Material contribution: an update for clinical negligence practitioners

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Material contribution is an area that often vexes clinical negligence practitioners. Despite clarity in *Holmes v Poeton Holdings Limited* [2023] EWCA Civ 1377 that material contribution applies in cases where there is an indivisible injury, it is perhaps unsurprising that the concept of material contribution that has developed as a result of industrial disease litigation continues to cause difficulty in its application to clinical negligence claims.

In this article, we suggest practical tips for practitioners to be able to assess at the outset of the claim whether material contribution is likely to apply, and we consider the doctrine in light of the recent judgment in *Zgonec-Rozej & Ors v Pereira* [2025] EWCA Civ 171.

In *Zgonec-Rozej* the claimants argued that Bourne J, the trial judge at first instance, ought to have found that his findings in respect of the breaches of duty by Dr Pereira, a consultant psychiatrist who had provided care to the late John Jones QC while he was a patient at the Nightingale Hospital, made a material contribution to Mr Jones' tragic death on the basis set out in *Bailey v Ministry of Defence* [2009] 1 WLR 1052 and *Williams v Bermuda Hospitals Board (NHSLA intervening)* [2016] UKPC 4. Nicola Davies LJ in *Zgonec-Rojez* (at §73) described *Bailey* and *Williams* as authoritatively summarising the scope of the doctrine of material contribution, which was a recognised exception to the 'but for' principle, which is the primary mechanism for determining factual causation in the law of tort.

We therefore consider the facts of and analysis in *Bailey* and *Williams*, and some of the key cases considered in those decisions.

A history of material contribution in clinical negligence claims: *Bailey v MoD*

The claimant in *Bailey* suffered serious brain damage whilst an inpatient in hospital. She was admitted to hospital suffering from a gall stone requiring surgical removal. She underwent an ERCP procedure. Her treatment in the aftermath of the ERCP was negligent. As a result, she had to undergo further major procedures over the following days which should not have been necessary, and which led to her being in a weakened state. In addition, she developed pancreatitis, which was an unfortunate, but non-negligent, complication of the ERCP. For twelve days she was in the ITU until she was transferred to the renal unit on 26 January. There she vomited in her sleep and aspirated the vomit, causing her to suffer a cardiac arrest and hypoxic brain damage.

The key factual causation questions in *Bailey* were whether adequate care would have led to early intervention and prevented the claimant becoming as ill and as weak as she became and, if so, whether that weakness was caused or materially contributed to by a lack of care that led to her being unable to prevent herself aspirating.

In *Bailey* the defendant relied on the case of *Wilsher v Essex Area Health Authority* [1988] 1 AC 1074 for the proposition that *Bailey* was to be decided on but for causation principles. In *Wilsher* the claimant, a premature baby, was given an excessive concentration of oxygen and suffered retrolental fibroplasia ('RF') leading to blindness. The medical evidence demonstrated that RF could be caused by four other distinct conditions. In the Court of Appeal the claim succeeded; in the House of Lords it failed. It was held that where the medical evidence could not tell whether excess oxygen did or did not cause or contribute to the Claimant's RF and where the RLF may have been caused by as many as five possible causes then the 'but for' test could not be satisfied.

The essential findings of Foskett J in *Bailey* were that there were two contributory causes to the Claimant's post ERCP weakness: post-ERCP pancreatitis (which occurred non negligently) and a negligent cause (a lack of care post-ERCP by a failure adequately to resuscitate the claimant which had been admitted in part). Since each cause, the judge found, materially contributed (i.e. in a more than de minimis way; albeit that he could not say whether the negligent and non-negligent causes was more or less than the other) to the Claimant's overall weakness, and since her weakness caused her aspiration and led

to cardiac arrest and brain damage, then causation was made out.

Thus, Waller LJ (§46) summarised the position as:

'In a case where medical science cannot establish the probability that 'but for' an act of negligence the injury would not have happened but can establish that the contribution of the negligent cause was more than negligible, the 'but for' test is modified, and the claimant will succeed.'

A note: divisible and indivisible diseases or injuries

An indivisible disease is not one determined by the dose or amount of the injurious causal agent causing the disease or illness; a divisible disease is dose-dependent.

We can do no better than to quote from Sarah Green in '*Causation in Negligence*,' which in our view ought to represent the statement of the law:

'It is trite negligence law that, where possible, defendants should only be held liable for that part of the claimant's ultimate damage to which they can be causally linked ... It is equally trite that, where a defendant has been found to have caused or contributed to an indivisible injury, she will be held fully liable for it, even though there may well have been other contributing cause.'

Thus, if a claimant proves a material contribution by a negligent cause or causal agent to an indivisible injury, then she ought to recover damages on a 100% basis; and in respect of an divisible injury, the tortfeasor is liable **to the extent to which** their negligence can be causally linked to the damage (our emphasis).

Williams v Bermuda Hospitals Board

The claimant went to the local hospital emergency department. He was suffering with acute appendicitis. He underwent an appendectomy, but there were complications said to have been suffered as a result of a negligent delay in carrying out his treatment. On arrival at A&E, the emergency doctor appropriately ordered a CT scan of the abdomen to determine whether the claimant was suffering with appendicitis, or another condition. There was a delay of about five hours before the scan was performed, and a doctor did not receive a report on the scan until about two hours later. During that time the claimant's appendix ruptured, and sepsis from the ruptured appendix caused injury to the heart and lungs. The trial judge's finding that the failure to order a scan on an emergency basis led to a delay of between 4 hours 15 mins and 2 hours 20 mins in the start of the index surgery.

The trial judge held that there had been a culpable delay but that the claimant had not proved that the negligence caused the complications. He awarded $2,000 in damages for his extra suffering during the period of culpable delay prior to the operation. The Bermuda Court of Appeal reversed the judge's decision on causation. The Privy Council upheld that decision.

Lord Toulson in the Privy Council (§41) observed that the trial judge found that the injury to Mr Williams' heart and lungs was caused by a single known agent, namely sepsis, which developed incrementally over a period of approximately six hours, causing myocardial ischaemia. The sepsis was not divided into separate components causing separate damage to the heart and lungs; its development and effect was a single continuous process, during which the sufficiency of the supply of oxygen to the heart steadily reduced. That process continued for not less than 2 hours 20 mins more than it should have done, and thus it was right to infer that the defendant's negligence materially contributed to the heart and lungs.

Williams ought then we suggest be seen as a case which provides authority for the proposition that where a) there is a single continuous damage-or injury-causing process b) leading to an indivisible injury and c) the Defendant's negligence has caused that process to carry on for longer than it would have done absent negligence, then the court can infer that the defendant's negligence made a material contribution to the injury or disease.

In essence, as long as the cumulative causes are part of the same process, it does not matter whether they occur together or indeed which comes first. The key question is whether the causes are working together in a continuous process as opposed to being separate independent causal components.

Zgonec-Rozej & Ors v Pereira [2025] EWCA Civ 171

At the time of his death, Mr Jones was a voluntary inpatient under the care of Dr Pereira, a Consultant Psychiatrist. The claim was brought by his wife and two children as dependants, and on behalf of his estate by his wife. The claimants alleged that there were deficiencies in the care provided by Dr Pereira to Mr Jones, and but for those deficiencies, his mental health would not have deteriorated to the point where he took his life, and that he would have continued to expand on his successful career as a barrister. It was argued that if the Court were

unable to determine but for causation, then the breaches had made a material contribution to his death.

Claims in negligence against the hospital and another consultant psychiatrist had been settled prior to trial, without an admission of liability.

At first instance, Bourne J found that there were separate breaches of duty in respect of the care provided, concerning failures in communication, failures in providing a sufficient handover, and failures in progressing psychological therapy.

Bourne J concluded that causation was not made out on a but for basis. On the facts of the case, it was possible to decide on the balance of probabilities that death would not have been avoided, and therefore the material contribution argument was unnecessary.

The claimants appealed. Permission to appeal was granted on multiple grounds, one of which was that the Judge's findings in respect of breach of duty made a material contribution to his death and causation was proved on the basis of *Bailey* and *Williams*.

The conclusions in respect of breach of duty that had been reached at first instance were not challenged on appeal.

Judgment in the Court of Appeal

It was argued on behalf of the claimants that, in light of the findings at first instance that there were a number of overlapping factors which had contributed to the late Mr Jones' death, this meant that material contribution did apply.

It was argued that the test for material contribution would apply as an alternative route for causation to be established, even if the but for test could be satisfied. Therefore, the Judge should have considered whether the failures combined and contributed in an indivisible but material way to cause the deterioration of Mr Jones' mental health and his death.

This ground of appeal was unanimously dismissed (emphasis added):

"The doctrine of material contribution is a recognised exception to the "but for" principle which is the primary mechanism used for determining factual causation in the law of tort. The scope of the doctrine of material contribution was authoritatively summarised by the Court of Appeal in Bailey*, (Waller LJ at para 46), and followed by the Privy Council in* Williams*.* ***Where the evidence before the court is such that factual causation can be determined on a 'but for' basis in either party's favour, the doctrine of material contribution does not arise.*** *The proposition now relied upon by the appellant is contrary to the settled state of the law".*

When should Claimant practitioners be considering material contribution?

It is settled that material contribution only arises where the Court is unable to determine causation on a but for basis in either party's favour.

In clinical negligence claims, practitioners are often looking at cases where there are multiple causal factors. Often, the claimant is unwell prior to the alleged negligence in any event, which needs to be considered from a causation perspective alongside alleged delays in treatment and alleged inadequate treatment. On the same theme, claimant practitioners are often required to grapple with both negligent and non-negligent factors in a patient's care.

We suggest that a practical method of working through whether material contribution is likely to apply to your case is to consider two questions:

1. How many potential causal factors are there which lead to the damage that is the subject of the claim? If the answer to that question is two or more, because of scientific uncertainty, consider whether all the potential causes are cumulative causes, or whether one or more of the causes is a distinct cause.

For example: If you have a case where sepsis is caused by pre-existing infection (non-negligent) and by a delay in treatment (negligent), those are causal factors that are arguably working together to result in the sepsis causing damage, and the causes are likely to be cumulative.

If you have a case akin to *Wilsher*, where there are multiple possible causes and they all operate independently of each other, and it is possible that the alleged negligent cause made no contribution at all to the damage, then the causes are not cumulative. If the causes are separate and the negligent cause cannot be shown to have caused the damage on a but for basis, then the claim will fail on causation.

2. Where you have two causes working together and the evidence supports that both of those causes would have had an effect on the injury that caused damage, can a material contribution from the breach of duty be shown on a balance of probabilities (in accordance with *Bailey* and *Williams*)? If the answer to that question is yes, consider whether the injury is divisible or indivisible.