Several, or Cumulative causes of injury: is the Def liable for all the injury suffered, or only that caused by his negligence? (A canter through Bailey)

Starting point: Problem: causation issues in medical claims are much more complex than in most cases: RTA case: neg driver runs over Claimant → amputation of his leg: negligent driver liable for loss of leg. Simple.

compare clin neg: C goes to see GP: pain in leg. Diag: v poor circulation of lower leg; needs urgent vascular surgery → has the surgery, which done incompetently; → eventually loss of lower leg, through poor circulation. But: danger of losing leg iae ks of poor circulation. Did the neg of the surgeon cause the loss of the leg? - Ex dfk problem, since the D can contend that he would probably have lost it anyway.

1. This illustrates the **Big, regular causation problem: where several injury has more than one cause:** - the “BONNINGTON CASTINGS” problem.

The law students puzzle: This was a case where the Claimant breathed in silica dust → Pneumo-coniosis Some of it was ‘guilty dust’ (charming phrase) caused by the neg of the employer, but most of it was ‘innocent dust’ from a non-neg source.. HL: the negligence does not have to be the “main” source: the C recovers if the negligence “caused or materially contributed to” the resulting injury – a v famous phrase. So the Defendant was liable for the *entirety* of the injury even though he was prob causatively responsible for a small proportion of it.

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2. Bonningtons was Not a Clin Neg case: So: **TO WHAT EXTENT DOES THIS PRINCIPLE OF SEVERAL CAUSES (SOME NEG, SOME NOT) APPLY TO CLINICAL NEGLIGENCE CASES?**

The recent decision is the case of **BAILEY**, [2008] EWCA CIV 883 in the CA: here there were 2 causes for the permanent brain damage suffered by the Claimant. The findings of the Trial Judge [old Icor man – so jmt bound to be excellent]:

2 causes of that brain damage, one of which was negligent and the other non-negligent. Non-negligent was the pancreatitis which was the cause of her admission to hospital; the negligence was the lack of post-operative care and resuscitation after her first operation, which → such a deterioration in her condition that → weakness → she was not fit enough to undergo a further operation on 12\(^{th}\) January → delay in surgery → Cardiac Arrest. If she had this operation she would have avoided all, or at least some, of the events which led to her cardiac arrest, and resulting brain damage.

Her weakness, J found, was the result of:

(i) the Debilitation due to her pancreatitis – which not due to any neg; and

(ii) the weakness and inability to react to her vomit, which was due to the neg.

(iii) Although it was not possible to say which contributed to a greater or lesser degree, liability was established because the negligence caused had “*contributed materially*” to the overall weakness, and it was the overall weakness that caused the aspiration, and resulting permanent brain damage.

(iv) He therefore found the Defendant liable for the entirety of the injury suffered. The big problem for him was that he was unable on the evidence to find the BF (‘but for’) test satisfied: - he was unable to find on the ev that “*but for the negligence, no injury would have
occurred”. From which it followed that C may have suffered the CA even if there had been no negligence at all.

Def pretty upset at this → appeal. BUT Court of Appeal upheld his decision: it said:

(v) in cases where the evidence proves that “but for” the neg the injury would probably not have occurred at all, → Claimant will obviously be successful; but

(vi) in cases where medical science cannot establish the probability that “but for” the negligence the injury would not have happened, but it can establish that the negligence contributed significantly to the weakness (i.e. its contribution was ‘not negligible’), and that weakness caused the injury, then the “but for” test is modified, and the Claimant succeeds nevertheless.

So came it that the CA upheld the decision that the Defendant was liable for the whole of the ILD suffered even though the Judge was not satisfied that there would have been no injury had there been no negligence.

3. So, as in Bonningtons, there was more than one cause of the injury. Move now to a typical “birth asphyxia” case: Mother in Stage 2 of labour; going on longer than usual being monitored on the CTG: periodic cord compression → fetus starts to become hypoxic [CHPA]. Most fetuses can manage 1 hour; here it goes on for 2 hours before baby delivered. Ev at trial: only after 1 hour was CTG so obviously pathological that dl was mandy; if → Emergency CS → delivery after 1.5 hours. So: fetus suffered hypoxia → permanent brain damage for 30 mins which not due to obstetric negligence; and then a further 30 mins of damaging hypox which was neg. → Big Question:

4. Applying the Bonningtons principles, or the Bailey principles does this mean that in clin neg cases where the Def has only caused part of the injury, he is nevertheless liable in law for the whole?

IMV no, provided that there is ev to enable the J to separate and apportion the damage suffered as between the non neg cause, and the negligent cause of the PERMANENT BRAIN DAMAGE. [Divisible damage]
The answer is to be found in the decision of *Holby v Brigham 2000 Lloyds Med LR 254* as well as: “[20] In my Judgment ...three House of Lords decisions show [that] the onus of proving causation is on the Claimant; it does not shift it to the Defendant. He would be entitled to succeed if he can prove that the Defendant’s tortious conduct made a *material contribution* to his disability. **But strictly speaking, the Defendant is liable only to the extent of that contribution.** However, if the point is never raised or argued by the Defendant, the Claimant will succeed in full as in *Bonnington* and *McGhee*. I agree with the [the Judge] that strictly speaking the Defendant does not need to plead that others were responsible in part. But, at the same time, I certainly think it is desirable and preferable that this should be done. Certainly, the matter must be raised and dealt with in evidence, otherwise the Defendant is at risk that he will be held liable for everything. In reality, I do not think that these cases should be determined on onus of proof. **The question should be whether, at the end of the day, and on consideration of all the evidence, the Claimant has proved that the defendant is responsible for the whole or a quantifiable part of his disability.** The question of quantification may be difficult and the Court only has to do the best it can using its common sense... but in my view the Court **must** do the best that it can to achieve justice, not only to the Claimant but the Defendant, and among Defendants.”

The facts in that case are the Claimant was exposed to asbestos dust for much of his working life including twelve years employment with the Defendant, also during substantial periods of up to five years with other employers. The Judge deducted 25% of the full value of the claim to allow for this contribution from other sources. The CA said “[25]: it might be said that the Judge should have made the Defendants liable to only 50%. If the other employers had been before the Court, then subject to exposure which ought to be considered *de minimis*, I think this is what he would have done. As it is, he erred on the side generosity to the Claimant. No one criticises him for that. This method of dividing responsibility on a *time exposure* basis is, I understand, adopted among insurers in such cases as these. In the absence of some unusual feature ... that seems to me to be not only the sensible, but correct approach in law.”
So: this is the solution, approved by the CA, where there is more than one cause of the injury, and the insults can be separated (e.g because they occur at different times):.

E.g: CHPA case: provided the damage is being caused at approximately the same continuing intensity, the Ct is likely to accept a suggestion from the experts that the insult will have been half as bad, if delivered half way through the damaging insult, and so allow 50% of the full value of the claim.

NOTE: accept that in *Fairchild v Glenhaven [2002 UKHL22]* a special solution was devised for mesothelioma cases – this special principle (Bingham’s “six principles”) take it out of the normal clin neg cases.

5. **A practical example/illustration of this route being applied in a clin neg case:**

*Tahir v Haringey Health Authority, 1998 Lloyds Med LR 104*

(i) The facts here were found by the Judge to involve a delay of 3 hours for the treatment which he held to be negligent. Unfortunately, the Claimant was contending for a 24 hour negligent delay, and the evidence called did not deal in the alternative with a 3 hour delay, and what injury resulted from that. The Judge, having held that the negligence resulted in only a 3 hour delay, having held that the negligence resulted in only a 3 hour delay, is therefore without evidence to assess the extent of the resulting injury, but she went on to make a very rough estimate that it caused £4,000 worth of damage. The Court of Appeal clearly accepted that the hospital would only have been liable for such proportion of injury as was caused by the negligent delay –had the Claimant produced evidence to demonstrate that the delay due to negligence did cause additional injury. In fact, the Claimant produced no such evidence, so there was no clear evidence that the delay in treatment added any injury at all. The Judge felt (probably correctly, but hard evidence was missing) that the delay would in fact have done just that, and so she concluded that a round sum of £4,000 would be a fair reflection of this additional injury due to the negligent delay. The Court held that it was not permissible for the trial Judge to have awarded any damages at all. Otton LJ, giving the
leading Judgment, stated that once a negligent delay was found it was “understandable that she felt (to paraphrase Mustill J) that the Court should make the best estimate that it could. However, I consider that in the absence of any evidence which either identifies or quantifies additional deficit, the arithmetic or apportionment method adopted by [the Judge] ... is not a valid method of assessing damages. Given the appropriate evidence, such an approach, linear or otherwise, might be appropriate but that was not the situation here”.

(ii) Both of the Judges agreed that the task was to identify what additional injury resulted from the negligent delay, but “neither [expert] identified any respect in which the Plaintiff is actually worse of on account of the delay”.

(iii) The importance of this decision (apart from confirming that where in a clinical negligence case part of the damage occurs before the negligence begins to cause damage, and part after that, the Defendant is not liable for the whole of the injury sustained), is to emphasise that the burden of proof is upon the Claimant. Note the words emphasised above; note that the detail of that burden is not high: as Sir Ralph Gibson’s Judgment put it: “If it was common ground, or if the Judge held upon evidence which he accepted that in probability each hour of delay caused significant aggravation of, or addition to, the residual disability suffered by the Plaintiff, then I would agree that the Judge could properly assess damages as she did. The fact that the doctors could not identify any particular form of residual disability resulting from such delay, or precisely quantify any worsening of any form of residual disability as a result of that delay, would not, in my Judgment, deprive the Plaintiff of any right to appropriate damages”.

6. MORAL/CONCLUSION TO BE DRAWN FROM THE ABOVE:

(i) Where the injury is indivisible (e.g. as in the case of Bailey when medical science was unable to identify which injury or level of injury came from which insult), the Claimant recovers in full against the Defendant.
(ii) But if the evidence shows that it is divisible (e.g. because it is over a period of time rather than one moment as in a traffic accident involving two negligent drivers) then the Defendant is liable only to the extent that its negligence contributed to an identifiable or quantifiable part of that injury – provided that the Court is satisfied that it IS divisible.

(iii) If it clearly is shown to be divisible, then the judge will try hard to make a fair apportionment – even where this involves using very crude tools indeed.

7. MORAL FOR DEFENDANT

The key is to provide evidence to satisfy the Judge that the injury is divisible, and, if possible, to provide some basis upon which he can link the period of negligence to an identifiable part of the injury sustained – even if in theory the burden of proof is on the Claimant. Thus in a chronic partial asphyxia case, during the birth of the Claimant, the Defendant should base its evidence, if possible, on trying to prove, for example:

(i) that it was mandatory to deliver by, say, 0600 hours but no earlier; but

(ii) Even if delivered at 0600 hours, extensive damage would nevertheless have been suffered already to the cognitive functions, but none yet to the mobility functions.

(iii) On those findings, the defence could argue that the Claimant was entitled to damages for mobility dysfunction, but not for any cognitive problem. Assuming success in proving those points, then, in my view, this is sound in law, and the Claimant would not be entitled to recover the full value of the claim as if the Defendant were caused the entirety of the injury.
Several, or Cumulative causes of injury: is the Def liable for all the injury suffered, or only that caused by his negligence? (A canter through Bailey)

1. A starting point: *Bonningtons Castings v Wardlaw*¹: did the negligence “cause or materially contribute” to the injury?

2. Does this principle apply to clinical negligence cases? The recent *Bailey v Min of Defence*² decision.

3. Does this mean that in clin neg cases where the Def has only caused part of the injury, he is nevertheless liable in law for the whole? See *Holby v Brigham 2000 Lloyds Med LR 254*

4. [If time:] A practical illustration of this route being applied in a clin neg case: *Tahir V Haringey Health Authority*³.

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¹ 1956 AC 613 [HL]
³ [1998] Lloyds Med LR 104

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