matter…"

The First Issue: Recoverability

7. Under section 58C(2) (d) and (e), an ATE premium taken out for clinical negligence proceedings must state how much of the premium relates to the liability to pay for an expert report or reports in respect of clinical negligence. If it does, that part will be recoverable under an order for costs.

8. Mr Marven for the Defendant argues that in fact two separate premiums are payable under the policy, as the use of the word "premiums" in the definitions quoted above demonstrates. Premium (a), which the Claimant seeks to recover as part of her costs, does not meet section 58C(2) (d) and (e), and so is not recoverable. That is because it is self – insured: so much is evident from the fact that the limit of indemnity specified against both premiums (a) and (b) is stated to include the premium itself. It follows that the figure of £5,680.00 payable for premium (a) represents the cost not just of insuring against liability for experts' reports but also of insuring the cost of insuring premium (a).

9. Mr Marven argues that if, for example, the insured did not want the cover provided under (b) of the certificate, so that the limit of indemnity under (b) was zero, it would be nonsense to suppose that the Premium payable under paragraph (a) was not self-insured. Insofar as the standard wording of the policy document seems to suggest that the premium or premiums payable are all insured under paragraph (b) rather than paragraph (a) it must give way to the more specific, more pertinent wording of the certificate of insurance itself.

10. Mr Laughland for the Claimant argues first that the policy, when properly read, does comply with the statute. A single premium is payable under this policy and described, as the statute requires, in two parts. Part (b) expressly provides cover for all disbursements including the whole of the premium itself. The use of the word "Premiums" in a heading in the policy terms is, in the right context, of no significance: this is one premium divided into two components, one of which is recoverable and the other not.

11. Mr Laughland also argues that the Defendant is seeking to introduce a sanction (irrecoverability of the premium) for alleged partial or complete non-compliance with the statute or statutory instrument when that is not evident from its wording. There has been no procedural irregularity justifying disallowance of the premium as a matter of principle. He contrasts section 58 of the Courts and Legal Services Act 1990, which expressly provides for non-compliant CFAs to be unenforceable.

Conclusion on Recoverability

12. Though I am not sure that I entirely agree with Mr Laughland's distinction between compliance with one set of statutory requirements and another, I do accept that it would be inappropriate to regard the Claimant's policy as non-compliant with section 58C and the 2013 Regulations simply because there may be some ambiguity or imprecision in its wording. In my view the question is whether, on a proper reading

by reference to established contractual principles of interpretation, the policy does or does not comply with the statutory requirements.

13. In the course of submissions I referred to *Investors Compensation Scheme Ltd v West Bromwich BS* [1997] UKHL 28 and established principles of contractual construction. Among those principles are that a contract is to be read as a whole. That would be the case even if the policy terms accompanying the certificate of insurance did not incorporate the words "this certificate", indicating that there is no distinction to be drawn between the certificate and the terms.

14. Taking that approach, it seems to me to be clear both that this policy is expressly designed to comply with Section 58C and the 2013 Regulations (as Mr Marven conceded, the wording of the policy tracks the statutory wording) and that it does comply.

15. The heading "Limit of Indemnity (in addition to the premium)" above both premiums (a) and (b) is, if read in isolation, potentially misleading in that it seems to indicate that premium (a) is self-insured. However for the reasons I have given it is wrong in principle to single out any part of the contract and read it in isolation. The wording relied on by the Defendant is no more than a heading. In contrast the detailed terms of the policy, explaining the insured risks, are clear (and I do not accept that it is right to treat the certificate of insurance as more important for the purposes of interpretation).

16. Premium (a) insures against the risk of liability to pay for expert reports in respect of clinical negligence, and nothing else. Premium (b) insures opponent's costs and the insured's other disbursements, expressly defined to include "the premium". As to what "the premium" is, the only definition is that quoted above under the heading "Definition of Premiums" and expressly incorporates the full amount payable by the insured; premiums (a) and (b) are distinguished only by reference to the timing of payment and the particular provisions limiting premium (a) to the amount assessed.

17. The words "Definition of "Premiums" are cited in support of the argument that the policy incorporates two stand-alone, self-insured premiums. I agree with Mr Laughland that it is artificial to single out that wording so as to read the policy as providing for two separate premiums. A better reading is that one premium is payable under this policy and it is, in accordance with the statutory requirements, divided into two parts to show which part of it is payable in relation to expert reports and is, in consequence, recoverable.

18. However I do not think that much really turns on whether one describes the policy as incorporating one premium in two parts or two premiums. It is compliant with the statutory provisions either way, because it provides the information that the statutory provisions require.

19. The argument that the policy incorporates two stand-alone, self-insured premiums supports Mr Marven's submission that one can strip out premium (b) and then see that premium (a), left in isolation, is self-insured. However I would not be able to accept his argument even on the basis that the policy provides for two premiums rather than (as I have concluded) two parts of one premium. I say that because, for the reasons I have given, premium (a) is not, on any proper construction of the policy, to be regarded in isolation. Premiums (a) and (b) work together as two parts of one whole

policy. It would be artificial and wrong to interpret the policy by reference to what it might mean if its terms were different. That would be the case even if this were a bespoke policy rather than (as it is) a block-rated standard policy, not open to individual negotiation.

20. In summary, whilst it is possible to interpret the policy, by reference to some loose wording, as non-compliant with the statute, that would in my view (with respect) be an incorrect and distorted reading defeating its purpose. The policy is compliant with section 58C and the 2013 regulations. Premium (a) is, in consequence, recoverable.

The Amount of the Premium

21. The reasonableness and proportionality of the Premium is in dispute. In order to consider the parties' submissions, it is necessary to review the history of the underlying action.

22. The Claimant instructed her solicitors, Bolt Burdon Kemp, in April 2013. The Claimant's case was that the Defendant had failed adequately to address the results of blood tests taken during her pregnancy and during labour, resulting in a traumatic birth, serious health risks to the Claimant and her baby and the development by the Claimant of obsessive compulsive disorder (OCD). The level of OCD was severe, rendering the Claimant (for example) unable to entrust the care of her daughter to others and so return to work.

23. A letter of claim was sent on 18 November 2013. On 23 December 2013 Dr Lesley Haines, consultant psychiatrist, reported that the Claimant's OCD had been triggered by her experiences during the birth of her daughter and the immediate aftermath. Dr Haines recommended treatment by way of Cognitive Behavioural Therapy (CBT), Exposure and Response Prevention (ERP) and medication, advising that the Claimant was likely to require at least two courses of individual psychological treatment combining CBT and ERP over a period of 27 weeks.

24. Doctor Haines' report and the Claimant's medical records were disclosed to the Defendant in January 2014, accompanied by a Part 36 offer in the sum of £55,000. There appears to have been further disclosure by the Claimant and time for acceptance of the Part 36 offer was extended, by agreement, to 19 March 2014, the date that the Defendant's Letter of Response was due under the pre-action protocol, so enabling the Defendant to complete liability investigations.

25. The Defendant requested disclosure of the Claimant's medical and counselling records and instructed DAC Beachcroft, solicitors. The Claimant attended an examination appointment with the Defendant's instructed expert on 3 April 2014.

26. Time for the letter of response was subsequently extended to 19 May 2014, time to consider the Claimant's Part 36 offer also being extended accordingly.

27. On 16 May 2014 the Defendant served its letter of response and confirmed that it had obtained expert opinions from an obstetrician, an anaesthetist, midwife and psychiatrist. They confirmed that as a result of their investigations, liability was admitted. The Defendant made a Part 36 offer in the sum of £35,000.

28. Following the submission of evidence by the Claimant to the Defendant in support of the Claimant's loss of earnings claim, the Defendant made an increased offer in the sum of £40,000 on 30 May 2014. That offer was accepted on 4 June 2014.

29. The Claimant's bill of costs was formally served with a Notice of Commencement dated 4 August 2014. The Defendant served its Points of Dispute dated 16 September 2014.

Proportionality

30. On a standard basis assessment the costs claimed by the Claimant will be disallowed insofar as they have been unreasonably incurred or are unreasonable in amount (CPR 44.3(1)). CPR 44.3(2)(a) also provides that costs which are disproportionate in amount may be disallowed or reduced even if they were reasonably or necessarily incurred.

31. It is common ground that the test for proportionality to be applied in this case is the post-1 April 2013 test set out at CPR 44.3(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."

32. In the Points of Dispute the Defendant, expressly, does not submit that the Claimant's costs as a whole are disproportionate. It takes issue with the proportionality of particular items, including the ATE premium.

33. With respect to the ATE premium the Points of Dispute challenge both its reasonableness and proportionality. They state that this was a relatively straightforward Clinical Negligence case which lasted a total of 5 months, liability being admitted promptly and no proceedings issued. Before the Claimant instructed solicitors, the Defendant had carried out a "root cause analysis" which identified clear failings in care, so liability and causation were "clear cut".

34. The Points of Dispute contend that a premium of £6,020.80 for an indemnity of £10,000 defies logic and makes no commercial sense: and that although it was not known by the Paying Party how the premium was calculated, the calculation must have been fundamentally flawed, as well as grossly disproportionate. The premium is compared to the actual costs of medical reports obtained in this case (£2,530.80) and

the Defendant asks, rhetorically, "Why would any Claimant pay an ATE premium that was nearly three times the potential exposure?"

35. Relying upon *Kelly v Black Horse* [2013] EWHC B17 the Points of Dispute contend that in the absence of compelling evidence as to how the premium had been calculated, the Court should apply, as a starting point, a "burn" premium, a formula incorporating an 11% risk figure (given that the risks in the case were very low) allied to a maximum exposure of £2,530.80, the actual fees paid. The proposed calculation is (£2,530.80 x 11%) + 25%, yielding a proposed premium of £347.99 + IPT.

36. On provisional assessment on 7 October the costs officer allowed the ATE in full and the Claimant's costs overall at £19,228.12, plus costs associated with Provisional Assessment. The matter was referred to a costs judge for a hearing under CPR 47.15(7), the only item under review being the ATE premium.

The Claimant's Evidence

37. Both parties have produced witness evidence in support of their case on the ATE premium. The Claimant has produced a witness statement dated 30 January 2015 from David Pipkin, an underwriter at ATE insurers Temple Legal Protection.

38. This is Mr Pipkin's evidence. He points out that every ATE insurance provider may have a different underwriting model. There is no universal model, but it is in Temple's business interest to set premiums at levels which are reasonable and which will be accepted as such by the Courts.

39. On 1 April 2013, following changes introduced by Legal Aid, Sentencing and Punishment of Offenders Act 2012 ("LASPO") most ATE premiums became irrecoverable from litigation opponents under an order for costs and the ATE market, in consequence, changed. Mr Pipkin attests to the fact that between late 2012 and March 2013, senior underwriters at Temple, sharing many years of experience of working in and shaping the ATE insurance market, held extensive discussions and obtained "a great deal of historical information" about settlement trends, success rates and costs of clinical negligence cases before setting a clinical negligence underwriting model and premium rates for the post – LASPO era. In setting the delegated scheme premiums Temple gathered as much information about litigation costs and dynamics, and based its underwriting model on what it reasonably believed might happen, of necessity incorporating a number of assumptions.

40. A firm of solicitors may obtain Temple ATE Insurance for a client in one of two ways. Under a delegated scheme, solicitors issue policies on behalf of Temple's underwriters, obviating the need to ask them to individually assess risk. Otherwise a solicitor may submit an application to Temple, which will carry out an assessment of the risk and, if acceptable, offer a premium in an effort to win the business.

41. Temple offers a number of delegated schemes to solicitors for use in different categories of case. Under the delegated schemes, each type of litigation has its own risk criteria and terms, set according to the nature of the business being insured.

42. For clinical negligence matters the criteria applied for inclusion within the delegated scheme are these. The subject-matter must (with certain exceptions which may

incorporate other heads of claim) be a clinical negligence claim against up to three opponents. The damages claimed must be £100,000 or less; the Client's date of knowledge (as defined under the Limitation Acts) must be less than two years prior to the date of issue of the Certificate of Insurance; the insured must have agreed to act under a Conditional Fee Agreement or other form of post - LASPO retainer that has been previously approved by Temple; the Client must have at least 51% prospects of succeeding in their claim, assuming that it is determined at a final hearing; the Certificate of Insurance must be issued before issue of proceedings; liability must not have been denied; and there must have been no Part 36 offers from any Defendant.

43. The delegated authority scheme permits the Solicitor, before a letter or Notice of Claim is sent, to take out Temple Insurance without the need to approach Temple. There are, says Mr Pipkin, economies of scale and other advantages to operating the scheme in this way. By stipulating that there must not have been a denial of liability or an offer Temple can avoid the increased costs and exposure that would arise where solicitors belatedly insure a case where it is already known that liability is to be disputed or where a Part 36 offer might not be beaten. If the solicitors are themselves acting under a Conditional Fee Agreement Temple can be satisfied that the solicitors consider that the claim has reasonable prospects for success. The terms of the scheme, says Mr Pipkin, create a fair "basket" of cases where the risks are spread as widely as possible.

44. The scheme avoids the increased costs and administrative burden entailed in assessing and setting a bespoke premium for each case. That would be time consuming for the Claimant's solicitors and expensive for Temple, as it would have to have the resources to evaluate substantial proposal forms and have an underwriter set a bespoke premium in every case. Such a bespoke system would result in higher administrative costs and higher premiums: the present system keeps premiums down and benefits paying opponents.

45. The level of indemnity for the costs of experts' reports relating to liability or causation is set at £10,000 for all cases within the delegated scheme. Cover is retrospective and the premiums (as the terms I have quoted illustrate) are deferred. Whilst in some cases (as here) the costs of such reports may be substantially less than £10,000 there will be others where numerous reports from experts in many disciplines will be required and the costs exposure may well be as high as £10,000. Temple settled upon providing a uniform level of indemnity as that ensures that the client and solicitors know at the outset what level of cover is provided. The alternative, creating a bespoke level of indemnity for every case, would incur additional costs. Mr Pipkin contends that a level of indemnity of £10,000 is a reasonable balance for the vast majority of cases falling within the "basket".

46. The ATE industry, says Mr Pipkin, remains a competitive market after 1 April 2013. The limitation on recoverability of ATE premiums in all but a few categories of case has added increased difficulty to that competition. A number of providers have left the market. Temple has done its best to create a product that is competitive and attractive to solicitors so as to meet the demand for ATE that undoubtedly remains.

47. During its discussions with Bolt Burdon Kemp, Temple was aware that they were seeking alternative prices and cover from a number of Temple's ATE competitors. This, says Mr Pipkin, meant that if Temple had any chance of winning their business

then they had to produce a competitively priced scheme. Temple succeeded, being selected by Bolt Burdon Kemp to be their first choice ATE Insurance provider.

48. At the time of inception of the Claimant's policy, says Mr Pipkin, Temple's Clinical Negligence delegated authority scheme with Bolt Burdon Kemp set, for damages claimed to £25,000, a recoverable "(a)" premium (as in this case) of £2,650. For claims of £25,000 to £100,000 the "(a)" premium was £5,680. In both cases the limit of indemnity was £10,000.

49. One of the driving factors in the model, says Mr Pipkin, is to ensure that the loss ratio is maintained at a level where it is worthwhile for the insurer to stay in the market. Temple's Pre-LASPO loss ratio across the clinical negligence book was 81%. Underwriting profits are marginal and Temple has to wait 2-3 years to recover premiums, in the meantime paying out significant sums on claims.

50. The premiums set out above, he says, represent the best assessment that could at the relevant time be made by the Underwriters in order to maintain the desired loss ratio but it is too early to say whether that will be achieved. The new market is still immature and faces uncertainty from premium challenges in the courts, such as the challenge considered in this judgment. Assumptions have had to be made about the level of claims frequency and the likely average claim exposure, all of which could prove to be wrong.

51. When Temple rated the premiums, says Mr Pipkin, it did not know how the competitors in the new ATE market would price their premiums or what level of indemnity they would offer. Given that it is now possible to compare a number of policies he suggests that there is little difference between them. (I refer to the parties' comparable evidence below).

52. Temple, says Mr Pipkin, have always graduated their clinical negligence premiums by reference to the level of damages, the reasoning being that increased quantum comes with increased risk, larger claims tending to be more complex and less likely to settle early. Temple may be one of the few (or the only) ATE providers who adopt his approach. It is too early to say whether that is the correct decision. It may well be that Temple has underpriced the lower premium, but he suggest that this pricing approach is proportionate to the level of damages claimed and, given the comparable premiums referred to, the resulting premiums appear to be very competitive.

53. Temple's book of clinical negligence business indicates that approximately 82% of cases are likely to settle for less than £25,000 (a premium of £2,650 plus IPT) and the remaining 18% for more than £25,000 (a premium of £5,680 plus IPT). This means the average premium to be paid by opponents will be (£2,650 x 82)/100 = £2,173 for cases that settle under £25,000 with an additional (£5,680 x18)/100 = £1,022 for cases that settle over £25,000, coming to £3,195. This compares favourably with the more significant premiums charged by DAS, ARAG and LAMP.

The Defendant's Evidence

54. The Defendant has filed a witness statement dated 13 February 2015 from Mr Ken Corness, an experienced Costs Lawyer. Mr Corness points out that no evidence has been served by the Claimant's solicitors explaining what if any steps they took to identify the best policy or the lowest premium for the claimant; or about any advice that was given to the claimant in respect of the best policy. Assuming that the Claimant's solicitors (as counsel confirmed in the course of the hearing) were not obliged to use this Temple policy, there is no evidence of any review of the market.

55. Mr Corness takes issue with Mr Pipkin's statement to the effect that Temple's Pre-LASPO loss ratio across the clinical negligence book was 81%, on the basis that this statement is not explained or supported by any figures. Mr Pipkin does not, he says, explain how the quoted figure led to the premium claimed in this case; he fails to provide any evidence as to any assessments that were made as to the likely proportion of unsuccessful claims post- 1 April 2013, though such assessments must have (or ought to have) been made; and he fails to explain the assumptions made in setting up the clinical negligence model.

56. Mr Corness observes that Mr Pipkin also fails to give any evidence as to what (thus far) has been Temple's experience in respect of frequency and level of claims or as to what proportion of claims in his experience (either pre- or post- LASPO), liability is admitted, whether at letter of response stage or later. He asserts, based on his understanding that a very significant amount of clinical negligence claims are concluded with admissions of liability (frequently before any such insurance premium would have been taken out) that in such claims there is really no or negligible risk of a call on the policy. The Claimant, he says, has not provided any evidence that such admissions have been taken into account when the premium is calculated. Given the level of premium, Mr Corness suggests that it has not.

57. Mr Corness also takes issue with Mr Pipkin's statement to the effect that the Temple premium is set by reference to whether damages are up to or above £25,000. That is first because no data or calculations are given to explain the statement that greater quantum produces a higher exposure to risk or how that leads to the levels of premium set, and second because Mr Pipkin, in explaining the logic of the premium calculation, refers to levels of settlement rather than to the claim as valued at the time the policy is taken out: this he says must be wrong.

58. Mr Corness submits that the claimant and her advisers have failed to discharge the onus on them to show that this premium was reasonably incurred or reasonable in amount and that the level of premium when compared with the level of cover is both unreasonable and disproportionate.

59. Mr Corness expresses concern at the high ratio of premium (a) to cover (56.8%) compared to premium (b) (3%). He argues that if the average value of a claim to which this policy applies is taken as £50,000, a (b) premium would be £1,500 for cover of £100,000 plus premium, suggesting that premium (a) ought to be £150. He suggests that it is difficult, if not impossible to avoid the conclusion that the insurer is greatly inflating its prices where there is the prospect of inter partes recovery.

60. Mr Corness also submits that the level of cover of £10,000 is excessive. The 2013 Regulations (and the Claimant's policy) refer only to the cost of expert reports, not other costs such as attendance at trial. They do not include the cost of reports on

quantum. The cost of the relevant expert report here was £2109.00 plus VAT: £2,530.80. Even if this matter had proceeded to trial, the Claimant was unlikely he says to have obtained more than one further report on liability, if that. On a worst case basis, Mr Corness suggests that relevant expert's reports would not have cost more than £4,000 - £5,000.

61. Mr Corness submits that in his experience, most clinical negligence claims worth less than £100,000 settle before proceedings are issued or shortly thereafter. He suggests that the average costs of a claimant's expert evidence in such cases would be around £2,000.00, inclusive of VAT. In this case, liability was admitted in a letter of response less than 6 months after the Defendant was provided with a letter of claim.

62. Mr Corness submits that at the time the policy was taken out in November 2013 it would have been evident to the Claimant that the likelihood of liability being admitted was very high, so that the level of risk was low to negligible. He refers to the "root cause analysis" carried out before the Claimant's solicitors were instructed which, he says, identified a number of failures.

63. Mr Corness suggests that any argument to the effect that if Temple's premium compares favourably with competitors in the ATE market, then the premium must be reasonable, is self-serving. The Claimant, he says, cannot prove the reasonableness of the premium simply by stating that other insurers are offering similar products: with any untested new insurance product, reasonableness has to be established.

The Defendant's Submissions

64. Mr Marven's submissions adopt the points made in the statement of Mr Corness, although I understood him, in oral submissions, to accept that the Claimant only has to show that the premium is reasonable and proportionate in amount if the Defendant has identified some real basis for arguing that it is not. I agree: I do not start with a presumption that the Claimant's ATE premium is unreasonable. This being a standard basis assessment, where some real issue does arise any doubt will be resolved in favour of the Defendant.

65. Mr Marven submits that this premium on the facts (a fairly typical clinical negligence claim, supported by one expert report, having settled early after an admission of liability) appears to be unreasonable and disproportionate. In such circumstances it is incumbent on the insurer to explain how the premium is calculated so as to show that it is in fact reasonable. If this case is in some way untypical the insurer should say so.

66. The evidence provided by Mr Pipkin fails says Mr Marven to provide any useful material, though the scheme criteria identified by Mr Pipkin suggest that the insurer is in fact limiting acceptable cases to a low level of risk. On the evidence the court cannot be satisfied that the policy was a reasonable choice. Thus the premium falls to be assessed at a low level without the benefit of any doubt going to the Defendant.

67. Mr Marven submits that if for example the anticipated average cost to the insurer in the event of a claim on the policy was £2,000 and the insurer only has to make payment in less than one in 10 cases, then (adopting the arithmetical approach approved by the Court of Appeal in *Rogers v Merthyr Tydfil CBC* [2006] EWCA Civ

1134 paragraph 109) this would point to a premium in the region of £150, as contended for by Mr Corness.

68. One must distinguish between the level of cover offered (which the Defendant characterises as inappropriately high) and real estimated maximum exposure, which is the figure that should be used in any reasonable premium calculation. Mr Corness' evidence addresses that, and the prospects of success in this particular case: by the time the Claimant's ATE policy was taken out the information available to the Claimant was sufficient to identify the Defendant, rather than the Claimant's GP, as the prospective defendant.

69. Mr Marven argues that the Defendant is not asking the court to interfere with, undermine or defeat the purpose of Temple's ATE model, nor putting Temple in a position in which it must claim its premium from the insured rather than the insured's opponent. Reduction on assessment, he submits, is already built into the model because the premium payable by the Claimant is limited to any reduced amount.

70. As judicial experience of excessive premiums has increased, costs judges have rightly been the more willing to disallow excessive premiums, for example in *Kelly v Black Horse* and *Redwing Construction Ltd v Wishart* [2011] EWHC 19 (TCC). and so this court should not hesitate to interfere with the premium claimed. *Coventry v Lawrence* [2014] UKSC 46 and *Marley v Rawlings* [2014] UKSC 51 also he suggests point to increasing judicial concerns about excessive additional liabilities. The court ought to approach the assessment of this premium in a way which reflects those concerns.

71. Mr Marven suggests that premium (a), being limited in any event to the amount recovered from the Defendant, is not subject to any genuine market competition. On the evidence the overall premium in this case appears to have been divided between the (a) and (b) premiums in an unbalanced way. To the extent that the court might be persuaded by comparable evidence that ATE insurers generally are now under commercial pressure to charge large recoverable, as compared to irrecoverable, premiums this raises concerns which justify the court's intervention.

72. Considerations of proportionality, under the new test in CPR r 44.3(5), lead he suggests to much the same reduction as do the Defendant's arguments on reasonableness. Under the post-April 2013 proportionality test even if (which would be disputed) the Claimant argues that it was necessary to incur this expense, it does not follow that it is to be regarded as proportionate: in that respect *Rogers v Merthyr Tydfil* no longer applies. Only a proportionate premium should be allowed, and here only a low premium is proportionate to the risk faced by the insurer.

73. There is nothing, he suggests, wrong in principle in identifying an individual item or items, on a detailed assessment, as disproportionate and reducing them to a proportionate figure before, at the conclusion of the assessment, standing back and considering whether the final total is proportionate. Here, it is appropriate to treat "the amount in issue" as the amount of indemnity and to consider whether, in comparison to it, the premium is disproportionate.

The Claimant's Submissions

74. Mr Laughland submits that the Defendant's criticisms of the sufficiency of the Claimant's evidence are ill-founded. The purpose of assessment of costs on the standard basis (whether summary, provisional or detailed) is to consider whether the costs claimed by the Receiving Party were reasonable and proportionate, with doubts resolved in favour of the Paying Party.

75. With respect to an ATE premium, the question is whether the Claimant was reasonable in having incurred that premium and whether such can reasonably be recovered from the Paying Party. This should not be an exercise in second-guessing insurance underwriters or for undertaking a detailed analysis of their methodology: especially not in a new and uncertain market.

76. Although the economics and behaviour of the ATE market are very different after 1 April 2013, previous exhortations for Judges not to substitute their opinions for those of insurance underwriters (as in *Rogers v Merthyr Tydfil*, considered below) remain valid; perhaps all the more so when the market is readjusting to the changed landscape.

77. Mr Laughland rejects the Defendant's criticism of Mr Pipkin's evidence as inadequate: Temple's precise calculations, he points out, are commercially sensitive. Evidence (if available) as to the size of the market for the new ATE products in March 2015, or evidence concerning Temple's experience of frequency of claims and their cost as at in March 2015, will not help determine the reasonableness or proportionality of a premium charged in November 2013, just over seven months after the economics of the whole ATE market significantly changed. The Defendant is inviting the court to apply hindsight.

78. Mr Marven and Mr Corness have pointed out that Mr Pipkin's explanation of the overall structure of Temple's clinical negligence scheme, in particular its setting premiums at two levels by reference to damages recovered, is not consistent with the terms of the Claimant's policy. Mr Laughland explained this apparent anomaly, in oral submissions, in this way. In late 2013, after the Claimant's policy was taken out Temple added an endorsement to its policies providing for premiums to be calculated in the manner described by Mr Pipkin. His evidence on that point, and the calculation of an average premium of £3195 based on Temple's experience, is submits Mr Laughland perfectly sound.

79. There was no obligation upon the Claimant or her solicitors to review the market before selecting any particular ATE product. Whilst selecting an unnecessarily expensive policy might handicap recoverability of the premium incurred, the Claimant is not obliged to consider all available options before choosing a particular product. In any event, Mr Laughland submits, the product does compare favourably with the market rates.

80. Mr Pipkin's statement explains why a limit of indemnity is set at £10,000 for the costs of obtaining medical reports on liability and causation. For a block- rated scheme operated on a delegated authority basis it is appropriate to have a consistent level of indemnity. Block-rated policies provide consistency and it is wrong in principle to judge a block-rated premium by reference to a notional individually assessed premium. Of course the block-rated scheme, of necessity, excludes cases where

matters such as denial of liability increase the risk; such cases may be insured by a bespoke policy.

81. Clinical negligence cases often require reports that deal separately with liability and causation and also require input from experts in more than one discipline. This case is one example: negligence in the field of obstetrics led to psychiatric harm. The Defendant's own Letter of Response confirmed that they had received the opinion of an expert obstetrician, expert anaesthetist, expert midwife and expert psychiatrist before admitting liability.

82. The premium is the same in all delegated scheme clinical negligence cases covered by Temple, so long as the damages are in excess of £25,000 (a lower premium is charged if the damages recovered are less than £25,000). The proportionality between premium and damages will vary from case to case depending on what amount is recovered, but the premium is self-evidently reasonable.

83. The Defendant seeks to link proportionality between the premium and level of indemnity for one part of the risk but this ignores the fact that the insurers' exposure between the risks covered by premiums (a) and (b) is not divisible. If the insured event arises then the maximum exposure under any of the policies is £100,000 (in addition to the premium) and all the premiums collected (comprising both elements) have to be sufficient to cover the insurer's exposure and enable the business to have a profit.

84. If Temple (or any other ATE insurer) is required to set premiums by reference to the anticipated expenditure on medical reports in every individual case, together with reference to the particular risks in that case, then there will have to be individual risk analysis of each case. Such would immediately substantially increase the costs burden on the insurer, and in consequence the premium.

85. Whilst Parliament has permitted recovery of the premium that insures against the risk of a Claimant having to pay the costs of the expert reports obtained in support of a claim for clinical negligence, it must be borne in mind that there will be many cases never seen by the Defendants or by courts on assessment of costs where proceedings were never intimated or issued because such reports proved unfavourable and the costs burden has fallen on the insurer.

86. That is sufficient to explain the difference in ratio between premium costs and indemnity cover in the (a) and (b) elements. Before a favourable expert's report is obtained the prospects of success must be regarded as very uncertain in the majority of cases. If the report or reports come back as negative then the indemnity will be called upon and the ATE insurer will pay for those reports, with no premium being collected as no damages were recovered or favourable costs order made.

87. If the expert evidence is favourable then the claim can proceed. The risk of the insurer having to pay out the risks covered by premium (b), in practice against irrecoverable disbursements and such adverse costs orders as may represent a cost to the Claimant following the introduction of Qualified One Way Costs Shifting (“QOCS”), (as for example where a Part 36 offer is not beaten) will be much lower.

88. The assertion in the Points of Dispute that a "burn" premium formula should be adopted, applying an 11% chance of failure in this case, is submits Mr Laughland wholly without foundation. First, it ignores the fact that Temple operates a block-rated policy.

89. Second, even on a "bespoke premium" basis the Defendant's analysis does not stand up. The "root cause analysis" relied upon by the Defendant has not been produced in evidence. The Defendant's current insistence that the Claimant must have been in a position to know that liability was very likely to be admitted does not sit well with the Defendant's requirement of an extension of time for serving its Letter of Response, the Defendant arranging to have the Claimant examined by an expert psychiatrist (something that can only have been to investigate causation as a possible defence) and the Defendant obtaining expert opinions in four different disciplines before admitting liability.

Comparable Policies

90. Mr Pipkin exhibits to his statement an advertisement indicating that in April 2013 DAS Law Assist would, at the pre-issue stage, have charged a standard premium of 200% of the actual cost of the clinical negligence liability and causation reports, which in this case would have been £5,060 plus 6% IPT. The advertisement also indicates that a much-reduced 25% premium would be payable after issue and (by inference) that recoverable premiums are not cumulative: in fact, on the evidence of actual DAS policies considered below, the indication that no further premium would be payable post-issue would not seem to be reliable.

91. Mr Pipkin also states that ATE insurers ARAG have quoted some lawyers £5,088 including IPT for ATE insurance, though it has not been possible to ascertain a specific level of indemnity because it appears that a single limit of indemnity was applied to include other risks covered by the policy. ARAG have not, he says, published any price rating: his information was obtained from discussions with a number of lawyers who had received quotes or pricing information from ARAG. Similarly he was advised by one lawyer that LAMP insurance offers a premium of £5,091 plus 6% IPT with a level of indemnity at in the region of £10,000.

92. Mr Corness compares the premium sought in this claim with premiums sought on policies before 1 April 2013. His argument is that the purpose of the Jackson reforms was to reduce the liability of the paying party for additional liabilities, but he says a simple comparison between pre and post April 2013 polices indicates that liability for ATE premiums has not been reduced at all, and may have increased.

93. Pre-LASPO policies provided cover over a much broader scope, typically an opponent's costs to trial, the insured's own disbursements and Counsel's fees. Mr Corness exhibits to his statement Temple ATE policies incepted prior to April 2013 providing an indemnity of £100,000 with, he says, a much lower premium, as well as examples from other providers which he says provide evidence that, generally, much cheaper cover was available before April 2013 for higher and broader indemnities and exposure.

94. Mr Corness relies in particular on a Temple policy taken out through Bolt Burdon Kemp on the 31 January 2013. He states that the relevant case settled at a similar

point to this one, with damages of £42,500. A premium of £1,855.00 was payable, with an indemnity limit of £100,000 covering opponent's costs and own disbursements. Given the similarities, he describes the fact that in this case the Defendant is faced with a £6,028.00 premium for cover of £10,000, covering only the cost of expert's reports, as baffling and so inexplicable as to require Bolt Burdon Kemp to call the premium into question.

95. Mr Corness also exhibits three post- 1 April 2013 insurance premiums which he says are considerably lower than the premium claimed in this case, in particular a clinical negligence policy with LAMP providing for a premium in the sum of £1,802.00 for cover of £9,000.

Conclusions on Reasonableness

96. The amount of the ATE premium claimed is in issue and in that context I must address both reasonableness and proportionality. Because costs reasonably or necessarily incurred may nonetheless be disallowed as disproportionate, I shall focus first on whether the amount of ATE premium sought from the Defendant by the Claimant has been reasonably incurred.

97. CPR 44.4 requires that on considering both reasonableness and proportionality I have regard to all the circumstances. For that reason, even if the Defendant had not relied upon comparable market evidence to support the proposition that Temple's ATE premium is not reasonable in amount, I would be unable to accept the Defendant's contention that the Claimant cannot rely upon comparable market evidence to support the proposition that in fact it is.

98. It is not suggested, nor should it be, that it was unreasonable for the Claimant to arrange ATE cover at all. The reasonableness of the Claimant's choice of ATE cover must be measured by reference to what is available to her. Hence the Defendant's criticism of a lack of evidence to the effect that she and her solicitors considered alternatives. That said, the choices available to the Claimant cannot be the only determinative factor: if all available choices were by any objective standard unreasonably expensive then it might still be appropriate to disallow or reduce the actual premium chosen.

99. As noted above I do not start from a presumption that the ATE premium is either unreasonable in amount or disproportionate, so that (as Mr Corness suggests) the Claimant must prove that it is not. It is for the Defendant as paying party to advance some viable case to the effect that the amount of the premium is either unreasonable or disproportionate, in which event any doubt will be resolved in favour of the Defendant.

100. As to how that is judged, in *Rogers v Merthyr Tydfil* Brooke LJ, at paragraph 119, said:

> "…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."

101. It does not follow that a judge would never, unassisted by expert evidence, be in a position to conclude that an ATE premium is unreasonable or disproportionate. I respectfully agree with Mr Marven that matters have moved on to some extent since *Rogers*. It may well be appropriate, for example, to reduce an ATE premium where (all other elements of the calculation aside) it is evident that the prospects of success of a given case must have been miscalculated or misrepresented to the insurer. *Kelly v Black Horse* and *Redwing v Wishart* both furnish examples of that.

102. However there must be some sound basis for arguing that the ATE premium is unreasonable in amount. I have come to the conclusion that the Defendant has been unable to establish that. In my view the Defendant's case does not, on examination, yield any point of substance. I say that for these reasons.

103. First, the Defendant's proposed individual assessment of risk in this case is of no assistance in judging the reasonableness of a block-rated scheme such as Temple's. Mr Marven made it clear that the Defendant is not suggesting that the use of a block-rated scheme is in itself objectionable, because that would be contrary to authority. It would not in any case be a viable argument, for the reasons advanced by Mr Pipkin. That leaves the Defendant either to raise some viable argument to the effect that the premium calculated under this particular scheme is, as a block-rated premium, unreasonable in amount or to show that the Claimant's choice of that block-rated scheme was unreasonable.

104. In my view the Defendant has not made out a case to the effect that the premium produced by Temple's block-rated scheme is, as a block-rated premium, in some way wrong or unreasonable. It would probably take expert evidence to do that, and I do not have any such evidence. What I do have is a set of general observations about clinical negligence cases which (for reasons I will explain) I do not find helpful, inappropriate comparisons to a hypothetical individually rated premium and the Defendant's argument that premium (a) should represent the same percentage of the limit of indemnity as does premium (b) and so be limited to £150.

105. Mr Marven accepted that this last argument may be seen as simplistic but argued that in the face of a clearly excessive premium for which there is no proper explanation from the Claimant, it (like the alternative calculation in the points of dispute) may provide a starting point. I cannot agree, because it seems to me to be wrong in principle. For the reasons given by Mr Laughland premium (a) and premium (b) insure different kinds of risk and cannot properly be compared in the way contended for.

106. I also accept that it is not incumbent upon the Claimant, in explaining the genesis of Temple's clinical negligence delegated authority scheme, to produce the further detailed evidence referred to by the Defendant. My understanding of Mr Pipkin's evidence is that it is intended to (and does) show that Temple applied its experience of

years in the ATE market to produce a post – 1 April 2013 policy that was intended to be viable and competitive. The outcome of that can be judged by reference to the comparable evidence considered below. Mr Pipkin's failure to explain the apparent inconsistency between his calculation of Temple's average premium and the terms of the Claimant's policy is an unfortunate omission, and I understand Mr Marven's objection to the way in which Mr Laughland attempted to fill the gap. However I have no real reason to doubt Mr Pipkin's evidence on Temple's average premium.

107. I have considered whether the Defendant has any real case based on the proposition that an individually assessed premium should have cost significantly less than the premium actually paid by the Claimant.

108. As to the first point I have the alternative ATE premium of £347.99 suggested by the Points of Dispute. This has not been produced by any ATE insurer but by the Defendant, offering its own calculation.

109. In my view it remains inappropriate for a Costs Judge, given the guidance offered by Brooke LJ in *Rogers v Merthyr Tydfil,* to simply substitute his or her judgement for that of an underwriter and substitute his or her own premium for the underwriter's. For that reason alone I would be unable to adopt the Defendant's calculation: nor (as an examination of the comparable evidence will show) does the proposed premium appear to bear much if any resemblance to what is actually available on the ATE market.

110. That aside, there are in my view obvious flaws in the Defendant's calculation which make it unsafe to use as a reference point. The express assumption in the Points of Dispute that the actual expenditure on expert reports in this case represents the insurer's maximum exposure, and the accompanying assertion that the (a) premium is three times the amount of exposure, is wrong on any analysis.

111. Mr Corness' alternative suggestion of likely maximum exposure is, like his observations on the likelihood of settlement, based on rather general observations about his experience of clinical negligence cases which – with due respect to his experience – can only have limited value as evidence. It is not supported by the sort of hard statistical evidence to which one might expect the Defendant to have access. It does not meet Mr Laughland's point about clinical negligence cases in which negative reports are received on liability so that the case ends without the prospective Defendant ever hearing about it. It cannot put me in the shoes of an ATE underwriter.

112. In any case the Defendant's case on maximum exposure seems to me to be based upon the proposition that insurance cover should be limited to what is expected to happen. Surely an insurance policy should rather cover what might (within reasonable limits) happen. This case itself illustrates the point: the Defendant needed the advice of experts from four different disciplines in order to concede liability. Had liability been contested the Claimant might have had to do something similar. The evidence I have seen offers no sound basis for characterising an indemnity limit of £10,000 in an individually rated policy, much less a block-rated policy, as unreasonable.

113. Nor do I accept the Defendant's suggested calculation of the particular risk faced by the Claimant at the time of taking out the policy. The Defendant's reliance on its "root cause analysis" (which, as Mr Laughland points out, I have not seen) seems to me to

assume that establishing breach of duty is sufficient to establish causation, in particular in relation to the Claimant's OCD. That is not the same thing and the Defendant's need to consult four experts before conceding liability speaks for itself.

114. Mr Marven submits that the Claimant should have been very confident of recovering some damages, but on the evidence before me that is not necessarily so and it would not be the right test, given that the premium (a) covered the cost of reports addressing the Defendant's liability for OCD.

115. The remaining argument for the Defendant is that, by reference to alternative available cover, the amount of premium incurred by the Claimant is unreasonable. This takes me to the evidence produced on comparable policies.

Conclusions on Comparable Evidence

116. My conclusion is that that the comparable evidence offered by the Defendant does not offer any indication that the amount of premium incurred and claimed by the Claimant is unreasonable.

117. Starting with the pre-April 2013 policies, I cannot accept that it is appropriate for a Costs Judge to entertain broad comparisons of two entirely different types of policy, encompassing different risks, in order to come to a wholly uninformed conclusion that one of them should be less expensive than it is. It might be that such a proposition could be supported by evidence from an underwriting expert but if so the Defendant has not produced it.

118. Mr Laughland submits that the economics and dynamics of the ATE market were wholly different before and after 1 April 2013. ATE premiums were, before that date, recoverable in all personal and clinical injury cases and a claimant's potential liability to pay opponents' costs in all cases made it very much easier to sell ATE policies. The introduction of QOCS and the abolition of recoverability of success fees, together with the cap at 25% of past damages, led to a general expectation that fewer personal injury or clinical negligence claims would be made.

119. I accept that the models needed to set appropriate premium rates would have to be different before and after 1 April 2013. In particular recoverable premiums, for the reasons given by Mr Laughland, represent the cost of insuring a different kind of risk.

120. Mr Corness' comparison between a pre-April 2013 Temple policy and the Claimant's policy also employs hindsight in relation to the actual settlement upon which he relies. He makes no reference to the fact that the pre-April 2013 policy provides for further staged premiums increasing to £22,975.50. The comparison offered between pre-and post – 1 April 2013 ATE policies does not stand up.

121. The post-2013 policies exhibited by Mr Corness are much more to the point. However they do not support the Defendant's case.

122. As I have observed, Mr Pipkin has exhibited evidence of a DAS LawAssist policy which appears to charge a premium calculated at 200% of the actual cost of the liability and causation reports plus premium. Two of Mr Corness' three examples are, similarly, DAS policies dating from after 1 April 2013. The first includes a

recoverable premium of £1,000 + IPT of £60: £1,060. However that is only Stage A of the premium (to the issue of proceedings) and offers a limit of indemnity of £500. The second DAS policy includes a Stage A limit of indemnity of £720 for a premium of £1,440 + IPT.

123. Both policies confirm Mr Pipkin's evidence that the DAS premium is calculated at 200% of cover and in both cases a further individually rated premium is payable at stage B, post-issue. Insofar as the premiums payable under those policies bear comparison to Temple's premium, they do not make it look unreasonable: quite the contrary.

124. Applying the DAS pre-issue formula to this case, Mr Laughland suggests that DAS would at stage A have charged the Claimant (£2,530.80 x 200%): £5,061.60 + IPT. This is little different to Temple's premium of £5,680 + IPT, and Temple's premium is not limited to stage A. Adopting Mr Corness' estimate of overall expert fees of £4,000 - £5,000 then a DAS Policy would have cost, to stage A, more than Temple's policy: something like (£4,500 x 200%): £9,000 + IPT.

125. The third post- 1 April 2013 policy relied upon by Mr Corness is a LAMP policy. The policy schedule shows a premium of £2,000 + IPT, of which £300 plus IPT is for "expert reports and other disbursements" but overall indemnity (including cover provided for adverse costs and own disbursements) is limited to £9,000. Compared to the Temple product, which gives £100,000 cover overall, that is described by Mr Laughland as a very unattractive product. Certainly it does not seem to bear any direct comparison to Temple's. It has not been suggested that the Claimant should have limited her total insurance cover to £9,000 and I would not have accepted any such suggestion had it been made.

126. In any event, as Mr Laughland submits, there is no evidence as to how the LAMP premium was calculated or whether it varies from case to case. It gives me no basis for supposing that the Temple premium might be unreasonable.

Proportionality

127. I am unable to accept Mr Marven's submission that I should, for the purposes of assessing the proportionality of the ATE premium, read the reference in CPR 44.3(5) to "the sums in issue in the proceedings" as referring to the amount of the ATE insurer's exposure so giving me a basis for finding the ATE premium disproportionate by reference to that exposure. That is not what the rule says.

128. In my view it is questionable whether it is right to single out a particular item of cost in applying the post-April 2013 proportionality test. The intention of Jackson LJ, when introducing that test, was that the proportionality of costs as a whole would be considered after costs have been assessed by reference to reasonableness, at which point to court might take the view that the remaining total is still disproportionate and reduce it to a proportionate sum. Jackson LJ has, since the new test was introduced, publicly endorsed that approach and I believe that it is generally adopted on assessment where the new test is applied. I think it may also be wrong, for the reasons advanced by Mr Laughland, to single out one part of the total premium paid by the Claimant for the purposes of judging proportionality.

129. However on the assumption that it is right to do both, considering (as I am required to do) all the circumstances and measuring the premium (as I am required to do) against the criteria set out in CPR 44.3(5), in particular the sums in issue and the complexity of the litigation, it seems to me that premium (a) cannot be said to be disproportionate.

Summary of Conclusions

130. On a proper construction the Claimant's ATE policy complies with statute and the part of the Claimant's ATE premium that relates to experts' reports on liability and causation is, in consequence, recoverable in accordance with statute.

131. It is for the Defendant to establish some case to the effect that the Claimant's ATE premium is unreasonable in amount. In that event, the Claimant would have to address the point. On a standard basis assessment, any doubt would be resolved in the Defendant's favour.

132. The Defendant has not managed to establish any real case to the effect that the (a) premium of £5,680, against cover of £10,000, is unreasonable. The Defendant relies on *Kelly v Black Horse* and *Redwing Construction Ltd v Wishart*, but those decisions concerned individually assessed premiums in which it was evident that at least one factor in the calculation of the premium (the assessment of risk, which a court is well equipped to judge) must have been wrong. There is nothing in this case to justify any such conclusion about Temple's block-rated premium. The arguments offered in support of that proposition invite me to substitute my judgment for that of Temple's underwriters on the basis of broad comparisons which have no validity, and on the basis of calculations and evidence which in my view do not stand up to analysis.

133. Nor does the available comparable evidence furnish any basis for the conclusion that the (a) premium is unreasonable in amount. The Claimant has, on the evidence, made a reasonable choice of ATE policy from such options as were available to her at the relevant time. I do not know whether or not she and her advisers considered the wider market before she committed to Temple's policy but there is no evidence to support any supposition that if they had, they would have found a suitable policy at less expense.

134. The Defendant is concerned that the recoverable ATE premium offered by Temple is not subject to real market competition and that ATE insurers are under commercial pressure to maximise recoverable premiums and minimise irrecoverable premiums.

135. I need more than suspicion or speculation to reduce an ATE premium. In implementing the 2013 reforms Parliament intended that that certain kinds of ATE premium should continue to be recoverable under orders for costs. For that intention to be achieved insurers must be able to offer a compliant product which is realistic and competitive. On the evidence Temple has come up with a compliant, competitive product which the Claimant has accepted.

136. The Defendant points out that reduction on assessment is part of the ATE insurer's "model". It does not follow that I can reduce the recoverable ATE premium, as suggested, by in the region of 95% without affecting the viability of the insurer's product. I do not find that credible.

137. To the extent (which is doubtful) that it is right to consider the proportionality of premium (a) in isolation it is not, by reference to the criteria set out at CPR 44.3(5), disproportionate and does not stand to be reduced on that ground.

138. Being neither unreasonable in amount nor disproportionate the premium is recoverable in full.