Cause & effect

Chris Pamplin looks back at clinical negligence case law and finds a relaxation in the burden of proof

IN BRIEF

- Causation in negligence cases has historically been determined by the "but for" test.
- The courts will depart from the *but for* test if it can be established that the defendant's negligence made a "material contribution" to the injury.

Causation in negligence cases has traditionally been determined by the "but for" test. However, in complex cases, while the experts might agree that a clinical practitioner fell short of the standard of competence expected of the profession, they might be unable to agree that it was this negligence that caused the claimant's injury. Three cases offer insights to how the courts deal with such a situation.

Telles v SW Strategic Health Authority

In *Telles v South West Strategic Health Authority* [2008] EWHC 292 (QB), a one-day-old child was found to have a heart defect and a high level of metabolic acidosis. Following the diagnosis, the child was admitted to the Bristol Children's Hospital for treatment. She subsequently underwent three operations. Following the enquiry into the cases of children's heart surgery at the Bristol Royal Infirmary, a claim was brought, on behalf of the child, maintaining that:

(i) the surgeons had been negligent in the first operation;
(ii) there had been further negligence in the clinical care received between the first and second operations; and
(iii) there had been further negligence during the third operation.

Upon hearing evidence, the court decided that clinical negligence had occurred only in connection with the first of the operations.

The difficult question then posed was the extent to which this negligence had resulted in the injury to the child. The child had suffered from periventricular leukomalacia (PVL). The issue to be determined was whether she had had this condition before the first operation, or whether the damage had developed after the first operation and prior to the second. In the former case, the negligence could not be the cause of the damage. In the latter case, the child's condition would most likely have been caused by the negligence.

The judge found on the evidence that the PVL was caused by hypoxia which the first operation had failed to cure because of a kinked and blocked shunt. In fact, the child had remained hypoxic from about 2.5 days before the first operation, right through until the second operation. This amounted to 15% of the whole of the damaging period. The expert evidence indicated that, from a scientific viewpoint, the amount of damage caused during that period was impossible to quantify and that it was anyway unlikely that damage would have been suffered equally over the whole period.

Did the negligence in this case satisfy the "but for" test on causation? Probably not. But the parties had agreed that if the judge was unable to make any apportionment between the two periods, then the child was entitled to full compensation.

Telles serves to highlight the difficulties posed by the "but for" test in cases where science is unable to make an apportionment and only part of the claimant's medical condition can be attributed to the defendant's negligence.

Bailey v MoD and Portsmouth Hospitals

In *Bailey v Ministry of Defence and Portsmouth Hospitals NHS Trust* [2007] EWHC 2913 (QB), a patient with obstructive jaundice suffered acute pancreatitis and serious internal bleeding following the failure of an operation to remove a gallstone. To stop the internal bleeding, the patient underwent a percutaneous trans-hepatic cholangiogram (PTC). However, during this procedure, she suffered a tear in the liver which caused further bleeding. An emergency laparotomy was undertaken the following day and the patient eventually suffered a cardiac arrest which resulted in permanent brain damage. It was alleged that the post-operative procedures had been at fault and that appropriate resuscitation had not been given in a timely fashion. It was alleged that this failure had caused the patient to be more ill than she would otherwise have been and had prevented a second operation from taking place shortly after the first to remove the gallstone.

The experts in this case took the view that the pancreatitis could have developed anyway, and they were unable to state that

the patient's arrest had resulted from the failure to give appropriate resuscitation after the first operation. It was generally agreed, however, that if appropriate resuscitation had been given, the patient would have been fit for a further operation the following day to remove the gallstone and check for bleeding. If this had been done, there would have been no need for the later PTC and there would have been no resulting damage to the liver.

Causation, then, was an exceedingly difficult question for the court to decide. It was impossible for expert evidence to prove that, but for the defendant's negligence, the cardiac arrest would not have happened.

Foskett J held that, although it had not been established that the cardiac arrest would not have happened if there had not been negligence on the part of the defendant, the claim should succeed because the negligence had "materially contributed" to this uncertainty. The evidence was that the patient had arrested when she aspirated after vomiting, and that she aspirated because of debilitating weakness which, the judge found, was caused partly by the pancreatitis and partly by the consequences of the defendant's negligence.

Boustead v NW Strategic Health Authority

In June 2008, Mackay J handed down his judgment in *Boustead v North West Strategic Health Authority* [2008] EWHC 2375 (QB). It was claimed that the medical care provided by the defendant hospital to the claimant and his mother was negligent and caused him to suffer an intraventricular haemorrhage (IVH) which resulted in brain damage leading to cerebral palsy.

The mother was young (14) and had concealed her pregnancy. She was admitted to hospital suffering loss of blood and period-like pains when she was already 28 weeks pregnant. She had further episodes of bleeding, and two days later decelerations of the foetal heart were seen. The consultant took the view that the pregnancy should be allowed to progress as he believed that, given the age of the mother, this posed less of a risk to her than a caesarean section.

The problems appeared to settle until five days later, when fresh blood loss and irregular contractions were recorded. Over the next 24 hours, the situation worsened with the mother showing signs of fulminating pre-eclampsia. Following consultation with colleagues, the consultant took the decision that the baby should be delivered vaginally and labour was induced by administering the drug syntocinon.

Repeated decelerations of the foetal heart were recorded and the syntocinon dose was initially halved but then increased. The claimant child was born later that day, eight days after the mother was first admitted to hospital. The baby suffered IVH in the first day of life, and this led to hydrocephalous, cerebral infarction and PVL.

Experts agreed that when decelerations of the foetal heart were first detected, the foetus was hypoxic but that it did not necessarily follow that hypoxic damage was being caused. However, the claimant's expert gave evidence that the decision to give syntocinon was inappropriate given the clear evidence of deceleration, and said that a reasonable obstetrician would have opted for a caesarean section at that point.

The judge rejected allegations that there had been negligence in failing to carry out a caesarean section after the mother had been in hospital for two days when there had been some evidence of foetal distress. However, the court agreed with the claimant's expert that the consultant had been negligent in his response to the mother's developing fulminating pre-eclampsia when, just under one week later, he had induced labour in preference to a caesarean section which would have ensured delivery of the child at least four hours earlier.

The causation issues were, again, difficult in this case. Given the mother's age and the stage the pregnancy had reached, it was argued that the principal patient was the mother, and the baby's prospects for survival were not good. The court agreed that, at least in the early stages, the consultant had followed clinical procedures that would have satisfied the tests in *Bolam v Friern Hospital Management Committee* [1957] 2 All ER 118 as modified by *Bolitho v City and Hackney Health Authority* [1998] AC 232. It was the procedures that had been followed once the decision had been taken to induce birth that were called into question.

The team had been clinging to a strategy that was no longer defensible, given that both the mother and the foetus were at risk at that stage. All the experts agreed that 10–20% of babies born at 28 weeks' gestation would go on to develop IVH. When all the risk factors that had been identified in this case were present, they agreed that more than 50% of babies with this combination of factors would develop some degree of IVH. The experts were, however, unable to identify or quantify the individual causal contribution made by each factor, including the decision to induce a vaginal delivery in preference to a caesarean section.

The court in this case decided that the hypoxia at birth had made a material contribution to the development of the IVH. Hypoxia would have been avoided if delivery had been by caesarean section. It was held that, accordingly, causation was established and the defendants were responsible for the claimant's injuries.

A lower burden of proof

The effect of the judgments in *Telles*, *Bailey* and *Boustead* is that in a relatively few cases there will be circumstances that allow the courts to find in favour of a claimant, even where the expert evidence fails to establish a causal link between the negligence and the injury. It appears that the courts will depart from the "but for" test if it can be established that the defendant's negligence made a "material contribution" to the injury and that such contribution is significant and more than *de minimus*.

There is, however, a distinction to be drawn between cases featuring a cumulative effect and those where there are a number of alternative possibilities for the cause of a claimant's injury. In the latter case, with no way of choosing one of the alternatives, there is no way to prove material contribution.

Conclusion

It is likely the gradual shift in the causation test is driven by public policy concerns, and the number of cases in which material contribution will be considered is likely to be small. The essential identifying factor in such cases appears to be that the negligence made a material contribution to the injury, and that: (i) the part of the injury that would have been caused in the absence of the negligence was unquantifiable; and (ii) the negligent cause formed part of a cumulative series of causes. NLJ

Dr Chris Pamplin is the editor of the *UK Register of Expert Witnesses* and can be contacted on *nlj@jspubs.com*. Website: *www.jspubs.com*