Issues of causation in spinal cord injury cases

APIL Spinal SIG Meeting
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GERARD McDERMOTT QC

Causation in SCI

- Not always an issue
- But maybe
  - Clinical negligence cases – pressure sore or failure to spot developing SCI
  - Other matters developing alongside and arguably adding to disability … or preexisting conditions
  - Cauda Equina – incremental damage
  - Contributory negligence – what would injuries have been had a seat belt been worn

Reaney v University Hospital of North Staffordshire NHS Trust [2015] EWCA Civ 1119; [2016] P.I.Q.R. Q3

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- Diagnosis of transverse myelitis - paralysed below mid-thoracic level and wheelchair-bound.
- Develops pressure sores in hospital . D admitted liability for the pressure sores and their consequences.
- 1st instance: but for the pressure sores, C would have required some care and assistance and physiotherapy.
- As a result of the pressure sores C now required 24-hour care, a larger property to accommodate the carers, a larger vehicle, A and E and increased need for physiotherapy.
- The Judge found that D had made C's position materially and significantly worse than it would have been but for the negligence. No deduction for C's needs that would have required in any event.
- D appealed. The issues were: did D cause (i) all of C's care and other needs as a result of its negligence; or (ii) those needs less the needs that she would have had but for its negligence?

Reaney – Court of Appeal

Held, allowing D's appeal:

1) Tortfeasor must compensate the victim for her condition only to the extent that it has been worsened by the negligence;
2) D was entitled to take C as it found her. If needs substantially of the same kind as her pre-existing needs, the damage was the additional needs. But, if needs caused by the negligence were **qualitatively** different from the pre-existing needs, then those needs were caused in their entirety by the negligence;
3) No findings that C's care and other needs were qualitatively different;
4) Whether a claimant can recover compensation for loss caused by another person is irrelevant to loss as a result of the negligence;
5) The need for care, is a causation issue.
6) Where pre-existing care needs - question is whether the care required is qualitatively different from that which would have been required but for the accident; and
7) The principle of material contribution did not need to be invoked by the Judge in this case.

Impact

- A need to assess whether care or damage is “qualitatively “ different;
- Not quantitatively different;
- A complete change in the nature of care might qualify
- But in general it will be a question of an assessment
- Maybe on quite a broad basis

Causation – Keep it simple

- Possible to construct interesting arguments
- And to delve into statistical information
- But at the end of the day:

> " [*C]ausation has been discussed by many eminent philosophers and also by a number of learned judges in the past. I consider, however, that what or who has caused a certain event to occur is essentially a practical question of fact which can best be answered by ordinary commonsense rather than abstract metaphysical theory*"
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> Lord Salmon in *Alphacell v Woodward [1972] AC 824 at 827*
>
> *Cited by Stewart J in Young v AIG*

Young v AIG Europe Ltd [2015] EWHC 2160 (QB)

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- RTA on **13 May 2013** for which liability was admitted by D on a 100% basis.
- Subsequently:
  - C suffered an MI on **15th May 2013**. Cardiology experts agreed the MI was caused by the RTA;
  - C was rendered paraplegic by virtue of a spinal haematoma; such neurological symptoms first developed on or around **17th May 2013**. Again, agreed that C's development of paralysis was as a consequence of the RTA.
- Thereafter, C suffered a stroke on **4 June 2013,** that being 20 days after suffering his MI. Issue was to determine whether that stroke was caused and/or materially contributed to by the RTA or any medical treatment received thereafter.
- The neurologists agreed that C would not have had his stroke when he did, but for the occurrence of the MI. The cardiologists agreed that the MI was caused by the RTA. C's case - C would not have had the stroke but for the RTA.
- D said C needed to show the mechanism of the stroke and that it was caused by the accident – rather than any background risk

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Young v AIG

- The cardiologists
    - Agreed on MI
    - Dr S said stroke 50/50
- The Disagreement
    - Coincidental or causative
- The epidemiological evidence
    - US and between 17 and 36 years ago
- And the history – clear
- Keep it simple ! – clinical judgment of 3 doctors

Young – the result

- Stewart J found that the evidence in favour of the accident probably being the cause of the stroke was very strong. He held that, absent the accident, C very probably would not have suffered the stroke he did and had a 30% risk of suffering a stroke over a 10 year period. Judgment in favour of the Claimant

Cauda Equina

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- The cauda equina or "horse's tail" is a matrix of nerves which fall below the conus medularis at the base of the spinal cord. CES is a syndrome which has a number of stages:
  - **CES-S – suspected CES**, typically severe back pain with bilateral neurogenic symptoms such as leg pain or weakness. Mechanical or referred leg pain is not neurogenic. A record of "sciatica" may not be evidence of CES-S, but may be a mis-description of neurogenic pain.
  - **CES-I – incomplete CES,** typically severe back pain with altered urinary sensation for example loss of desire to void, diminshed sensation, poor stream and need to strain. There may be painful retention of urine. There may also be saddle anaesthesia and sphincter disturbance.
  - **CES-R – CES** as above but with painless retention of urine.
  - **CES-C – Complete CES** often with no urinary or bowel function and with sexual dysfunction.
- Progression can be very rapid but may follow an acute onset or chronic back pain.
- So-called Red Flags for CES are urinary dysfunction, bowel dysfunction, bilateral neurogenic symptoms, saddle anaesthesia and sexual dysfunction.

Cauda Equina

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- In terms of causation, referral should be for specialist investigation which will include an MRI scan. X-rays are not helpful. Referral should be urgent, even as an emergency.
- Treatment is by way of surgical decompression. Once a patient has CES-C, and arguably once they have CES-R, it will often be too late for surgery to make a difference to outcome. Therefore if actual referral is made at that stage, the time from referral to surgery should not necessarily be taken as an indication of the likely time between referral and surgery if referral had been made at an earlier stage.
- Classically, litigation arises when the patient first presented with CES-S or CES-I which then progressed to CES-R or CES-C before surgery was performed. If progression was very rapid, then proving causation may be very difficult. It is thought that surgery when a patient is at an earlier stage of CES will prevent progression to a later, more injurious stage.
- **Time of the essence**

Managing a CE claim

- Essential to have a full timetable including C's account – a change from hour to hour
- And also to consider what disciplines are required – which may depend on route of referral
  - GP ?
  - Ambulance
  - A and E
  - Orthopaedic ?
  - Neuro Surgeon
  - Nurse ?
  - Radiology
  - Causation inextricably linked with liability and prognosis
  - Incremental damage

Cases on Cauda Equina

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- *Zarb v Odetoyinko* [2006] 2880 – Tugendhat J
  - D successful – even if to surgeon not clear they would operate
- *Oakes v Neininger & Ors* [2008] EWHC 548 (QB) – Akenhead J
  - GP B of D –and one ambulance crew- denied better outcome
- *Hussain v Bradford Teaching Hospital NHS Foundation Trust* [2011] EWHC 2914 (QB) – Coulson J
  - D successful - prospects of good recovery following surgery less than50%
- *McEleney v Kamal Ohri et al* [2007] CSOH 203A
  - C successful – 3 day delay following trip to GP. But not in relation to motor deficits

Contributory Negligence

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Incidence of SCI – close correlation with seat belt use in RTAs

Essential to do

- Injury causation analysis
- Involving reconstruction expert
- Perhaps a separate seat belt expert
- And a clinician
  - A and E Consultant …
  - or maybe Spinal or Neuro Surgeon
  - Witness evidence as to nature of collision
- Remember burden of proof
- And the potential of differential impact

And always

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- Once analysis has been done
- Keep it simple !