Ordinary, not gross, medical negligence as a break in the chain of causation

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Personal injury lawyers have long worked on the basis of the "rule" in Webb v. Barclays Bank & Portsmouth Hospitals NHS Trust [2002] PIQR P8 that (quoting judgment of the Court paragraph 55):

> "... we agree with the editors of *Clerk & Lindsell on Torts* when they say:
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> > "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**" (18th ed., 2-55)."

It turns out that there was and is no such rule.

Andrew Baker J found as much in Jenkinson v. Hertfordshire County Council [2023] EWHC 872 (KB). His reasons for finding that there is no such rule included:

(a) The rule was not applied by the Court of Appeal in Webb to decide that case.

(b) In Rahman v. Arearose [2001] QB 351 an NHS Trust which had negligently operated on an injured eye resulting in blindness conceded that they (the Trust) had sole responsibility for the blindness. The concession was regarded by the Court of Appeal as inevitable/ obviously correct. There was, however, no suggestion that the Trust's negligence was *gross*, and if only *gross* negligence operated as a break in the chain of causation from the original injury then the concession would have been wrong, not inevitable.

(c) If the rule that was thought to come from Webb v. Barclays really existed, it was a recipe for litigation within litigation over whether treatment was so poorly executed as to become an inappropriate medical response.

Andrew Baker J's conclusion is that (para 43) "*In my judgment, the Specific Rule [in Webb] does not exist as a principle of law defining a necessary ingredient of a* novus actus *defence in the context of medical interventions.*"

To be clear, Baker J has said that there is no rule to the effect that medical treatment of an injury caused by a defendant's tort *cannot* break the chain of causation unless it is so grossly negligent treatment as to be a completely inappropriate response to the injury. Simply saying that there is no such rule *might* mean:

(i) that medical treatment *can* break the chain of causation even if it is not such gross negligence; or

(ii) *even gross negligence* cannot break the chain of causation.

Baker J means the first of those possibilities: medical negligence that is not so gross as to be a completely inappropriate response to the injury can break the chain of causation from an original tort.

What plainly, and understandably, underpins Baker J's approach is the fact that what a court should be deciding, and *wants* to decide, is the extent of the loss for which a defendant ought fairly or reasonably or justly be held liable.

The context of Jenkinson was a refusal by a District Judge to allow a defendant to amend to plead intervening clinical negligence. The claimant had sustained an ankle fracture falling into an uncovered manhole or drain gully, for which the defendant admitted liability. The defendant wanted to amend its defence to allege that, but for negligent medical treatment, the claimant would have been back to work within 3 to 6 months, negligent surgery meaning that he had a much worse outcome. The DJ's reasoning was that the amendment served no purpose because the defendant could not prove that the intervening clinical negligence was "*so grossly negligent as to be a completely inappropriate response to the injury inflicted by the defendant*". That is, the DJ worked on the basis a defendant could only raise clinical negligence as a defence to a claim if the clinical negligence was gross. Andrew Baker J said that the amendment should have been

allowed on two bases. Firstly, and by far the most important for PI practitioners, clinical negligence does not have to be gross before it would be fair not to hold an original tortfeasor responsible for the consequences of the negligence. He went on to find, as a second reason for allowing the appeal against refusal to allow amendment, that the DJ should not have found, on the evidence, that the defendant would not be able to show gross negligence even if it was necessary.

Practical effects

This decision might well mean that defendants will now raise clinical negligence as a defence more readily than previously. For a long time defendants have faced a problem: they knew (or thought they knew) that they needed to prove *gross* clinical negligence for it to be a partial defence in a claim, and that was a deterrent for defendants raising this issue. They would tend to deal with the claimant's claim and then, in appropriate cases – essentially when the allegation of clinical negligence was strong enough and the costs were worth it – pursue a contribution claim against the negligent doctor/ Trust/ Board.

Perhaps defendants will now take the view that they might as well raise clinical negligence in the claim brought by the claimant more readily. That would lead to more claimants joining more doctors as second defendants, therefore more multi-handed litigation.

Both sides of litigation should, however, be cautious. A defendant who raises a partial defence to the effect that some of the loss flowed from clinical negligence such that it would not be fair for the defendant to be considered responsible for it, can expect to see the relevant doctor/ Trust/ Board added to the claim by a claimant. If the doctor turns out *not* to have been negligent, the defendant can expect to be held responsible for the costs of that exercise.

A defendant will have to weigh up costs/ benefits in the usual way: what is the chance of getting a contribution from the Trust? What is the potential saving? What is the cost risk? Is it better to get the Trust on the hook soon? That would increase the costs of the claim,

because there will be 2 defendants, but a settlement split between parties might be more palatable to an insurer.

There is nothing to stop a defendant proceeding as it always has done – dealing with the claimant's claim and *then* pursuing the Trust. In such subsequent litigation there was never a need to prove *gross* negligence. That high hurdle (from Webb) only applied to a defendant attempting to use subsequent clinical negligence as a defence in a claim brought by the claimant. In many cases that traditional approach will remain the appropriate thing to do. An advantage of that traditional approach is that, having dealt with the claimant's claim, a defendant knows exactly what is at stake (generally a lot less than is claimed). A disadvantage is that if the judge does not have both defendant and doctor/ Trust/ Board in front of her/him at the same time, the judge might be influenced towards a more modest, or no, contribution from the Trust on the basis that the judge *knows* that the defendant is responsible (since the defendant paid the claimant), whereas the defendant still has to fight to persuade the court that the clinical negligence (if proved) contributed to the loss to a meaningful extent.

The decision will have to be made on a case-by-case basis. Defendants should no longer think that they cannot use 'ordinary' (rather than gross) clinical negligence as a partial defence to a claim.

Claimants, meanwhile, can expect to have defendants raising clinical negligence as a partial defence. They ought to do what they can to protect themselves in the litigation and on costs. That would involve warning the defendant that the defendant's contention will lead to the doctor/Trust/Board being joined, and the defendant being held liable for the costs of that exercise (including the costs of the extra defendant) if it transpires that the Defendant's contention was wrong. The claimant would also need to follow the protocol with the doctor/ Trust/ Board, potentially needing to seek an extension of time to do so.

Even with a claimant protecting itself as best it can, there is potential for problems. Suppose that a defendant contends that a proportion of the loss flows from clinical negligence,

leading to a claimant exploring that issue with an expert. Suppose then that the claimant's expert says "no negligence". What is the claimant to do? Presumably it would have to pursue the Trust on the basis of "claimant does not contend that you were negligent, but defendant does, so we are joining you to the claim just in case". Hardly an auspicious beginning to litigation.

That said, the claimant must surely join the doctor/ Trust/ Board unless the defendant's position is plainly wrong. Otherwise the claimant might find itself at trial facing an argument that some part of the loss flows from ordinary (i.e. not so gross as to be a completely inappropriate response) medical negligence, and it would not be fair to hold the defendant responsible for that part of the loss.

Part of Andrew Baker J's reasons for finding that there was no such thing as the "rule" in Webb v. Barclays was that the existence of such a rule was a "*recipe for litigation within litigation over when treatment otherwise proper in kind is so poorly executed as to become an inappropriate medical response*". In essence he is saying that by clarifying that there is no such rule – medical negligence does *not* have to be so gross to break the chain of causation – he is making a finding that will result in less litigation. Perhaps this decision will lead to the joinder of more parties, and rather more litigation.

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