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King's Bench Walk

Crossover Claims

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What is a Crossover Claim?

- A claim where a clinical negligence claim is superimposed on a personal injury claim

- I.e. an accident which has caused injury which is then followed by negligent treatment of that injury. For example:

  - An accident at work causing a spinal bleed – bleed is missed by A&E and C becomes paraplegic
  - RTA causing fracture – inadequately fixed by orthopaedic surgeons – non-union and permanent symptoms
  - Football tackle causing leg fracture – infection develops - amputation

An Attractive Proposition for an Insurer?

- Take a road traffic accident with a neck injury to a blameless claimant leading to a complete spinal cord injury that with proper treatment would have been far less serious. The RTA insurer pays out and if the hospital had been negligent that would be no concern of the claimant's legal team. But the insurers would be paying in full for something that they might only be modestly responsible for. A claim brought by the insurers against the medical providers may lead to a reduction in the damages payable by the insurer.

An Attractive Proposition for a Claimant?

- Now look at it from the point of view of a claimant who is in the firing line for a finding of contributory negligence for his role in causing the road traffic accident, say 50%. Contributory negligence is probably not going to attach to the clinical negligence element so only the damages awarded against the other RTA party will be deducted.

A Bold New Direction?

- Consider the example of a claimant who is in a RTA. The claimant suffers minor head injuries, and psychiatric injury. A neurologist is instructed two years on and negligently constructs a thesis of a severe brain injury from which the claimant will not recover much further. The psychiatrically-vulnerable claimant nosedives, with long-term consequences. Why should the insurers of the RTA defendant pay for that nosedive?
- Strictly speaking this is prof neg, rather than clin neg

Communities of Interest

- The advantage for both claimant and defendant of a claim against clinicians (assuming it is appropriately brought) may be that a community of interest may develop between claimant and defendant on the medical evidence as to condition and prognosis.
- The same may however be true for the defendant – join the hospital and in appropriate cases there may be another set of medical experts alleging exaggeration.

Breach of Duty in Clinical Negligence (1)

- Clinical negligence claims have a different test for standard of care.
- The basic test in any ordinary negligence claim is whether the putative defendant's acts or omissions fell below the appropriate standard, and if so s/he is negligent, if he fails to do what a reasonable person would in the circumstances. When a person professes to have professional skills, as doctors do, the standard of care must be higher. McNair J in *Bolam v Friern Hospital Management Committee* put it this way in what has become known as the Bolam test.
- "I myself would prefer to put it this way, that he is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art. I do not think there is much difference in sense. It is just a different way of expressing the same thought. Putting it the other way round, a man is not negligent, if he is acting in accordance with such a practice, merely because there is a body of opinion who would take a contrary view. At the same time, that does not mean that a medical man can obstinately and pig-headedly carry on with some old technique if it has been proved to be contrary to what is really substantially the whole of informed medical opinion. Otherwise you might get men today saying: "I do not believe in anaesthetics. I do not believe in antiseptics. I am going to continue to do my surgery in the way it was done in the eighteenth century." That clearly would be wrong."[1]
- [1957] 1 WLR 582

Breach of Duty in Clinical Negligence (2)

- The case of *Bolitho v City & Hackney Health Authority* added a layer: where evidence is given that other practitioners would have adopted the method employed by the defendant doctor, it must be demonstrated that the method was logically defensible [1997] 3WLR 1151

But it may just be administrative error

- Failure to make referral for tests
- Failure to report tests
- Failure to notify patients of appointments or test results
- Negligent advice about waiting times
- Don’t forget that GP surgeries, not just hospitals can be in the mix

Rule of Thumb

- A rule of thumb in all cases of any seriousness is to ask whether the outcome is surprising. If it is then investigation is needed.
- However even in cases where there may be low expectations of treatment, for example some of the pain cases, it will be worth considering if there is clinical negligence.
- For example where over-medication and lack of adequate review has created a morphine dependency/materially degraded prospects for recovery

Civil Liability (Contribution Act) 1978 s1

- (1) … any person liable in respect of any damage suffered by another person may recover contribution from any other person liable in respect of **the same damage** (whether jointly with him or otherwise).

- (4) **A person who has made or agreed to make any payment** in bona fide settlement or compromise of any claim made against him in respect of any damage (including a payment into court which has been accepted) **shall be entitled to recover contribution in accordance with this section without regard to whether or not he himself is or ever was liable** in respect of the damage, provided, however, that he would have been liable assuming that the factual basis of the claim against him could be established.

Civil Liability (Contribution Act) 1978 s2

- (1)Subject to subsection (3) below, in any proceedings for contribution under section 1 above the amount of the contribution recoverable from any person shall be such as may be found by the court to be **just and equitable** having regard to the extent of that person's responsibility for the damage in question.

- (2)Subject to subsection (3) below, the court shall have power in any such proceedings to exempt any person from liability to make contribution, or to direct that the contribution to be recovered from any person shall amount to a complete indemnity.

Civil Liability (Contribution Act) 1978 s2

(3)Where the amount of the damages which have or might have been awarded in respect of the damage in question in any action brought in England and Wales by or on behalf of the person who suffered it against the person from whom the contribution is sought was or would have been subject to—

(a) any limit imposed by or under any enactment or by any agreement made before the damage occurred;

(b) any reduction by virtue of section 1 of the Law Reform (Contributory Negligence) Act 1945 or section 5 of the Fatal Accidents Act 1976; or

(c) any corresponding limit or reduction under the law of a country outside England and Wales;

the person from whom the contribution is sought shall not by virtue of any contribution awarded under section 1 above be required to pay in respect of the damage a greater amount than the amount of those damages as so limited or reduced.

Chain of Causation (1)

- Older cases often tended to look at a later tort and conclude that the chain of causation was broken.
- However post-war the law moved decisively away from the proposition that subsequent negligence would break the chain of causation.
- In *Rouse v Squires* an obstruction was negligently created on the M1 when Lorry 1 jack-knifed. Almost immediately, and without fault, a car collided with Lorry 1. The car's rear lights remained illuminated. Lorry 2 observed the collision and came to a halt, itself illuminating the obstruction with its headlights. Lorry 3 being driven too fast crashed into the second lorry, causing it to crush the claimant who waschelping out in the vicinity of the original collision. The Court of Appeal held that the negligence of the driver of the third lorry did not break the chain of causation between the driver of Lorry 1's negligence in blocking the road and the claimant's death. Lorry 1's driver was held 25% to blame for the claimant's death. [1973] QB 899

Chain of Causation (2)

- On the other hand, in *Knightley v Johns* a road tunnel was blocked by negligent driving. A police inspector took charge. He did not immediately close the tunnel. He later instructed police motorcyclists to ride the wrong way back through the tunnel, against the traffic, to ensure that the tunnel was closed. One of the motorcyclists was hit by a third driver who was driving too fast into the tunnel. The Court of Appeal absolved the driver who blocked the tunnel of liability; the police inspector's conduct broke the chain of causation. Stephenson LJ :
- "Negligent conduct is more likely to break the chain of causation than conduct which is not; positive acts will more easily constitute new causes than inaction; mistakes and mischances are to be expected when human beings, however well trained, have to cope with a crisis; what exactly they will be cannot be predicted, but if those which occur are natural the wrongdoer cannot, I think, escape responsibility for them and their consequences simply by calling them improbable or unforeseeable. He must accept the risk of some unexpected mischances."

[1982] 1 All ER 851

Chain of Causation (3) – A Trip to Australia

- In *Mahoney v Kruschick Demolitions* Gibbs CJ held that foreseeability of consequences of the first in time tort was the key, and analysed situations where the chain of causation would be broken:

- “However, in the ordinary case where efficient medical services are available to an injured plaintiff, the original injury does not carry the risk of medical treatment or advice that is "inexcusably bad" (*Martin v. Isbard* (1946) 48 WALR 52, at p 56), or "completely outside the bounds of what any reputable medical practitioner might prescribe" (*Lawrie v. Meggitt*, at p 8) or “so improper that it is in the nature of a gratuitous aggravation of the injury" (*South Australian Stevedoring Company Limited v. Holbertson* (1939) SASR 257, at p 264) or "extravagant from the point of view of medical practice or hospital routine" (Hart and Honore Causation in the Law, (1959), p.169). In such a case, it is proper to regard the exacerbation of a plaintiff's condition as resulting solely from the grossly negligent medical treatment or advice, and the fact that the plaintiff acted reasonably in seeking and accepting the treatment or in following the advice will not make the original tortfeasor liable for that exacerbation.”

(1985) 156 CLR 522

Chain of Causation (4) – Back to Blighty

- In *Webb v Barclays Bank PLC and Portsmouth Hospitals NHS Trust*, the claimant fell and injured her leg as a result of the negligence of her employer. Surgical negligence led to the injured leg being amputated when it should not have been. The Court of Appeal dealt with a claim for contribution by the employer against the hospital. It cited *Mahoney* with approval. Henry LJ went on to set out and to agree with the following passage from Clerk & Lindsell (18th Edition 2-55):

- "Moreover, it is submitted that only medical treatment so grossly negligent as to be a completely inappropriate response to the injury inflicted by the defendant should operate to break the chain of causation."

- The Court held that the surgeon's negligence, in advising amputation without first sufficiently investigating and then explaining the alternatives, was not gross negligence and therefore did not break the chain of causation. Using its powers under the Civil Liability (Contribution) Act 1978, the Court assessed the responsibility of the employer at 25% and the surgeon at 75%.

[2002] PIQR P61

Chain of Causation (5) – Webb Continued

- "We have in mind that:
  - the original wrong-doing remained a causative force, as it had increased the vulnerability of the claimant and reduced the mobility of the claimant over and above the effect of the amputation;
  - the medical intervention was plainly foreseeable, and it was also foreseeable that the claimant's pre-existing vulnerability would impose its own risks;
  - given the doctor's conduct was negligent, but not grossly negligent, and given the findings expressed at a) and b) it would not be just and equitable, nor in keeping with the expansive philosophy of the 1978 Act for the wrongdoer to be given, in these circumstances, a shield against i) being liable to the claimant for any part of the amputation damages; and ii) being liable to make such contribution to the Trust's amputation damages as was just and equitable. "

Chain of Causation (6) Brush up your handwriting

- *Prendergast v Sam & Dee Ltd*, the Court of Appeal concluded that a pharmacist's negligence in misreading a prescription, and consequently dispensing the wrong drug, did not break the chain of causation from the doctor's initial negligence in writing an illegible prescription. It was reasonably foreseeable that the prescription would be misread.

[1989] 1 Med LR 36

A Very Difficult Case (1)
Rahman v Arearose Ltd, [2001] QB 351

- C managed a burger outlet in a high crime area. He was viciously assaulted sustaining multiple injuries including a fracture to the orbital wall of his right eye. The employer had failed to take adequate care for the claimant's safety. He was treated at University College Hospital where, during a bone grafting operation and due to the negligence of the surgeon, his optic nerve was damaged so that he lost the sight of his right eye. As a result both of the assault and the operation, he also suffered from very severe PTSD, depression and a personality change. In consequence of these psychiatric injuries, he was unable to work and he required lifelong care.

Rahman

- On the basis of the matters set out above it would be expected that the issue whether the employer should be held liable to compensate the claimant for the consequences of the loss of his sight and subsequently greatly exacerbated psychiatric injury, should be determined by determining whether UCH's negligence was gross negligence which broke the chain of causation.

Rahman

- Laws LJ impliedly thought not. He held that it was not the law that “later negligence always extinguishes the causative potency of an earlier tort” .
- However the employer was not held liable for the loss of sight, nor for most of the subsequent severe psychiatric injury.
- The Court diverted into the issue of concurrent tortfeasors having held that as between Defendants the Civil Liability (Contribution) Act 1978 “same damage” provision only applied to concurrent tortfeasors. Laws LJ held that the Act applies only where “there is simply no rational basis for an objective apportionment of causative responsibility for the injury between the tortfeasors”.
- Laws LJ delivered the only judgment; Schiemann and Henry LJJ agreed.

Rahman

- To be a concurrent tortfeasor it was necessary to fall into one of two categories: (a) where there are two causes, either of which would have been sufficient to produce the consequence. (eg a man is shot by two different men acting independently and either shot would have proved fatal on its own) and (b) where there is one indivisible injury which would not have been caused except for the occurrence of both torts. For example, a man is shot by two different men acting independently and neither shot would have proved fatal on its own, but the combination of both is.

Rahman

- Laws LJ held that the psychiatric damage and consequent loss of earnings suffered by Mr Rahman did not fall into (b) because:

"on the evidence the respective torts committed by the defendants were the causes of distinct aspects of the claimant's overall psychiatric condition, and it is positively established that neither caused the whole of it. So much is demonstrated by the document which sets out the conclusions of the three [psychiatric] experts. It is true that this agreed evidence does not purport to distribute causative responsibility for the various aspects of the claimant's psychopathology between the defendants with any such degree of precision as would allow for an exact quantification by the trial court; no doubt any attempt to do so would be highly artificial. But the lack of it cannot drive the case into the regime of the 1978 Act to which, in principle, it does not belong. ...

Rahman

… It is at once plain beyond doubt that neither tort caused the whole of the claimant's psychological deficit. Thus for instance the phobia of black people was entirely caused by the assault. The PTSD is largely due to the assault. But if this is to be characterised as a case of concurrent torts, and if only the second defendant had been sued, the claimant would have recovered damages for these aspects in their entirety as surely as in fact he has done by suing both, and would have so recovered against a defendant who it is affirmatively established was not responsible, certainly not wholly responsible, for those aspects of his injury. That would plainly be unjust; and it would confound the very basis, as I have explained it in paragraph 18, upon which the common law has built the doctrine of concurrent torts. It also shows why, in my judgment, one cannot fix on the adverb "largely" (which is used both in relation to the PTSD and the claimant's depression) so as to draw a rough-and-ready conclusion to the effect that this is really an indivisible injury and therefore "same damage" within section 1(1) of the 1978 Act."

(At paras 23 and 24)

Rahman

- Laws LJ therefore required the court to identify whose negligence caused which part of the psychiatric injury, and where no scientific division was possible, the losses should be apportioned on a percentage basis.
- In dividing up the damages for psychiatric injury, care and loss of earnings, he adopted the trial judge's conclusion that the causative potency of the hospital's tort was three times greater than that of the employer and divided the damages: 25% to the employer and 75% to the hospital.
- In other words, whilst not finding any break in the chain of causation caused by the UCH negligence, Laws LJ held the employer liable for only 25% of the psychiatric injury and consequent loss and had the claimant sued only the employer he would not have recovered 75% of his losses. That is radically different from *Webb*.

Rahman – In Error?

- It is possible to discern the starting point of this case as being the concession on the part of UCH that UCH was solely responsible for the blindness, but the 1978 Act should surely not have been deployed at all until the extent of the employer's liability had been established as a starting point pursuant to ordinary common law principles.

But Rahman is enticing for defendants in the first accident

- C falls at work, attends hospital with neck pain, the hospital investigate, but miss a fracture. With adequate treatment the claimant would have been left with some neck pain, but the lack of treatment leaves the claimant with severe neurological deficit. Is the spinal injury the same damage? If we also say that the negligent failure to treat leads to psychiatric injury is that the same damage?
- Not so nice for claimants though

Here Comes the Cavalry (1)

- *Wright v Cambridge Medical Group:* infant claimant developed a bacterial super-infection whilst being treated at Hospital for complications from chicken pox but discharged with the infection undiagnosed. The infection rooted in a femur and caused discomfort. A GP told the mother to return if things worsened. They did, and by the next day so the mother telephoned the GP. The GP failed to make arrangements to have the child seen . That was admitted to be negligent, and it was agreed that had the child been seen, she would or should have been referred to hospital.

- Further deterioration. A GP referred her immediately to hospital but junior doctors made incorrect diagnoses and gave ineffective medication, there was no consultant involvement for some days. Permanent hip damage resulted.

Here Comes the Cavalry (2)

- Note however that the failure to join the hospital elicited critical comment in the Court of Appeal. The hospital was not joined by claimant or defendant. The claim failed at trial. The claimant appealed.

Here Comes the Cavalry (3)

- Lord Neuberger MR, Smith and Elias LJJ held that a claimant bears the burden of proving causation, but where as here the claimant had proved (1) that she ought to have been referred to hospital and (2) that, had she been referred, competent treatment on the part of the hospital doctors would have avoided her injury, she had the benefit of a presumption that she would in fact have been competently treated in hospital.
- The negligent GP defendant had failed to prove that, even had she been referred the hospital would negligently have failed to prevent the injury.
- So the Claimant had established that, but for the GP's negligent failure, she would have avoided the injury.

Here Comes the Cavalry (4)

- Both the negligence of the GP and the negligence of the hospital were *but for* causes of the claimant's injury.
- Neuberger MR and Dame Janet Smith (in the majority) held that as the GP's negligence had reduced the time available to the hospital to diagnose and treat the claimant by a third (Neuberger) or more than a third (Smith), the GP's negligence remained a cause of the injury ultimate injury.

Here Comes the Cavalry (5)

- Lord Neuberger MR explained why he would have found for the claimant, even if it was proved that the hospital would have been negligent and that the injury would not have been avoided

"Accordingly, it seems to me that, in a case where a doctor has negligently failed to refer his patient to a hospital, and, as a consequence, she has lost the opportunity to be treated as she should have been by a hospital, the doctor cannot escape liability by establishing that the hospital would have negligently failed to treat the patient appropriately, even if he had promptly referred her. Even if the doctor established this, it would not enable him to escape liability, because, by negligently failing to refer the patient promptly, he deprived her of the opportunity to be treated properly by the hospital, and, if they had not treated her properly, that opportunity would be reflected by the fact that she would have been able to recover damages from them."

[2011] EWCA Civ 669

Cavalry Take Wrong Turning?

- In the 2017 case of *Darnley v Croydon Health Services* the Court of Appeal followed *Rahman* and found that C's decision to leave A&E broke the chain of causation (the breach of duty being the negligent advice that the waiting time was 4-5 hours).

- The Supreme Court disagreed. His decision to leave was reasonably foreseeable and was based, in part, on the misleading information.

Recap

- (1) A rule of thumb: if the outcome is surprisingly bad start asking why
- (2) It may be tactically useful for both claimants and defendants to join the hospital
- (3) Indeed, it may be important to do so if there are potential findings of separate damage
- (4) That said the Courts seem more and more willing to short-circuit matters and simply ask whether it is just for the first tortfeasor to have ongoing liability and work back from there

- (5) If the hospital negligence is truly and utterly appalling – gross negligence - there is scope for an insurer to get out with little exposure.
- (6) Will require a cost/benefit analysis. Clin neg claims are much more expensive to run than defending a PI claim.
- (7) If the PI claim is settled and D then pursues the medical provider separately, they will likely require C's cooperation. C may not be willing to cooperate.
- (8) If D applies to join a medical provider as a part 20 D, C must give consideration to also applying to proceed against that medical provider if there is a risk that D may not be liable at all

A Crossover Claim in Action – Wright v Barts (1)

- *Wright v Barts Health NHS Trust* [2016] EWHC 1834
- Mr Wright was at work when he fell through a skylight. He sustained multiple injuries, including a series of fractures at different levels of the spine as well as in the hip and pelvis. He was taken to hospital. At the end of his treatment he had suffered a complete spinal cord injury at T7 level and was Frankel A paraplegic.
- He brought a claim put at more than £3 million for the entirety of his loss against roofing contractors County Contract Roofing Limited [CCR]. CCR did not employ Mr Wright but had sub-contracted work to him. They negotiated on the basis that Mr Wright was contributorily negligent as the senior supervisor on site and his involvement in the risk assessment for the job.

Wright v Barts (2)

- In the meantime Mr Wright's solicitors sent a letter of claim to the hospital trust, alleging negligent treatment that had caused a much worse outcome than should have been the case.
- Mr Wright compromised his claim against CCR on the basis of a substantial discount for contributory negligence. The hospital trust was informed of the compromise agreement and thereafter proceedings were issued against the hospital trust. The hospital trust argued that the claim should be struck out for abuse of process as the roofer had been compensated in full for his loss by the agreement with the roofing company and there should be no double recovery.

Wright v Barts (3)

- So back to basics
- Ascertain the total losses.
- CCR had a liability for the whole of Mr Wright's loss unless the negligence of the hospital was such as to break the chain of causation between the fall and the final outcome. Substandard medical treatment is a hazard of life and by causing Mr Wright's initial injury he required treatment and thus CCR had exposed Mr Wright to the hazard of substandard treatment.
- See Clerk & Lindsell 21st Edition at 2-119 and Webb v. Barclays Bank and Portsmouth Hospitals NHS Trust [2001] EWCA Civ 1141 at [55]: medical treatment would only break the chain of causation if it were "so grossly negligent as to be a completely inappropriate response to the injury inflicted by the defendant."

Wright v Barts (4)

- If negligence could be established against the hospital then the hospital would also be liable for Mr Wright's loss to the extent that it was attributable to their negligence.
- So the loss which occurred after CCR's negligent act would be divided into two parts: (A) that which would have occurred even if the treatment had been appropriate, and (B) the additional loss suffered over and above the first part.
- Both the hospital and CCRL would be liable for the Part B additional loss
- To the extent that CCRL was able to establish contributory negligence its liability would be reduced. That defence was not available to the hospital.

Wright v Barts (5)

- The hospital submitted that the compromise of the claim against CCR rendered it an abuse of process to proceed against the hospital because the claimant had already been compensated for his loss
- Alternatively, that compromise operated as a defence to the claim because the claimant could no longer prove any loss
- There certainly has been case law which at first blush supports the hospital's contentions: Jameson v. CEGB [2000] 1 AC 455 established that settlement of a claim against one tortfeasor in a claim for mesothelioma discharged the claim against the other concurrent tortfeasors and barred a subsequent claim against one of them. See also Heaton and others v. AXA Equity and Law Life Assurance Society plc and another [2002] 2 AC 329 wherein Lord Bingham noted that there may be manifold reasons why a compromise sum may not reflect the full extent of liability, ranging from an uninsured defendant to a desire for an early end to litigation

Wright v Barts (6)

- Edis J asked this question: what was Mr Wright's full loss?

- CCR was not liable to compensate Mr Wright for the whole of the loss for which both it and the hospital were liable because of the contributory negligence discount. But if Mr Wright's claim against the hospital succeeds then the hospital is liable to compensate him for the whole of that loss if his current claim succeeds. Equally the hospital is not liable for the part of the loss which was not caused by the alleged clinical negligence. CCR had neither paid nor purported to pay the whole loss caused by the hospital (on the assumption that the claim against it succeeds on the merits). Indeed on the face of the compromises agreement CCR had paid only 20% of that claim as it did of the claim for the rest of the loss.

Wright v Barts (7) Bells & Whistles

- The claim against CCR was compromised at £400,000 plus costs of £150,000. The compromise agreement recited that this reflected 80% contributory negligence. Whilst a finding of substantial contributory negligence was a given, the 80% figure was artificial: it derived from Mr Wright's perspective both the risk of contributory negligence and in the background a family tension given the involvement of a close family member in the circumstances giving rise to the accident.

- The driver for the recital of 80% contributory negligence was to enable CCR's insurers to deal with the NHS Recovery Scheme under which insurers pay the costs of treating those who have been injured by the fault of their policy holders.

- It will no doubt be a point for discussion in future as to how such recitals are to be dealt with by the NHS Resolution – a percentage is indicated, the reasons for any given percentage will be case specific and from a claimant's perspective may reflect many issues
- The compromise agreement did not include any reservation of the right by the claimant to proceed against the hospital, nor any agreement by Mr Wright to indemnify CCR against any liability it may have to the hospital in any contribution proceedings.

- And as Lord Bingham noted in Heaton and others v. AXA Equity and Law Life Assurance Society plc and another [2002] 2 AC 329 there may be manifold reasons why a compromise sum may not reflect the full extent of liability, ranging from an uninsured defendant to a desire for an early end to litigation
- In fact Edis J did not accept the 80% as being an accurate figure but did accept that as against CCR a substantial discount for contributory negligence was inevitable. He went further though, finding that the facts of Mr Wright's illustrated a general principle that a settlement with one concurrent tortfeasor does not release the others unless it is clear that it was intended to have that effect, or unless the payment clearly satisfies the whole claim.

Summary

- These claims can be very worthwhile for Defendants, and if handled properly, for Claimants
- Be careful with the final agreement: a full memorandum of agreement is important for C – to show that a claim against the later tortfeasor (eg a hospital) survives, and for the original D where a contribution is sought from a concurrent tortfeasor who is liable for the same damage (or in the event of being sued for a contribution)
- A reservation of right to go against another defendant would be advisable albeit probably not essential
- Consider very carefully whether the figure arrived at between C and original tortfeasor can be justified

Thank you!