Causation update
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Contextual point 1: In considering causation in clinical negligence cases it is important to be clear about what is “the injury”

1. In clinical negligence claims the distinction often needs to be drawn between the effects of the condition requiring treatment and the alleged consequences of delay in treatment or sub-standard treatment.

2. Any relatively minor effects admitted to result from delay or short-lived sub-standard treatment cannot be used as a “hook” upon which to establish (without more) causation of all consequences of the original condition: per Lord Hoffmann in Gregg v. Scott [2005] 2 AC 176 at [86-7]. See also Wright v. Cambridge Medical Group [2011] EWCA Civ 669 [2011] Med. L.R. 496 at [49 – 52] and [92].

Contextual point 2: The causation of injury by negligence is a relative not absolute concept

3. Lord Nicholls in Kuwait Airways Corp. v. Iraqi Airways [2002] AC 883 posed the question:

[71] In most cases, how far the responsibility of the defendant ought fairly to extend evokes an immediate intuitive response. This is informed common sense by another name. Usually, there is no difficulty in selecting, from the sequence of events leading to the plaintiff's loss, the happening which should be regarded as the cause of the loss for the purpose of allocating responsibility. In other cases, when the outcome of the second inquiry is not obvious, it is of crucial importance to identify the purpose of the relevant cause of action and the nature and scope of the defendant's obligation in the particular

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circumstances. What was the ambit of the defendant's duty? In respect of what risks or damage does the law seek to afford protection by means of the particular tort?

4. See another example by Laws L.J. in *Rahman v Arearose* [2001] QB 351 [2000] 3 WLR 1184, a case involving clinical negligence after an injury resulting from employer’s negligence, at [32]: "The law makes appeal to the notion of a proximate cause" (original emphasis). Having posed it himself at [32] Laws L.J. answers the question "How proximate does it have to be" at [33]:

"[33] … the real question is, what is the damage for which the defendant under consideration should be held responsible." (underlined emphasis added, italicised emphasis original).

5. In *Spencer v. Wincanton Holdings* [2009] EWCA Civ 1404 [2010] PIQR P8 the Court of Appeal essentially found that where a second accident had befallen the Claimant after a negligently caused first accident the boundary of liability was what was “fair”:

[38] ...............I agree with Sedley L.J that, as Lord Nicholls recognised frankly in *Kuwait Airways Corp v Iraqi Airways Co (Nos 4 and 5)* [2002] 2 AC 883 at [70], the courts have to make a value judgment when dealing with the issue of “remoteness of damage”. “Causation” and “remoteness” are two epithets which describe the same process of legal decision making: how to apply responsibility for things that happen. The question is always: having established the facts, what is the extent of the loss for which a defendant ought fairly, or reasonably, or justly to be held liable? (per Aikens L.J with my emphasis);

The “but for” test as the basis of approach

6. In *Barnett v. Chelsea and Kensington HMC* [1969] 1 QB 428, where the Claimant’s husband had been poisoned by arsenic at work, it was established that however negligent a failure to provide treatment, the onus was upon the Claimant to establish that that negligence was causative of her husband’s death. The onus was not discharged where the fatal outcome was inevitable even with prompt and proper treatment.

7. In *Hotson v. East Berkshire HA* [1987] AC 750 Simon Brown J. (as he then was) awarded 25% of damages to a boy whose hip fracture had resulted in avascular necrosis. This was on the
basis that there had been a negligent failure to appreciate the gravity of the fracture and at the time of the negligent failure there were 25% prospects of successful treatment. The House of Lords held that the proper finding was that on a balance of probabilities proper treatment would not have avoided avascular necrosis - the 75% being greater than 50%.

8. In *Wilsher v Essex Area Health Authority* [1988] 1 AC 1074 a premature baby negligently received an excessive concentration of oxygen and suffered retrolental fibroplasia leading to blindness. However the medical evidence demonstrated that this could occur in premature babies who had not been given excessive oxygen, and there were four other distinct conditions which could also have been causative of the fibroplasia. In the Court of Appeal the claim succeeded by a majority who placed reliance on the House of Lords decision in *McGhee v. NCB* [1973] 1 WLR 1. The House of Lords overturned this decision saying *McGhee* was distinguishable. Reliance was placed by the Lords on the dissenting judgment in the Court of Appeal of Browne–Wilkinson VC:

“To my mind, the occurrence of RLF following a failure to take a necessary precaution to prevent excess oxygen causing RLF provides no evidence and raises no presumption that it was excess oxygen rather than one or more of the four other possible agents which caused or contributed to RLF in this case..........A failure to take preventative measures against one out of five possible causes is no evidence as to which of those five caused the injury”.

9. *Barnett, Hotson* and *Wilsher* are all still good law. For instance although specifically discussed (at [36] and [40] respectively) by Lord Toulson giving the judgment of the Privy Council in February 2016, neither *Hotson* nor *Wilsher* were doubted in *Williams v The Bermuda Hospitals Board* (as to which see further below).

The “but for” test applied to a case of negligently late medical referral – the rejection of an attempt to claim for loss of a chance

10. This is the case of *Gregg v. Scott* [2005] 2 AC 176. The Claimant’s GP had failed to refer him in good time for treatment of a developing cancer. The 9 months delay resulted in deterioration in the Claimant’s prospect of “cure” (defined by consent as disease-free survival for 10 years) from 42% at the time of negligence to 25% by the time of trial. The approach of the
Judge at first instance was upheld by the Court of Appeal and the House of Lords (the latter by 3 to 2) to the effect that the Claimant had not established injury caused by negligence. That was essentially because his prospects of cure were never better than 50%. Thus a robust application of the “but for” test.

11. At [90] Lord Hoffmann stated:

“… a wholesale adoption of possible rather than probable causation as the criterion of liability would be so radical a change in our law as to amount to a legislative act. It would have enormous consequences for insurance companies and the National Health Service. In company with my noble and learned friends, Lord Phillips … and Baroness Hale … I think that any such change should be left to Parliament.” (emphasis added)

Save under the *Fairchild* exception material increase of risk of injury will not establish causation

12. Although for many years *McGhee v. NCB* was thought to have been decided upon the basis that causation could in certain circumstances be established by material increase in risk, *Fairchild* stated this not to be the case.

13. Two relatively recent cases have reinforced that proposition: *AB v. Ministry of Defence* and *Williams v. University of Birmingham* [2011] EWCA Civ 1242. In the latter paragraphs [27] to [31] of the Judgment of Aikens LJ make it clear that proof of causation by "material increase in risk" is restricted to cases of mesothelioma meeting *Fairchild* criteria.

14. *Doubling* the risk *may* constitute proof of causation but that is on conventional “but for” grounds (under a balance of probabilities standard): *XYZ v Schering Health Care Ltd* [2002] EWHC 1420 (QB); 70 BMLR 88. However the court has urged caution in the application of such a test: see per Lady Hale at [170] in *Sienkiewicz v. Greif* (referred to further below) and Lord Toulson (giving the judgment of the Privy Council) at [48] in *Williams v. The Bermuda Hospitals Board* (ditto).

The “but for” test is not inviolable – experience has shown it can and will be departed from by the highest court in the name of policy: see *Fairchild* and *Chester v Afshar*.
15. The material contribution test where injury results from more than one source, only one of which has a negligent cause: a concept arising from disease cases and clearly established by Bonnington Castings v. Wardlaw [1956] AC 613. This was recognised as a departure from the but for test in Fairchild (ref below) by Lord Rodger at [129]. However see further below on “material contribution”.

16. The House of Lords took an approach now acknowledged as a clear departure from “standard” causation principles in Fairchild v. Glenhaven [2002] UKHL 22 [2003] 1 AC 32 (impossibility of proving location of material asbestos exposure in cases of mesothelioma). That decision now forms its own enclave. Its effect, potentially rendering a single short term employer liable for the fault of numerous others, was mitigated by Barker v Corus [2006] UKHL 20, [2006] 2 AC 572 permitting time/exposure-based apportionment (see in particular per Baroness Hale in Barker at [121] – [128] cited by Lord Mance in Zurich v IEGL at [30]) only for Barker to be overturned for mesothelioma cases very quickly by section 3 of the Compensation Act 2006. The expansion of the Fairchild approach to cases involving asbestos-related lung cancer was successful but only with the rider that apportionment under Barker follows, as the 2006 Act expressly overturned Barker only as to mesothelioma and not as to lung cancer: see section 3(1)(b) of the Act and Heneghan v. Manchester Dry Docks Ltd. & ors. [2016] EWCA Civ 86. Similarly in Guernsey, where the English common law applies but where there is no equivalent of the 2006 Act, any liability under the Fairchild doctrine falls to be apportioned under Barker: see the Supreme Court decision in Zurich Insurance plc v. International Energy Group Limited [2015] UKSC 33 [2015] 2 WLR 1471.

17. In the context of medical practice see Chester v. Afshar [2004] UKHL 41 [2005] 1 AC 134. The claimant established causation 3 to 2 in the House of Lords for the serious consequences of the materialisation of a small risk about which she had not been warned (as found). She did not seek to prove that she would never have undergone the operation if so warned. As Lord Hoffmann put it:

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2 In Bonnington the presumption (and the basis for analysis of causation) was that the claimant had suffered a single indivisible injury from two separate causes. The irony is that a case such as Bonnington would nowadays be treated as a divisible injury allowing apportionment between competing causes and thus lessening the liability for negligence – see the footnote to this effect at [32] in Williams referred to below. Similarly in 2010 in AB v. Ministry of Defence at [134] Smith LJ said that the Court of Appeal felt that a case such as Bonnington would now be resolved by apportionment of damages rather than the creation of an exception to the but for rule.
The judge made no finding that she would not have had the operation. He was not invited by the claimant to make such a finding. The claimant argued that as a matter of law it was sufficient that she would not have had the operation at that time or by that surgeon, even though the evidence was that the risk could have been precisely the same if she had it at another time or by another surgeon. A similar argument has been advanced before this House.

Ms. Chester succeeded in establishing Mr. Afshar’s liability on a policy basis, namely the enshrining of the importance of properly informed consent to surgery, in the face of two powerful dissenting speeches from Lords Bingham and Hoffmann. Lord Steyn in the majority finding for the Claimant made it clear this was a policy decision:

... [N]ot all rights are equally important. But a patient's right to an appropriate warning from a surgeon when faced with surgery ought normatively to be regarded as an important right which must be given effective protection whenever possible.

... Standing back from the detailed arguments, I have come to the conclusion that, as a result of the surgeon's failure to warn the patient, she cannot be said to have given informed consent to the surgery in the full legal sense. Her right of autonomy and dignity can and ought to be vindicated by a narrow and modest departure from traditional causation principles.

On a broader basis I am glad to have arrived at the conclusion that the claimant is entitled in law to succeed. This result is in accord with one of the most basic aspirations of the law, namely to right wrongs. Moreover, the decision announced by the House today reflects the reasonable expectations of the public in contemporary society.

The importance of properly informed consent as to medical treatment was of course fundamental to the decision of the Supreme Court departing from Sidaway and refining the Bolam test for breach of duty in Montgomery v Lanarkshire Health Board [2015] UKSC 11 [2005] 2 WLR 768.

Trying to maintain the fence
20. Notwithstanding the willingness of the Court to find innovative solutions to difficult causation questions (such as in *Fairchild* and in *Chester v. Afshar*) it has nonetheless sought to maintain causation within principled limits.

21. In *Sienkiewicz v. Greif* [2011] UKSC 10 [2011] 2 AC 229 (an asbestos exposure case) Lord Brown at [183], [186] and [187] and Lord Mance at [189] spoke strongly of the dangers that arise in departing from the “but for” test. As set out above the current position in asbestos cases where liability is established against only 1 of a number of employers is that the victim of one type of cancer (mesothelioma) recovers damages in full under the Compensation Act 2006 whereas the victim of a different type of cancer (lung cancer) recovers only a fraction depending what proportion of his/her working life was spent with the liable employer. Argument can reign over which is the “just” result but the discrepancy seems unjustifiable.

22. An attempt to apply the *Fairchild* approach to a slipping accident on holiday (with very serious consequences) was rejected in *Clough v. First Choice Holidays* [2006] EWCA Civ 15 [2006] PIQR P22:

   [43]…….Accidents like this happen all too frequently, and even though negligence by an identified tortfeasor is established, the question still remains whether the negligence caused the claimant's injuries. A successful claim for damages for personal injuries consequent on negligence or breach of duty requires the court to be satisfied that the injuries were indeed consequent on the defendant's negligence. Even if it may have some application in different situations, the distinction sought to be drawn by Mr Burton between material contribution to damage and material contribution to the risk of damage has no application to cases where the claimant's injuries arose from a single incident. In this Court any modification of the principles relating to causation in the context of claims for damages for personal injury must be approached with the greatest caution (Per Lord Judge P.)

23. In *Gregg v. Scott* (see above) the Court applied robust “but for” principles on a balance of probabilities test and rejected any claim for loss of a chance. This stance was maintained in *Wright v Cambridge Medical Group* [2011] EWCA Civ 669 [2013] QB 312: see per Lord Neuberger at [85].

24. In the *Atomic Veterans* case (*AB v. Ministry of Defence* [2012] UKSC 9 [2013] 1 AC 78) the Supreme Court in considering causation issues within an argument on limitation applied its own
striction from *Sienkiewicz v. Greif* (see above) and agreed with the Court of Appeal in saying that save in a Fairchild case material increase in risk will not suffice to establish causation: see per Lord Wilson at [27], Lord Brown at [75] - [77], Lord Mance at [86] and Lord Phillips at [156] – [158]. Note Lord Phillips dissented in the result but still saw the claims as put as likely to fail on causation.

### “Material contribution to injury” in a case of clinical negligence

25. Somewhere between “but for” and material increase in risk comes material contribution to injury. It is important to state at the outset that as is clear from what follows save for the very specific “Fairchild exception”, the court compensates for material contribution to injury, *not* material increase of risk of injury: see *Heneghan* per Lord Dyson MR at [45].

26. In *Bailey v. Ministry of Defence* [2008] EWCA Civ 883 [2009] 1 WLR 1052 it was held by the Court of Appeal that it was sufficient for the Claimant to establish liability for injury resulting from clinical negligence where the negligence made a *material contribution* to the injury, a concept imported from disease cases in personal injury, particularly *Bonnington*. In *Bailey* the MoD as managers of a hospital appealed unsuccessfully against a judgment of Foskett J. which held them liable for serious brain damage suffered by the claimant following cardiac arrest caused by aspiration of vomit. The cardiac arrest occurred at an NHS hospital to which the Claimant had been transferred and was allegedly caused by a lack of care during an earlier period of about 20 hours at the MoD hospital. The judge held that the physical cause of the claimant’s aspiration and subsequent cardiac arrest was her weakness and inability to react to her vomit, and that the contributory causes of the weakness were (a) the negligent post-operative care at the MOD's hospital and what flowed from that and (b) pancreatitis (a non-negligent cause), each of which had made a material contribution to her overall weakness. Thus he held causation to be established, following *Bonnington*.

27. The Court of Appeal expressed no difficulty in dismissing the appeal. It held that in a case where medical science could not establish the probability that "but for" an act of negligence the injury would not have happened but could establish that the contribution of the negligent cause was more than negligible, the "but for" test was modified, and the claimant would succeed. In Mrs. Bailey’s case cumulative causes (including the negligent cause) had acted so as to create a weakness and thus the judge had applied the right test. It is important to note that the court steps in and applies the “material contribution” approach where medical science cannot provide an answer (see
eg per Waller LJ in Bailey at [46]). This is to be distinguished from a case where medical science could provide the answer but the claimant simply does not have the supportive evidence.

28. Bailey v. MoD was followed and applied in

(a) Canning-Kishver v Sandwell & West Birmingham Hospitals NHS Trust [2008] EWHC 2384 (QB) (Claimant succeeded where would have failed on pure “but for” test and where other non-negligent causes of atrophy of the neonatal cerebellum could not be ruled out)

(b) Ingram v. Williams [2010] EWHC 758 (QB); [2010] Med. L.R. 255 (birth injury claim - Claimant failed on breach of duty but would have succeeded in full on causation even though clearly other contributing factors to substantial disability)

(c) Popple v Birmingham Women’s NHS Foundation Trust [2011] EWHC 2320 (QB) (a birth injury claim – application of Bailey not crucial to outcome),

(d) Ceri Leigh v London Ambulance Service NHS Trust [2014] EWHC 286 (QB) [2014] Med LR 134 (PTSD from episode of dislocating knee as sitting down on bus – held negligent 17 minute element of 51 minute wait for ambulance was causative of entire PTSD)

29. Attempts to apply Bailey have failed where the Court was not satisfied on the expert evidence that the breach of duty had made a material contribution to the outcome:

(a) Appleton v Medway NHS Foundation Trust [2013] EWHC 4776 (QB)

(b) ST v Maidstone & Tunbridge Wells NHS Trust [2015] EWHC 51 (QB) [2015] Med LR 70

Williams v. The Bermuda Hospitals Board

30. The issue of establishment of causation by material contribution was revisited by the Privy Council in Williams v. The Bermuda Hospitals Board [2016] UKPC 4 [2016] 2 WLR 774. In that claim there was negligent delay in obtaining and considering a CT Scan in a case of rupturing appendicitis. The consequent delay in commencement of the operation to deal with abdominal sepsis was between 2 hrs 20 mins and 4 hrs 15 mins. Pus from the appendix’s rupture had caused myocardial ischaemia and consequent complications necessitating a period on life support in the ICU. The claimant had subsequently made a good recovery but the injury at issue was the deterioration necessitating the period in ICU. It was held that the rupturing process had begun
during the period of negligent delay and continued until operation. It could not be established that the rupture (with leaking sepsis) would not have occurred at all but for the negligent delay.

31. The claimant had failed at first instance upon the basis that it had not been established on the evidence that an earlier operation would have avoided the stormy post-operative course. The Court of Appeal of Bermuda overturned that finding, purporting to apply Bailey and holding that the prolongation of the period of sepsis made a material contribution to the need for ICU treatment.

32. The Privy Council dismissed the Hospital Board’s appeal on the basis that by allowing contamination by sepsis to go on longer than would have been the case the negligent delay was sufficiently causative to render the Hospital Board liable for all of the consequences of sepsis. The Privy Council expressly applied Bonnington and holding it indistinguishable where the two combining causes were sequential as in Williams (non-negligent period of sepsis followed by negligent period of sepsis) rather than simultaneous as in Bonnington (dust from negligent and non-negligent sources).

33. The Privy Council then went on obiter to discuss Bailey. Curiously the conclusion was that Bailey was a case of “but for” causation. After reciting at [46] an extract from the first instance judgment in Bailey of Foskett J. Lord Toulson said at [47] that the Court of Appeal in Bailey had been incorrect to see it other than as a “but for” case. He said that because “the totality of the claimant’s weakened condition caused the harm” then Bailey was a “but for” case. The cotemporaneous non-negligent weakness merely heightened the claimant’s vulnerability to negligently caused weakness and the egg-shell skull rule applied. With great respect this does not seem a satisfactory analysis. The case of Williams does seem to be an application of Bailey.

34. The other potentially unsatisfactory aspect of this line of authority is the dependence upon judicial inference as to medical cause and effect and in particular as to whether or not negligence made a material contribution to the injury. In Bailey an inference was drawn by the Court as to the effect of the negligence on the Claimant’s ability to resist aspiration of her vomit: see [32] of the Court of Appeal judgment where the point was said to be “a statement of the obvious”. Underpinning that inference was a separate inference by Foskett J. that the claimant was still suffering material weakness as at 26 January from a stormy course lasting from 11/12 January to 19 January (see para [60] of Foskett J judgment cited in Williams at [46]). In Williams itself the Privy Council held (at
that it was entitled “to infer on the balance of probabilities” that the negligent delay made a material contribution to the injury (emphasis added).

35. In both Bailey and Williams the court presumed to treat the inference it made as straightforward, but is it right to do that without evidence, especially if the result is liability for an entire injury that \textit{ex hypothesi} the defendant did not solely cause? Furthermore what is the answer in more difficult cases where inferring a material contribution is not “a statement of the obvious”? If some cases require evidence of material contribution why not all?

\textit{John v Central Manchester NHS Foundation Trust}

36. Williams was considered and applied in \textit{John v Central Manchester NHS Foundation Trust} [2016] EWHC 407 QB [2016] 4 WLR 54 (Picken J.). The claimant suffered a significant head injury (acute sub-dural haematoma) in a fall and was admitted to hospital. It was held there was negligent delay in undertaking a CT scan and further negligent delay in arranging transfer by ambulance for the necessary neurosurgery. It was found as a fact that pre-operatively the claimant had suffered raised intracranial pressure (“ricp”) which lasted 7 hours before decompressive surgery (see [71-2]), of which approximately 5\frac{3}{4} to 6 hours was negligent delay (see [79]). The claimant was left with a global cognitive deficit with some impairment of executive function.

37. The claimant accepted (at [82]) he could not succeed on a “but for” basis. Essentially he accepted there would have been some residual effect from his original injury and from a non-negligent post-operative infection.

38. Prior to trial the hospital maintained (see [91]) that Bonnington, Bailey and Williams had no application, because the approach in such cases was limited to “single agency” injuries, whereas in this case there were three (original injury, ricip and infection). It was argued that the approach should be as under Wilsher and the claim should fail.

39. In closing submissions at trial the hospital effectively accepted causation was established but sought to argue as a fallback position that apportionment was appropriate (see [92-4]). The judge stated at [97] this concession was rightly made. The hospital sought to rely upon \textit{Holby v Brigham & Cowan (Hull) Ltd} [2000] ICR 1086, a case of asbestosis (a dose-related divisible injury) where an employer’s liability was held by the Court of Appeal to be limited to an apportioned
share of the total. The argument was that since the case was not a “single agency” case (there were 3 potential causes of the brain damage) then the *Holtby* approach was appropriate. This argument was rejected by the judge. He held that the approach in *Bonnington* and *Bailey* was not restricted to single agency cases, citing *obiter* passages from *Wilsher* to support that conclusion: (see [95 – 97]) and held that once causation of injury was established by material contribution then there was no question of apportionment: see [98-101].

40. Since the judge held
   a) that the claimant had been the victim of approximately 5 ¾ to 6 hours of negligent delay [79]
   b) that the claimant had suffered damaging ricp for a total of about 7 hours [68]
   c) that ricp had made a material contribution to the brain injury and its effects [102-104]
he concluded that the claimant was entitled “to recover without deduction”: see [105].

41. However there then seems to have been an inconsistency in the claimant’s approach to the assessment of damages. The general damages assessment (at [107]) did not expressly factor in any reflection of pain suffering and loss of amenity that would have been suffered in any event. No reduction was permitted to the relatively very modest claim for past care and assistance (see [108]) to reflect care and assistance that would have been required given the initial injury (and potentially the non-negligent post-operative infection).

42. However in his claim for past loss of earnings the claimant sought an assessment based upon the premise that 6 months’ absence would have been necessitated by the original head injury ([109]) and furthermore the rate sought for past and future loss of earnings was calculated upon a “but for” basis, making the assumption that in any event regardless of negligence “[the claimant] would have suffered some minor cognitive deficits that would have prevented him working as a GP” (see [111]). Thus instead of claiming loss of the “substantial” earnings as a GP working as a locum in 5 surgeries and as a prison doctor (see [2]) the “but for” salary put by the claimant as the basis of his loss of earnings claim was only £25,000. The Judge assessed the loss of earnings claim by taking a broad brush approach and saying the likely earnings were £20,000pa saying (at [113]) “it seems to me that on a balance of probabilities, [the claimant] would have struggled to earn at a level of £25,000 per annum.” No one seems to have appreciated this approach was entirely at odds with the finding at [105] that the claimant was entitled “to recover without deduction.” That is
especially so given that the judge later restated the point that no apportionment of damages was appropriate at [120].

Reaney v. University Hospital of North Staffs

43. The approach to the assessment of damages in John v Central Manchester should be considered in the context of the decision in Reaney v. University Hospital of North Staffordshire NHS Trust [2015] EWCA Civ 1119 [2016] PIQR Q43.

44. In Reaney the defendant hospital had negligently allowed serious bedsores to develop in a patient in her late 60s who would in any event have suffered the effects of severe spinal injury (T7 paraplegic). It was common ground that her spinal injury would have necessitated some care (a few hours a week initially rising to 31.5 hours per week at age 75). It was also common ground that as a result of the existence of the long term effects of the bedsores the claimant would need significantly more care (2 carers for 24 hours per day) with a consequent accommodation need. The trial judge Foskett J. found that the need for physiotherapy was also increased from 6 then (at age 70) 12 sessions pa to 18 and 24 sessions respectively.

45. The trial judge over two hearings awarded and then assessed as recoverable the entire cost of care and physiotherapy upon the grounds that the tortfeasor had to take the claimant as it found her and that a superimposed injury on an existing disability can have a much greater effect than if suffered in isolation. He reached his conclusion on a “but for” basis but went on to say he would have relied if necessary upon Bailey to hold that the defendant’s negligence had materially contributed to the claimant’s overall disability. He also purported to follow a decision of Edwards-Stuart J in Sklair v Haycock [2009] EWHC 3328 (QB).

46. The Court of Appeal held this was the wrong approach. It applied the approach in Steel v. Joy [2004] EWCA Civ 576 [2004] 1 WLR 3002 (following Performance Cars v Abraham [1962] 1 QB 33) in saying that a tortfeasor could not in any circumstances be liable for a loss that had already occurred before his negligence: see in particular in paras. [16 - 18]. Thus the claimant could not recover damages to meet a loss or need which had already arisen – whether or not the claimant had actually received compensation to meet that loss or need: see [17] citing para [70] of Steel v. Joy and see further below.
47. The slight qualification was as to a distinction (at [19] and stated as common ground between the parties) between a need which was quantitatively changed by the occurrence of the second incident (the tort) and a need which was qualitatively changed. In the former case ie “more of the same” then only the excess is recoverable. If the latter then all is recoverable. There was no further definition. It was submitted in Reaney (at [23-4]) that both the care and the physiotherapy needs were qualitatively different because of the negligence but the court was not persuaded on either point (see [25]) and on that basis the judge’s conclusion that all such costs were recoverable could not stand. The same applied to the judge’s conclusions about other heads of claim (see [26]). Thus the matter was remitted to the judge for a reassessment (see [37]).

48. The Court of Appeal went on to make 3 points (obiter):

a) it is irrelevant whether or not the claimant is actually in receipt of compensation to meet needs arising from the pre-existing injury or condition ([28-9])

b) the decision in Sklair was considered (at [30-33]) – the decision was correct if seen as one of causation of the major loss (the need for 24 hour care) which the Court of Appeal in Reaney said (at [32]) could be described as “qualitatively different” to the regime originally contemplated

c) Bailey had no relevance to the issue in Reaney. Causation of the relevant injury (severe bedsores) was not in issue. What was in issue was to what needs that injury gave rise as distinct from pre-existing needs. Bailey was not relevant on that question.

49. This decision still appears to leave open room for argument as to what is a quantitative change and what is a qualitative change. If the result of classifying a need arising from the latter is to award damages in full even where the earlier need was significant then one would expect that a qualitative change must be something properly regarded as completely novel.

Considering John and Reaney

50. The principle in Reaney should have underpinned the approach in John v. Central Manchester. The claimant Dr John had a pre-existing condition (a significant head injury causing acute subdural haematoma) for which he could not recover compensation from the hospital however badly it treated him. It matters not in principle whether the pre-existing injury occurred 6 years or 6 hours previously. However difficult the task the court should have been invited to assess likely needs arising from that injury regardless of any subsequent negligence. It might be that for the subsequent
events then an inability to separate the effects of the negligent delay and the post-operative infection would have made the hospital liable for all of those consequences on a “material contribution” basis, but there was still a need to differentiate that aspect from the likely effect of the original injury.

51. The irony is that the claimant himself effectively did this for the court and the defendant in the claim for loss of earnings which as put was relatively very limited (see above). It is a puzzle as to why no-one thought that that approach needed to be applied across the board to all heads of claim. On the other hand since the loss of earnings claim made up the greater part of the eventual award (approx. £300,000 of the £450,000 awarded) then no great injustice was done.