THURSDAY NIGHT TRAINING

SESSION 5 THURSDAY 28 AUGUST 2014

woodward
solicitors

INTRODUCTION TO CAUSATION

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- Discussion & Role Play

Contents

Introduction

Causing an injury or a loss by itself is not sufficient to create legal liability.

For example in negligence, to succeed the Claimant must show that the Defendant (1) owed them a duty of care; (2) breached that duty; (3) by so doing caused damage to the Claimant (ie establish causation); and (4) that damage must not have been too remote. Causation is only one element.

But For

The usual method of establishing factual causation is the" but-for" test:-

'But for the Defendant's act, would the harm have occurred?'

A shoots and wounds B. 'But for A's act, would B have been wounded?' The answer is 'No.' So we conclude that A caused the harm to B. The "but for" test is a test of necessity. It asks was it 'necessary' for the Defendant's act to have occurred for the harm to have occurred.

Intervening events

Imagine the following. A critically injures B. As B is wheeled to an ambulance, she is struck by lightning. She would not have been struck if she had not been injured in the first place. Clearly then, A caused B's whole injury. However, at law, the intervention of a supervening event renders the Defendant not liable for the injury caused by the lightning.

The effect of the principle may be stated simply:

> if the new event, whether through human agency or natural causes, does not break the chain, the original actor is liable for all the consequences flowing naturally from the initial circumstances. But if the new act breaks the chain, the liability of the initial actor stops at that point, and the new actor, if human, will be liable for all that flows from his or her contribution.

Eggshell skull rule

The term refers to a hypothetical person with a skull as delicate as the shell of an egg. The Defendant cannot claim his unawareness of the victim's skull fragility as a defence for the consequence of the wrongful contact.

QUIZ

1. In medical records:

   (a) What is the symbol for nothing or zero?

   (b) What is the symbol for diagnosis?

   (c) How would 2 weeks usually be expressed?

   (d) What does the abbreviation "hx" mean?

   (e) What does the abbreviation "OE" or "O/E" mean?

   (f) What does the abbreviation "URTI" mean?

   (g) What does the abbreviation "S/B" mean?

2. If a medical expert states in a report he has prepared for you that your client's injury was "possibly caused" by the accident or working conditions what would you consider doing?

3. In general, if you receive a medical report from the Defendant what should you do?

4. What part of the body does a nephrologist specialise in?

5. What type of Consultant deals with allergic reactions of any kind?

ROLE PLAY

FACTS

The Claimant was born on 9 May 1974. Between April 2010 and June 2013 she was employed as an insurance adviser by the Defendant, a firm of insurance brokers.

The main part of the Claimant's work comprised inviting customers to renew their insurance policies. The policies related to household insurance and motor insurance. In addition, the Claimant carried out a number of other administrative and clerical functions. The Claimant sat at a workstation in the Defendant's office. She prepared letters inviting renewal on her computer using a standard form keyboard and mouse. After such letters had been typed up, from time to time they had to be collected from the computer.

In May 2012 the Defendant decided to introduce a bonus scheme for its renewal staff. This was known as the "star performance renewal scheme" and was intended to reward staff with additional daily payments according to the number of renewals which they completed.

Before the introduction of the bonus scheme the Claimant was doing about 50 renewals per day. After the scheme had been put in place the number of renewals which the Claimant dealt with per day increased. The extent of that increase has been a matter of controversy. It is clear however that the number of renewals per day never rose above about 70.

In late July or August of 2012 the Claimant was involved in a minor road traffic accident. She was a passenger in a car which stopped suddenly, she was thrown forward in her seat and put her hands out to protect herself, causing them to strike the dashboard.

During the summer of 2012 the Claimant started to notice aching in both wrists which became steadily worse. During August of 2012 the Claimant told her Manager about the pain in her wrists. She also told him about the road traffic accident. He gained the impression (whether rightly or wrongly) that the two matters were related and suggested that the Claimant should consult her GP.

The Claimant took her annual holiday in the last fortnight of September 2012. During that period the symptoms subsided.

At the beginning of October the Claimant returned to work after her holiday. The pain in her wrists returned. On 11 October 2012 the Claimant consulted her GP about the pain in her wrists. The GP's notes record that he examined the wrists and considered the possibility of carpel tunnel syndrome and repetitive strain injury.

On 23 October the claimant consulted her GP again and was signed off work for two weeks. The GP's notes for that date read as follows:

"Both wrists painful. Quite incapacitating. Not tried NSAID yet start. Certificate tenosynovitis."

The Claimant returned to work in early November. Initially the Claimant was put to work on projects other than renewals, but quite soon the Claimant was once again dealing with renewals. It does seem, however, that the number of renewals which the Claimant was dealing with per day, was lower than the number of renewals which she had been dealing with per day before 23 October.

On 27 November 2012 the Claimant consulted her GP. He made the following brief entry in his notes:

"Hand improving because not typing. Heading for another job."

The Claimant asserts that in late December 2012 and early January 2013 the number of renewals which she did each day progressively increased. However the contemporaneous records show that the number of renewals undertaken by the Claimant per day remained roughly constant during this period and subsequently. The Claimant was doing between 25 and 30 renewals per day.

The wrist pain which the Claimant had previously suffered returned in January 2013 and grew worse. On 24 February 2013 the Defendant's human resources director sent a questionnaire to her GP, seeking medical advice. The GP duly returned that form with his responses to the questions put by the Defendant. It is not entirely easy to read all that the GP wrote. However, one of the things which he put on the form was that the Defendant should minimise repetitive tasks.

During 2013 there were other issues between the Claimant and her employers, as a result of which the Claimant invoked the grievance procedure. In due course the Claimant accepted voluntary redundancy. In June 2013 the Claimant ceased to be employed by the Defendant.

In June 2013 and for a period afterwards the Claimant continued to experience pain in her wrists, for which she considered that her former employers were responsible.

PROCEEDINGS

The Claimant claims damages for personal injuries and consequential losses on the grounds of negligence and breach of statutory duty by the Defendant as her employer.

The Claimant's case has evolved over time. In it's final form her case may be summarised as follows. The introduction of the bonus scheme in May 2012 led to an increase in the number of renewals dealt with by her each day.

Between May 2012 and June 2013 the Defendant failed to comply with its duties under Regulations 2, 4, 6 and 7 of the Health & Safety (Display Screen Equipment) Regulations 1992 or to take reasonable care to protect the Claimant from suffering wrist injury. As a result the claimant developed a form of work related upper limb disorder ("WRULD"), namely tenosynovitis.

Tenosynovitis means inflammation of a tendon sheath. The tendons affected in the Claimant's case are tendons in the thumb and index finger on both sides.

The Claimant's medical expert, Dr Hull, made a diagnosis was that the Claimant developed tenosynovitis as a result of increased use of the keyboard in and after the summer of 2012. Mr Warwick, the Defendant's medical expert, disagreed with that diagnosis.

A significant feature of this case was that the number of keystrokes made by the Claimant per day, both before and after May 2012 was not great. Each renewal involved an average of 150 keystrokes. So even if the claimant did 70 renewals in a day, that would only involve 10,500 keystrokes. That is approximately the equivalent of what a good touch typist achieves in half an hour. The Claimant is not a touch typist. These observations are relevant when considering the medical causation issue. The amount of typing which the Claimant undertook between June 2012 and June 2013 is not such as would normally cause personal injury.

In cross–examination Dr Hull explained that posture, repetition and lack of rest were important in the development of tenosynovitis. If the Judge found that those factors were not present, then the diagnosis was unlikely to be tenosynovitis caused by the Claimant's work. Mr Warwick expressed similar views on this aspect in his evidence.

It is clear on the evidence that the Claimant's workstation and posture were satisfactory. The volume of the Claimant's work was not such that there was neither excessive repetition or insufficient rest.

Having considered the medical reports and the oral evidence of Dr Hull and Mr Warwick, the Court rejected Dr Hull's diagnosis of tenosynovitis.

Although the diagnosis of tenosynovitis has been rejected, the fact remains that during the Claimant's employment and for a period afterwards the Claimant suffered a considerable amount of pain and aching in her wrists. Those symptoms were genuine.

The question arises therefore as to why the Claimant suffered these symptoms. In their joint statement prepared for the Court the medical experts accepted that the Claimant developed symptoms in her wrists and hands (more marked on the left than the right) in the summer of 2012. They considered that the road traffic accident may or may not be relevant. They recorded that by the time they examined the Claimant, in early 2014, her symptoms were mild and minimal. The experts also summarised their areas of disagreement. In relation to causation they recorded as follows:

"Dr Hull noted the onset of symptoms towards the end of the working day with a gradual increase in onset of symptoms earlier in the working day, relief with rest such as weekends, holidays and time off work. He noted that the symptoms had virtually resolved following her redundancy in June 2013.

Mr Warwick feels that this relation of symptoms to work should be interpreted as meaning that work simply aggravates symptoms from any painful condition rather than primarily causes that condition."

JUDGMENT

The Judge dismissed the claim. He held that:

- The Defendant had not been negligent
- The Defendant had been in breach of regulations 2, 6 and 7 of the 1992 Regulations and
- The breaches had not been causative of injury to the Claimant.

In relation to the medical issues, the Judge rejected Dr Hull's diagnosis of tenosynovitis. He preferred the view of Mr Warwick that the Claimant's symptoms were not caused by her work, although they were "exposed" by it.

Finally, the Judge assessed damages in case he should be held to be wrong on the issues of liability and causation. He assessed general damages for pain, suffering and loss of amenity at £4,000. He assessed damages for loss of earning capacity in the sum of £8,000. He noted that special damages were agreed between the parties at £31.90.

TASKS

1. The Claimant appealed. As a group discuss the strengths and weaknesses of her claim.

2. Role play:

   The Court hearing the Appeal have decided that the Defendant has been negligent and in breach based upon a consideration of the evidence in the Court bundle. The Court have in the asked for a 2 or 3 minute submission explaining why the claim should succeed.

Sorting Medical Records for Clinical Negligence and Serious PI Claims

Where there is a large bundle of medical records or the case is likely to be complex (eg as in many clinical negligence claims) some leading Practitioners or their support staff, sort GP records into sections. The individual sections are then sorted into chronological order. The bundle is indexed and paginated.

Computer records

Treatment Summary records

Lloyd George cards

Vaccination and Immunisation History

Clinical Data (eg x-ray results, scan results, blood test results etc)

Correspondence & Miscellaneous

Additional sections can be created if there are a lot of pages of a particular type of record or to have the most relevant records easily accessible. In a NIHL claim, for example, there may be a section headed "Audiology" or "ENT records".

GP RECORDS KEY WORDS IN NIHL CLAIMS

also any entries relating to Solicitors requesting GP records.

1. Angina
2. Audiogram
3. Cochlea
4. Diabetes
5. Ears
6. Ear drum
7. Ear surgery
8. Ear syringed
9. Hearing
10. Hearing Aids
11. Heart attack
12. Heart by pass
13. Hypercausis
14. Inner Ear
15. Loss of balance
16. Middle ear
17. Median Nerve
18. Menieres Disease
19. Otitis Externa
20. Otitis Media
21. Oto... anything
22. Otologically
23. Pinna
24. Referral to ENT Consultant
25. Rinnies Test
26. Romberg Test
27. Rubella
28. Stroke
29. Tinnitus
30. Wax
31. Webers Test
32. Any head injury
33. Dizziness

RTAS,

ASPRIN

DIABETIC.

SMOKER.

MEDICATIONS

1. Betahistine
2. Prochlorperazine
3. Gentisone ear drops
4. Sofradex
5. Cerumol ear drops
6. Docusate sodium ear drops
7. Cyclizine
8. Any medication starting ... Quin....

O/e on Examination.

c/o Complaining of.

GLOSSARY OF MEDICAL TERMS

Common Hieroglyphs

++	much/many
#	fracture
Δ	diagnosis
ΔD ΔΔ	differential diagnosis
Rx	treatment
O	nil/nothing/no
↑	up, increasing
→	constant, normal or lateral shift (eg, of apex of heart)
↓	down, decreasing
⊥	central (of the trachea)
1/7	one day
2/52	two weeks
3/12	three months
T 38^6	temperature 38.6
T−2/40 or 2/52	term (ie, date baby due) less 2 weeks
T+1/40 or 1/52	term plus one week
35^4	35 weeks and 4 days
37^3	37 weeks and 3 days
π	period

Common abbreviations

aa	of each (Greek)
AAL	Anterior axillary line
ac	Before meals
ACTH	Adrenocorticotrophic hormone
ad	up to
add	adduction
ADH	Antidiurectic hormone
ADL	Activities of daily living
ad lib	to the desired amount
ADP	Adenosine diphosphate
AE	Air entry
AFB	Acid fast bacillus (TB)
AFP	Alpha-fetoprotein maternal serum and occasionally amniotic amniotic fluid levels tested in pregnancy to screen for neural tube defect in foetus)
AID	Artificial insemination - donor
AIDS	Acquired Immune Deficiency Syndrome
AIH	Artificial insemination - husband
AJ	Ankle jerk (reflex: see also BJ, KJ, SJ, TJ)
alt dieb	Every other day
Al S	Alimentary system
Anti-D	This gamma globulin must be given by injection to Rhesus negative mother who delivers/aborts Rhesus positive child/foetus to prevent mother developing antibodies which would damage a subsequent Rhesus positive baby.

Apgar	Apgar score: means of recording baby's condition at . observing and "scoring" (0, 1 or 2) 5 parameters
Applic	Applications
aq	Water
aq dest/ster	Distilled water/sterilised
aq dest	Distilled water
AR	Analytical standard of reagent purity
ARC	Aids related complex (less damage can result in full blown AIDS)
ARDS	Adult respiratory distress syndrome
ARM	Artificial rupture of membranes
ASD	Atrial septal defect
AST	Aspartate aminotransferase
ATP	Adenosine triphosaphate
aurist	ear drops
A/V	Anteverted
bd	both
b.d.	twice a day
BJ	Biceps jerk (reflex: see AJ)
B.S.	British Standard
Blood Sugar	Normal 2.5 - 5.5 mmol/1
Blood Urea	Normal 2.5 - 6.6 mmol/1
BMR	Basal metabolism rate
BNF (plus date)	British National Formulary (prescriber's bible supplied free to all NHS doctors). New edition each year. You can buy one for about £10.00 from medical bookshops.
BO	Bowels open

BP (plus date)	British Pharmacopoeia
BP	Blood pressure
BS	(i) Breath sounds (ii) Bowel sounds (iii) Blood sugar (iv) British Standard
c	With (latin: cum)
C_2H_5OH	Alcohol
Ca	(i) Carcinoma/cancer (ii) Calcium
Caps	Capsules
CAT scan	Computed axial tomograph
cp	compare
CIN	Cervical intraepithelial neoplasia (cervical cancer)
CMV	Cytomegalovirus
CNS	Central nervous system
CO	Complaining of
CO_2	Carbon dioxide
COETT	Cuffed oral endotracheal tube (see COT and ETT)
comp	compounded of
COT	Cuffed oral tube (endotracheal tube used for ventrilating a patient who cannot breathe unaided)
CPD	Cephalo-pelvic disproportion (baby too big to fit through pelvis)
crem	a cream
CSF	Cerebro-spinal fluid

CTG	Cardiotocograph trace during labour of baby's heart a. mother's contractions
CVA	Cardiovascular accident (stroke)
CVS	Cardiovascular system
Cx	Cervix
CXR	Chest X-ray
D	Diagnosis (GOK - God only knows)
DIC	Disseminated intravascular coagulation (a serious complication of many conditions - relates to widespread thrombosis)
dil	dilute
DNA	(i) Did not attend (ii) Deoxyribonucleic acid
D & V	Diarrhoea and vomiting
DOA	Dead on arrival
DOPA	Dopamine
DVT	Deep vein thrombosis
D/W	Discussed with
Dx	Diagnosis
ECG	Electrocardiography
ECT	Electroconvulsive therapy
EDD	Expected date of delivery
emf	Electromotive force
EM	Electron micrography
EMG	Electromyo/gram/graph
emp	emplastrum - a plaster
enem	enemata - enemas

EOG	Electro-oculogram
ER	External rotation
ERCP	Endoscopic retrograde cholangio-pancreatography/scope
ERPC	Evacuation of retained products of conception
ERG	Electroretinogram
ESR	Erythrocyte sedimentation rate
Ex	Extension
FB	Finger's breadth
FBC	Full blood count
FBS	Foetal blood sampling (ob)
FH	Family history
FHH	Foetal heart heard
FHHR	Foetal heart heard regular
FHR	Foetal heart rate
Flex	Flexion
FLK	Funny looking kid
FMF	Foetal movements felt
FSE	Foetal scalp electrode
FSH *or*	Family/social history Follicle-stimulating hormone
GA	General anaesthetic
garg	gargles
glc	gas liquid chromatography
GTT	glucose tolerance test

GFR	glomerular filtration rate
GIT	Gastrointestinal tract
GM	Geiger Muller
GUT	Genitourinary tract
Hb	Haemoglobin
HCG	Human chorionic gonadotrophin
HCO	History of present complaint *or* HPC
hn	hac nocte - tonight
hs	hora somni - at bed time
HS	Heart sounds
HSA	Human serum albumin
HVS	High vaginal swab
Hx	History
ICF	Intracellular fluid
ICS	Intercostal space
IgA, IgB, IgG, IgM	Immunoglobulins
IJV	Internal Jugular vein
IM	Intramuscular
Implant	Implantation
In aq	In water
Inj	Injections
IP	Intraperitoneal
IR	Internal rotation
Irrig	Irrigations

IVI	Intravenous infusion
K	Potassium
KJ	Knee jerk
KPa	Kilopascal, approx 7.5 mm Hg
L	Litre
LA	Local anaesthetic
LATS	Long acting thyroid stimulator
LFT	Liver function tests
LH	Lutenizing hormone
LIH	Left inguinal hernia
Linc	Linctus
Lin	Liniments
Liq	Solutions
LMP	Last menstrual period
LN	Lymph node
LOA	Left occiput anterior
LOC	Loss of consciousness
LOL	Left occiput lateral
LOP	Left occiput posterior
LSCS	Lower segment Caesarean section
LSK	Liver, spleen, kidneys
m	mix
mane	in the morning
mcg	microgram

MCL	Mid clavicular line
mg	milligram
mmtg	mm of mercury unit of pressure
ml	millilitres
mp	melting point
MSH	Melanophore stimulating hormone
MSU	Midstream Specimen of Urine
N & V	Nausea and vomitting
NAD	Nothing abnormal detected
NBM	Nil by mouth
Neb	a spray
ng	nanogram
NG	Neoplastic growth
NG	Nasogastric
NGT	Nasogastric tube
NMCS	No malignant cells seen
NOF	Neck of femur
N/S	Normal size
O_2	Oxygen
Occulent	Eye ointment
OA	Occipito-anterior
od	daily
OD	Outside diameter
OE	On examination

OM	Every morning
OE	Every evening
OP	Occipito-posterior
PR	Pulse rate
Pa	Pascal
PAS	Periodic acid - Schiff reaction
pc	after meals
PCG	phonocardiogram
PCV	Packed cell volume
PERLA	Pupils are equal and react to light and accommodation
PE	Pulmonary embolism
pes	pessaries
PET	Pre-eclampsia toxaemia
ph	acidity/alkilinity scale
PH	Past history
PID	Pelvic inflammatory disease *or* Prolapsed intravertebral disc
PMH	Past medical history
PN(R)	Percussion note (resonant)
PNS	Peripheral nervous system
PO	Per or - by mouth
PR	Per rectum
PV	Per vagina
PRN	As required/as occasion arises
RBC	Red blood cells

Rh	Rhesus
rh	relative humidity
RIA	Radio immune assay
RIH	Right inguinal hernia
ROA	Right occiput anterior
ROL	Right occiput lateral
ROM	Range of movement
RPF	Renal plasma flow
RQ	Respiratory quotient
RS	Respiratory system
RT	Reaction time
RTI	Respiratory tract infection
S/B	Seen by
S/D	Systolic/diastolic
SEM	Scanning electron microscope
SH	Social history
SJ	(?) jerk
SOA	Swelling of ankles
SOB	Shortness of breath
SOS	Si opus sit (if necessary see other sheet
SROM	Spontaneous rupture of membranes
SVC	Superior vena cava
SVD	Spontaneous vaginal delivery

TCI 3/52	To come in three weeks time
TGH	To go home
THR	Total hip replacement
TID	Three times a day
TJ	Triceps jerk
TFTS	Thyroid Function Tests
TSH	Thyroid stimulating hormone
U & E	Urea and electrolytes
Ung	Ointments
UG	Urinogenital system
URTI	Upper respiratory tract infection
VE	Vaginal examination
VF	Ventrical fibrillation
VT	Ventrical tachycardia
V/V	Vulva and vagina
WBC	White blood count/corpuscle

Definitions

Carpals—Wrist bones.

Clavicle—Bone which forms the anterior part of the shoulder (collarbone).

Femur—The bone extending from the pelvis to the knee.

Fibula—The outer and smaller of the two bones of the leg beneath the knee.

Humerus—The bone extending from the shoulder to the elbow.

Ilium—The higher, expansive portion of the hipbone.

Ischium—Lower portion of the hipbone.

Metacarpals—The bones of the hand.

Metatarsals—The bones of the feet.

Patella—The kneecap.

Phalanges—The bones of the finger and toes.

Radius—The bone on the outer side of the forearm.

Sacrum—Curved bone of the lower back, just above the tailbone.

Scapula—Large bone forming the posterior part of the shoulder (shoulder blades).

Skull—The bony framework of the head.

Sternum—The narrow, flat bone in the front of the rib cage, in line with the thorax (breastbone).

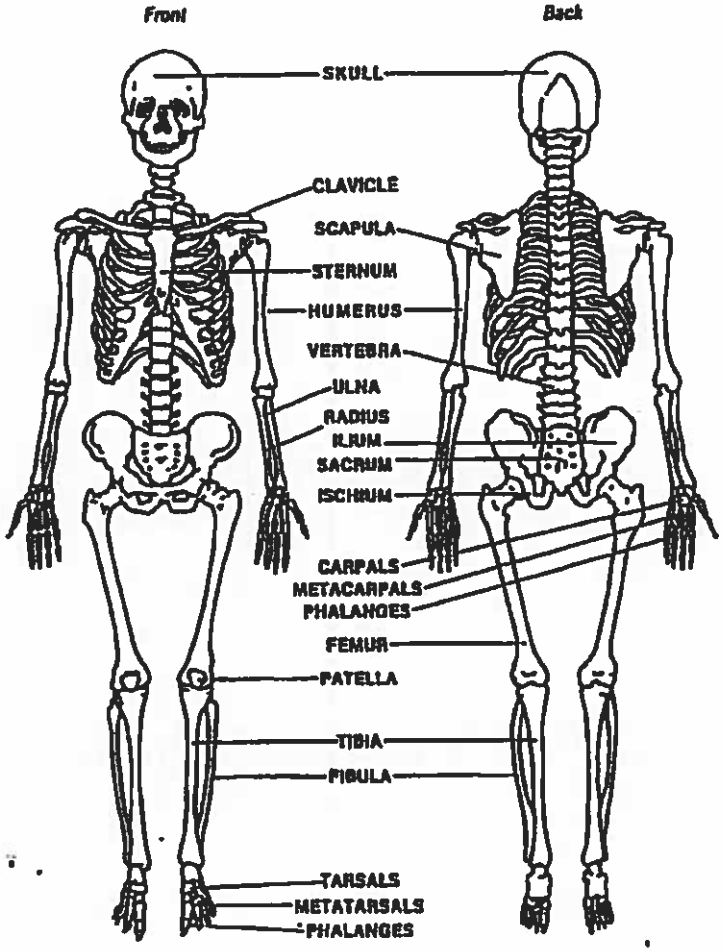
Tarsals—The seven bones of the ankle.

Tibia—The inner and larger bone of the leg below the knee.

Ulna—The inner and larger bone of the forearm.

Vertebra—Any one of 33 bones of the spinal column.

THE SKELETON



DIGESTIVE SYSTEM

Definitions

Anal canal—The terminal portion of the large intestine.

Anus—Outlet of the intestinal tract.

Ascending colon—That portion of the large intestine extending from the appendix in an upward direction to the liver.

Cecum—The first portion of the large intestine.

Descending colon—That portion of the large intestine which extends downward from the transverse colon to the sigmoid colon.

Duodenum—That part of the small intestine extending from the pylorus to the jejunum.

Esophagus—The muscular food canal extending from the pharynx to the stomach, (Cervical Part)—upper portion of the esophagus near the pharynx; (Thoracic Part)—that part of the esophagus which passes downward through the chest area; (Abdominal Part)—that portion of the esophagus which enters the abdominal cavity.

Gallbladder—A pear-shaped sac on the under-surface of the liver which acts as a receptacle for bile discharged from the liver.

Ileum—The lower portion of the small intestine which extends from the jejunum to the ileo-cecal valve.

Jejunum—A long connecting link of the small intestine which extends from the duodenum to the ileum.

Liver—A large organ which excretes bile, produces many life-sustaining functions, a main source of body heat, assists in blood purification, stores Vitamin B-1, and assists in the formation of Vitamin K.

Pelvic (sigmoid) colon—The final S-shaped portion of the large intestine, situated in the pelvic area.

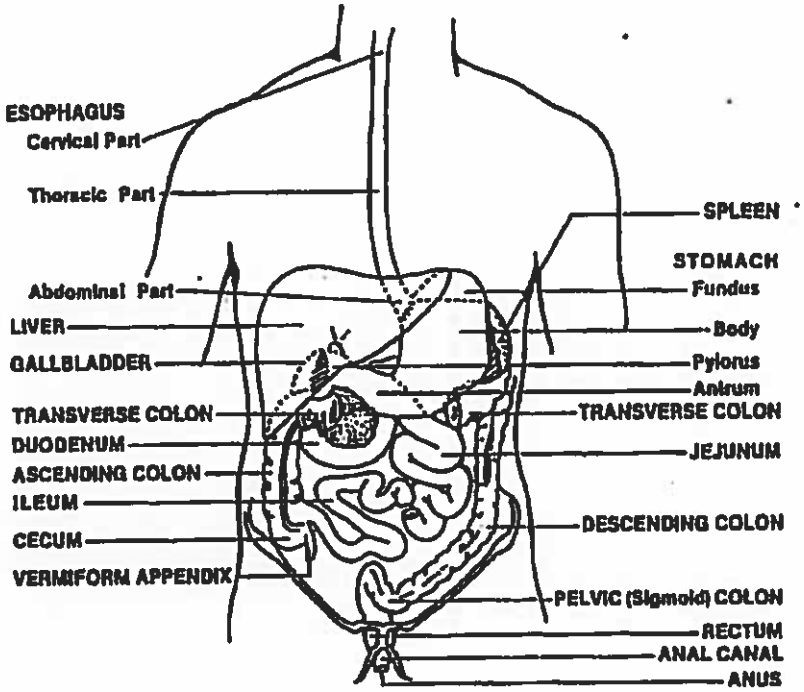
Rectum—The terminal part of the large intestine.

Spleen—An organ situated in the upper left quadrant of the abdomen; its main function is blood filtering and blood lymphocyte (special white blood cell) formation, and removal of bacteria from the blood stream.

Stomach—One of the main organs of digestion. It contains four segments: the Fundus, the Body, the Antrum, and the Pylorus.

Transverse colon—That part of the large intestine which takes a transverse course from the liver to the spleen.

Vermiform appendix—A worm-shaped tube connected to the cecum.



Definitions

Balloon of the endotracheal tube—An inflatable balloon attached to the endotracheal tube which, when inflated, prevents leakage of air around it, and the aspiration of foreign material into the lungs.

Cervical spine—The first seven bones of the spinal column.

Endotracheal tube—A tube inserted in the windpipe to provide oxygen to the lungs.

Esophagus—The gullet; a muscular passageway for food, extending from the pharynx to the stomach.

Larynx—The voice box containing the vocal cords.

Nasopharynx—That part of the pharynx situated above the soft palate.

Thyroid gland—A ductless gland which produces the thyroid hormone that regulates metabolism and body weight.

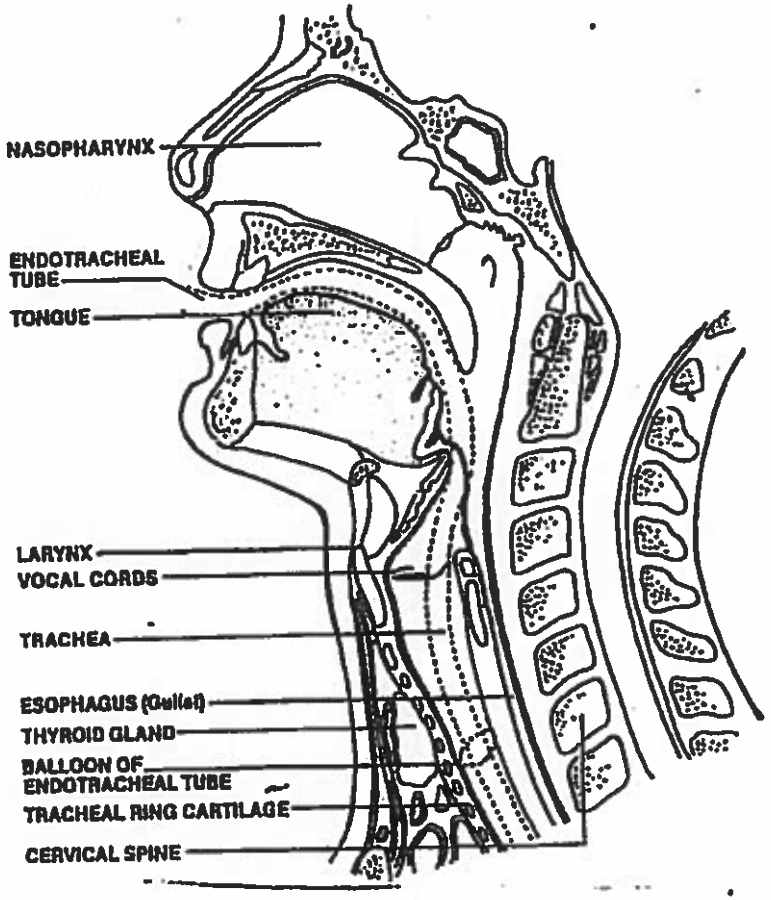
Tongue—A freely-movable, muscular organ in the mouth, designed to assist food in mastication, taste food, and produce speech.

Trachea—A cartilagenous tube extending from the larynx to the bronchial tubes; often called the windpipe.

Tracheal ring cartilage—A part of the skeleton occurring in the cartilages in the trachea.

Vocal cords—Two membraneous bands situated in the voice box, which, when drawn tense, are caused to vibrate by the passage of air from the lungs, resulting in speech sounds.

Showing Endotracheal Tube in Position



Definitions

Aortic arch—One of three divisions of the aorta.

Celiac artery—The first branch of the abdominal artery.

Femoral arteries—The blood vessels which supply blood to the femoral region - from the thighbone to the knee.

Hepatic artery—The artery supplying blood to the liver.

Iliac artery—The artery which supplies blood to the region of the groin.

Left carotid artery—Supplies blood to the left side of the head and neck.

Left subclavian artery—Supplies blood to the left arm.

Popliteal artery—Major artery to the lower leg passing through the posterior part of the knee.

Renal artery—Supplies blood to the kidneys, ureters, and adrenals.

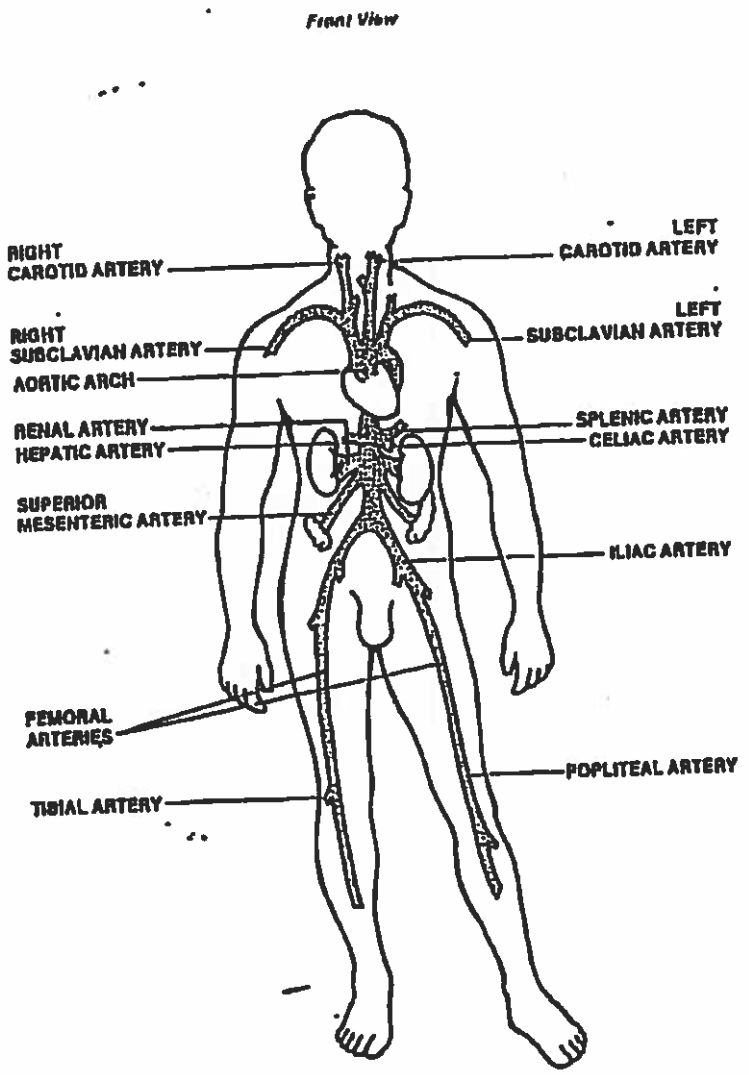
Right carotid artery—Supplies blood to the right side of the head and neck.

Right subclavian artery—Supplies blood to the right arm.

Splenic artery—Supplies blood to the spleen.

Superior mesenteric artery—Supplies blood to all of the small intestine, except the higher portion of the duodenum.

Tibial artery—Supplies blood to the lower extremities.



BASIC GUIDE TO THE MORE COMMON SPECIALITIES

1) Any aspects of birth - conduct of mother's labour and fetus in utero - ***Obstetrician***

2) Post-natal and children up to 14 years - ***Paediatrician***

   (Many Paediatricians will specialise within the field, eg, Paediatric Neurologists. Many will also specialise in neonatal as opposed to general paediatric matters).

3) Brain and central nervous system - ***Neurologist/Neurosurgeon***

4) Spinal surgery - ***Neurosurgeon*** (rather than Orthopaedic Surgeon)

5) Cancer treatment - ***Oncologist/Oncological Surgeon or Radiotherapist***

6) Bones and fractures - ***Orthopaedic Surgeon*** (Many Orthopaedic Surgeons will specialise in the treatment of parts of the body ie, hand, foot.

7) Eye treatment - ***Ophthalmologist***

8) Eye surgery - ***Ophthalmic surgeon***

9) Heart surgery - ***Cardiologist***

10) Surgery of the heart, vascular system, lungs, etc - ***Cardiothoracic Surgeon / Cardiac Surgeon / Cardiovascular/General Surgeon***

11) Lung and Chest treatment - ***Chest Physician***

12) Bladder - ***Urologist or Genito-Urinary Surgeon*** or, say, associated with hysterectomy or prolapses - ***Gynaecologist***

13) Kidney - ***Nephrologist***

14) Allergic reaction of any kind - ***Immunologist***

15) Drug related matters - ***Pharmacologist***

16) Diseases of the endocrine glands and their dysfunction - ***Endocrinologist***

17) Conditions relating to the skin - ***Dermatologist***

18) Neonates (children less than 4 weeks) - Many specialities, not just ***Neonatologists***

19) Blood - ***Haematologist***

20) Body generally - ***General Physicians and General Surgeons*** (however, increasingly specialised, ie, ***Chest Physicians***

21) Breast - either ***Plastic or General Surgeon***

22) Ear Nose and Throat - ***ENT Surgeon or Otorhinolaryngologist or otolaryngologist*** (ear and throat)

23) Rectum - ***Colorectal/Anorectal Surgeon***

24) Stomach and bowels - ***Gastroenterologist or Gastroenterological and General Surgeons***

25) Female reproductive organs - ***Gynaecologist***

26) X-rays - ***Radiologist or Neuroradiologist***

27) ***Anaesthetists*** - For any accident during an operation, an anaesthetist is required in adition to the surgeon.

MEDICAL QUALIFICATIONS

Royal College of Physicians

MRCP — Member of the RCP. The Colleges highest qualification

FRCP — Fellow of the RCP. Only given by election, seniority, chronology or general decay.

Royal College of Surgeons

FRCS — Highest qualification

MRCS — Qualifying Diploma

Royal College of General Practitioners

MRCGP — Member RCGP. Higher Diploma

FRCGP — Fellow RCGP. By election etc

Qualifying Degrees

MBBS — Batchelor of Medicine awarded by most universities. Some universities are different (eg, Oxford, BM BCh)

MRCS LRCP — Awarded by the Conjoint Board of the Royal College of Surgeons and Licentiate of the Licentiate of the Royal College of Physicians. The same status as MBBS but not awarded by a university.

		FRCP	FRCOG	FRCGP	By election
	FRCS	MRCP	MRCOG	MRCGP	Highest Qualification
MBBS	MRCS	LRCP			Qualifying Degrees

BAO	Bachelor of the Art of Obstetrics
BDS	Bachelor of Dental Surgery
BDSc	Bachelor of Dental Science
BM	Bachelor of Medicine
ChB	Bachelor of Surgery
DA	Diploma in Anaesthetics
DLO	Diploma in Laryngology and Otology
DO	Diploma in Ophthalmology
FFARCS	Fellow of the Faculty of Anaesthetists of the Royal College of Surgeons
FRCPath	Fellow of the Royal College of Pathologists
FRCPsych	Fellow of the Royal College of Psychiatrists

Research Degrees

MD or MS, occasionally MChir and at Oxford DM. These have roughly the same status as PhD or DPhil and will vary according to university.

THE HOSPITAL HIERARCHY

A. *'THE FIRM'*

1) Consultant - Senior Specialist in a particular field and the head of a 'firm' of hospital doctors. It is the Consultant who will have overall charge of a patient's treatment.

2) Senior Registrar - Will do all that a Consultant can and indeed, many Senior Registrars are every bit as competent as a Consultant but may merely be awaiting one of the rare vacancies for a Consultancy to become available.

3) Registrar - Doctor who is acquiring specialist experience and holds a Registrar post in a hospital speciality. A Registrar will perform operations without supervision unless a very difficult procedure is involved.

4) Senior House Officer (SHO) - May do routine operations under the supervision of a more senior member of the 'firm'.

5) House Officer (HO) - This is the first appointment of any newly qualified doctor, and as a House Officer, they will gain experience within a hospital before embarking on a career as a specialist family doctor, etc. They are frequently resident in the 'house' ie, the hospital.

NOTE: NHS patients have no right to choose who performs any operation. Although a Consultant will normally make ward rounds, it is possible that the patient will not see them throughout any treatment or before or after an operation.

UNIVERSITY HIERARCHY

Professor and Senior Lecturer - equivalent status to Consultant Lecturer - equivalent grade to senior registrar, occasionally to registrar.

There are also associate specialists, hospital practitioners, staff grades and clinical assistants.

B. *NURSING STAFF*

1) Sister or Charge Nurse (male equivalent)

2) Staff Nurse

(Note: The 'Nurse in Charge' is the person responsible for the patients, nursing and other staff on a particular ward)

3) **Final Year RGN student nurse**

4) **Second Year RGN student nurse**

5) **First Year RGN student nurse**

6) **Nursing Auxiliaries - not trained nurses but will help with duties such as bathing and distributing meals**

7) **RMN - Registered Mental Nurse**

8) **Midwives (known as student midwives when qualifying and registered midwives when qualified)**

With project 2000, student nurses will still be on the wards, but less visible. There will, however, be a new worker, the health care support worker who has a short period of training in practical tasks to replace the service contribution of student nurses.

C. OTHER PROFESSIONALS WHO WILL ASSIST THE 'FIRM'

1) **Anaesthetist - Anaesthetisa is a specialist area in which doctors can progress in the same way to Consultancy level**

2) **Radiologist - Medical practitioner in diagnostic and therapeutic art of X-ray**

3) **Radiographer - X-ray technician**

4) **Physiotherapist - Following disease or injury will, by physical manipulation attempt to restore function**

Neutral Citation Number: [2008] EWCA Civ 1374

Case No: B3/2008/0481

IN THE SUPREME COURT OF JUDICATURE
COURT OF APPEAL (CIVIL DIVISION)
ON APPEAL FROM PORTSMOUTH COUNTY COURT
HIS HONOUR JUDGE DIXON
5PO 04194

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 11/12/2008

Before :

THE MASTER OF THE ROLLS
LORD JUSTICE DYSON
and
LORD JUSTICE JACKSON

Between :

GOODWIN	**Appellant**
– and –	
BENNETTS UK Limited	**Respondent**

(Transcript of the Handed Down Judgment of
WordWave International Limited
A Merrill Communications Company
190 Fleet Street, London EC4A 2AG
Tel No: 020 7404 1400, Fax No: 020 7831 8838
Official Shorthand Writers to the Court)

Mr Martin Porter QC (instructed by Larcomes) for the Appellant
Mr Jonathan Waite QC and Ms Claire Toogood (instructed by Berrymans Lace Mawer) for the Respondent

Hearing dates : 11 November 2008

Judgment
As Approved by the Court

Lord Justice Jackson :

1. This judgment is in six parts as follows:

Part 1. Introduction

2. This is an appeal by the claimant against the rejection of her claim for damages for personal injuries sustained in the course of her employment. The claimant contends that the defendant's breaches of statutory duty and negligence caused her to sustain tenosynovitis as a result of keyboard use whilst working at the defendant's office.

3. In this judgment I shall refer to work related upper limb disorder as "WRULD". I shall refer to the Health and Safety (Display Screen Equipment) Regulations 1992 as "the 1992 Regulations". Regulation 1 of the 1992 Regulations provides as follows:

> "(2) In these Regulations–
>
> (a) "display screen equipment" means any alphanumeric or graphic display screen, regardless of the display process involved:×
>
> (c) "use" means use for or in connection with work;
>
> (d) "user" means an employee who habitually uses display screen equipment as a significant part of his normal work: and
>
> (e) "workstation" means an assembly comprising–

(i) display screen equipment (whether provided with software determining the interface between the equipment and its operator or user, a keyboard or any other input device),

(ii) any optional accessories to the display screen equipment,

(iii) any disk drive, telephone, modem, printer, document holder, work chair, work desk, work surface or other item peripheral to the display screen equipment, and

(iv) the immediate work environment around the display screen equipment."

Regulation 2 of the 1992 Regulations provides as follows:

"2. (1) Every employer shall perform a suitable and sufficient analysis of those workstations which–

(a) (regardless of who has provided them) are used for the purposes of his undertaking by users; or

(b) have been provided by him and are used for the purposes of his undertaking by operators,

for the purpose of assessing the health and safety risks to which those persons are exposed in consequence of that use.

(2) Any assessment made by an employer in pursuance of paragraph (1) shall be reviewed by him if–

(a) there is reason to suspect that it is no longer valid; or

(b) there has been a significant change in the matters to which it relates;

and where as a result of any such review changes to an assessment are required, the employer concerned shall make them.

(3) The employer shall reduce the risks identified in consequence of an assessment to the lowest extent reasonably practicable."

Regulation 4 provides:

> "4. Every employer shall so plan the activities of users at work in his undertaking that their daily work on display screen equipment is periodically interrupted by such breaks or changes of activity as reduce their workload at that equipment."

Regulation 6 provides:

> "6. (1) Where a person–
>
> (a) is already a user on the date of coming into force of these Regulations; or
>
> (b) is an employee who does not habitually use display screen equipment as a significant part of his normal work but is to become a user in the undertaking in which he is already employed,
>
> his employer shall ensure that he is provided with adequate health and safety training in the use of any workstation upon which he may be required to work."

Regulation 7 provides:

> "7. (1) Every employer shall ensure that operators and users at work in his undertaking are provided with adequate information about–
>
> (a) all aspects of health and safety relating to their workstations; and
>
> (b) such measures taken by him in compliance with his duties under regulations 2 and 3 as relate to them and their work.
>
> (2) Every employer shall ensure that users at work in his undertaking are provided with adequate information about such measures taken by him in compliance with his duties under regulations 4 and 6(2) as relate to them and their work.
>
> (3) Every employer shall ensure that users employed by him are provided with adequate information about such measures taken by him in compliance with his duties under regulations 5 and 6(1) as relate to them and their work."

4. The Health and Safety Executive published helpful guidance concerning the 1992 Regulations. This guidance would or should alert employers to the need to protect keyboard workers against the risk of WRULD.

5. After these brief introductory remarks I must now turn to the facts.

Part 2. The facts

6. The claimant was born on 9 May 1974 and so is now aged 34. Between April 2000 and June 2003 the claimant was employed as an insurance adviser by the defendant, a firm of insurance brokers. The offices at which the claimant worked were as follows. The claimant began working in the defendant's Portsmouth office. In January 2001 the claimant was transferred to the defendant's Eastleigh office. In March 2001 the claimant was transferred to the defendant's Southampton office. In May 2001 the claimant was transferred back to the defendant's Portsmouth office, where she remained until she was made redundant in June 2003. The claimant's line manager was Mr Richard Burton who was based at the Southampton office. Mr Gareth Andrews was team leader of the renewals department at the Southampton office. He also had some responsibility for the claimant's work.

7. The principal part of the claimant's work comprised inviting customers to renew their insurance policies. The policies related to household insurance, motor insurance and so forth. In addition, the claimant carried out a number of other administrative and clerical functions. The claimant sat at a workstation in the defendant's office. She prepared letters inviting renewal on her computer using a standard form keyboard and mouse. After such letters had been typed up, from time to time they had to be collected from the computer.

8. In May 2002 the defendant decided to introduce a bonus scheme for its renewal staff. This was known as the "star performance renewal scheme" and was intended to reward staff with additional daily payments according to the number of renewals which they completed. This was reflected in the award of stars. However, the scheme was on the basis that individual reward also depended in part upon the performance of the whole team of which the individual was a member. The purpose of the scheme was to meet concern amongst clerical and administrative staff that they were not getting the opportunities to earn extra money, which opportunities were available to sales staff. The scheme proved to be extremely popular. The defendant quickly discovered that it had not structured the scheme as it would have liked, because it was too generous to enable the defendant to sustain the scheme. Accordingly the defendant revised the terms of the scheme with effect from 1 August 2002. In simple terms the effect was that rewards to individual members of staff were still dependent upon the number of additional renewals achieved each day, but the rates of return were less generous.

9. Before the introduction of the bonus scheme the claimant was doing about 50 renewals per day. After the scheme had been put in place the number of renewals

which the claimant dealt with per day increased. The extent of that increase has been a matter of controversy. It is clear however that the number of renewals per day never rose above about 70.

10. In late July or August of 2002 the claimant was involved in a minor road traffic accident. She was a passenger in a car which stopped suddenly, she was thrown forward in her seat and put her hands out to protect herself, causing them to strike the dashboard.

11. During the summer of 2002 the claimant started to notice aching in both wrists which became steadily worse. During August of 2002 the claimant told Mr Burton about the pain in her wrists. She also told him about the road traffic accident. Mr Burton gained the impression (whether rightly or wrongly) that the two matters were related. Mr Burton suggested that the claimant should consult her GP.

12. The claimant took her annual holiday in the last fortnight of September 2002. During that period the symptoms subsided.

13. At the beginning of October the claimant returned to work after her holiday. The pain in her wrists returned. On 11 October 2002 the claimant consulted her GP about the pain in her wrists. The GP's notes record that he examined the wrists and considered the possibility of carpel tunnel syndrome and repetitive strain injury.

14. On 23 October the claimant consulted her GP again and was signed off work for two weeks. The GP's notes for that date read as follows:

> "Both wrists painful. Quite incapacitating. Not tried NSAID yet - start. Certificate tenosynovitis."

The claimant returned to work in early November. Initially the claimant was put to work on projects other than renewals, but quite soon the claimant was once again dealing with renewals. It does seem, however, that the number of renewals which the claimant was dealing with per day, was lower than the number of renewals which she had been dealing with per day before 23 October.

15. On 27 November 2002 the claimant consulted her GP. He made the following brief entry in his notes:

> "Hand improving because not typing. Heading for another job."

The claimant asserts that in late December 2002 and early January 2003 the number of renewals which the claimant did each day progressively increased. However the contemporaneous records (summarised by Mr Burton at his exhibit "RB7") show that the number of renewals undertaken by the claimant per day remained roughly

constant during this period and subsequently. The claimant was doing between 25 and 30 renewals per day.

16. The wrist pain which the claimant had previously suffered returned in January 2003 and grew worse. On 24 February 2003 the defendant's human resources director sent a questionnaire to Dr Dinapala, the claimant's GP, seeking medical advice. The GP duly returned that form with his responses to the questions put by the defendant. It is not entirely easy to read all that the GP wrote. However, one of the things which he put on the form was that the defendant should minimise repetitive tasks.

17. During 2003 there were other issues between the claimant and her employers, as a result of which the claimant invoked the grievance procedure. In due course the claimant accepted voluntary redundancy. In June 2003 the claimant ceased to be employed by the defendant.

18. In June 2003 and for a period afterwards the claimant continued to experience pain in her wrists, for which she considered that her former employers were responsible. Accordingly the claimant took legal and medical advice and, in due course, commenced the present proceedings.

Part 3. The Present Proceedings

19. By a claim form issued in the Portsmouth County Court on 15 July 2005 the claimant claimed damages for personal injuries and consequential losses on the grounds of negligence and breach of statutory duty by the defendant as her employer.

20. The claimant's case has evolved over time. In its final form the claimant's case may be summarised as follows. The introduction of the bonus scheme in May 2002 led to an increase in the number of renewals dealt with by the claimant each day. Between May 2002 and June 2003 the defendant failed to comply with its duties under Regulations 2, 4, 6 and 7 of the 1992 Regulations or to take reasonable care to protect the claimant from suffering wrist injury. As a result the claimant developed a form of WRULD, namely tenosynovitis. Tenosynovitis means inflammation of a tendon sheath. The tendons affected in the claimant's case are the flexor tendons of the thumb and index finger on both sides.

21. The action was tried before HH Judge Dixon over four days in November 2007. The claimant called four factual witnesses at trial, namely herself and three former colleagues at work. She called a medical expert, Dr Hull, and an expert ergonomist, Mr Hinckley. The defendant called two factual witnesses, namely Mr Burton, who was the claimant's manager, and Mr Morley who was Mr Burton's manager. The defendant also called a medical expert, Mr Warwick, and an expert ergonomist, Mr

Pearce. I shall refer to the evidence given by those witnesses, so far as necessary, in parts 4 and 5 below.

22. The judge delivered his reserved judgment on 4 January 2008, dismissing the claimant's claim. The judge held that the defendant had been in breach of regulations 2, 6 and 7 of the 1992 Regulations, but those breaches had not been causative of injury to the claimant. The judge held that the defendant had not been in breach of regulation 4, nor had the defendant been negligent. In relation to the medical issues, the judge rejected Dr Hull's diagnosis of tenosynovitis. He preferred the view of Mr Warwick that the claimant's symptoms were not caused by her work, although they were "exposed" by it. Finally, the judge assessed damages in case he should be held to be wrong on the issues of liability and causation. He assessed general damages for pain, suffering and loss of amenity at £4,000. He assessed damages for loss of earning capacity in the sum of £8,000. He noted that special damages were agreed between the parties at £31.90.

23. The claimant was aggrieved by the court's rejection of her claim on liability and causation. Accordingly she has appealed to the Court of Appeal.

Part 4. The Appeal to the Court of Appeal and the threshold question

24. By a notice of appeal dated 29 February 2008 the claimant appeals to the Court of Appeal on five grounds. These five grounds are as follows:

(i) The judge erred in finding that the defendant had not been in breach of his duty under regulation 4 of the 1992 Regulations.

(ii)The judge erred in finding that the defendant had not been negligent.

(iii) The judge erred in finding that, had the defendant complied with its duties, it would not have acted differently towards the claimant's work or that, even if it had acted differently towards the claimant's work, such differences would not have made any difference to what happened. This was referred to as the "general causation issue".

(iv) The judge erred in finding that the claimant's injury was not caused by the claimant's work. This issue was referred to as the "medical causation issue".

(v) The judge erred in rejecting the claimant's "fallback" argument that the recurrence of symptoms in early 2003 was caused by the defendant's negligence and/or breach of the 1992 Regulations.

25. Although medical causation only features as the fourth ground of appeal, logically this issue must be considered first. It is the threshold question. If the claimant fails on medical causation, then that is the end of her claim. If the claimant succeeds on medical causation then she crosses the threshold and the other four grounds of appeal will require consideration. I therefore turn to ground 4, the issue of medical causation.

26. Dr Hull's diagnosis was that the claimant developed tenosynovitis as a result of increased use of the keyboard in and after the summer of 2002. Mr Warwick disagreed with that diagnosis.

27. A significant feature of this case was that the number of keystrokes made by the claimant per day, both before and after May 2002 was not great. Each renewal involved an average of 150 keystrokes. So even if the claimant did 70 renewals in a day, that would only involve 10,500 keystrokes. That is approximately the equivalent of what a good touch typist achieves in half an hour. The claimant is not a touch typist and these observations reflect in no way to her discredit. They are, however, relevant when considering the medical causation issue. The amount of typing which the claimant undertook between June 2002 and June 2003 is not such as would normally cause personal injury.

28. In cross–examination Dr Hull explained that posture, repetition and lack of rest were important in the development of tenosynovitis. If the judge found that those factors were not present, then the diagnosis was unlikely to be tenosynovitis caused by the claimant's work: see day 3, pages 131–133. Mr Warwick expressed similar views on this aspect in his evidence.

29. It is clear on the evidence that the claimant's workstation and posture were satisfactory. The volume of the claimant's work was not such that there was either excessive repetition or insufficient rest.

30. Having considered the medical reports and the oral evidence of Dr Hull and Mr Warwick, I am quite satisfied that the judge was entitled to reject Dr Hull's diagnosis of tenosynovitis.

31. Although the diagnosis of tenosynovitis has been rejected, the fact remains that during the claimant's employment and for a period afterwards the claimant suffered a considerable amount of pain and aching in her wrists. Those symptoms were genuine. The judge found the claimant to be an honest witness, even though mistaken in her recollection about a number of matters of detail.

32. The question arises therefore as to why the claimant suffered these symptoms. In their joint statement prepared for the court the medical experts accepted that the claimant developed symptoms in her wrists and hands (more marked on the left than the right) in the summer of 2002. They considered that the road traffic

accident may or may not be relevant. They recorded that by the time they examined the claimant (October 2003 and July 2006 respectively) the claimant's symptoms were mild and minimal. The experts also summarised their areas of disagreement. In relation to causation they recorded as follows:

> "Dr Hull noted the onset of symptoms towards the end of the working day with a gradual increase in onset of symptoms earlier in the working day, relief with rest such as weekends, holidays and time of work. He noted that the symptoms had virtually resolved following her redundancy in June 2003. Mr Warwick feels that this relation of symptoms to work should be interpreted as meaning that work simply aggravates symptoms from any painful condition rather than primarily causes that condition."

Mr Warwick made a similar observation in the concluding section of his report.

33. Mr Warwick retreated somewhat from the limited concession which he had made in writing, when he came to give his oral evidence. Nevertheless, I regard that concession as properly made, indeed inevitable. There was a clear pattern to the claimant's symptoms in and after the summer of 2002. In periods when the claimant was engaged upon typing significant numbers of renewals her symptoms grew worse. In periods when (a) the claimant was off work or (b) she was at the office but only doing a small amount of typing, her symptoms abated. The underlying cause of the pain in the claimant's wrists is not known and has not been established on the evidence. What has been established, however, is that after the summer of 2002 the claimant's symptoms were aggravated whenever her work consisted principally of typing up renewals. Of course coincidences can happen, as Mr Warwick pointed out in oral evidence. However, the concession made by Mr Warwick in his written report and in the experts' joint statement is plainly correct. The judge ought to have held, on the balance of probabilities, that the pain which the claimant suffered in her wrists was aggravated by her keyboard work.

34. I therefore conclude that to this extent the claimant succeeds on the fourth ground of appeal. Between the summer of 2002 and June 2003 the claimant's keyboard work aggravated the pain which the claimant suffered in her wrists. It is clear to me on the evidence that the claimant's keyboard work made a material contribution to that pain.

35. Since the claimant has succeeded on the threshold question, I must now turn to the other grounds of appeal.

Part 5. Breach and Causation

36. In this part of the judgment I shall address the first, second, third and fifth grounds of appeal.

37. As to the first ground of appeal, there is no dispute that the 1992 Regulations were applicable to the claimant's employment. The claimant was an employee of the defendant, who used a workstation for the purposes of the defendant's business. Accordingly regulation 4 of the 1992 Regulations imposed upon the defendant a duty to plan the claimant's activities so that her daily work on the display screen equipment was periodically interrupted by such breaks or changes of activity as would reduce her workload at that equipment.

38. It is clear from the evidence at trial that the defendant did not comply with regulation 4. Indeed the defendant was unaware of the existence of the 1992 Regulations. The defendant never devised any plan for the claimant, which would meet the requirements of regulation 4.

39. All employers of staff who use display screen equipment should be aware of the 1992 Regulations and should take steps to comply with those regulations. Indeed both the expert ergonomists in this case would have expected the defendant to be familiar with the 1992 Regulations: see paragraphs 7 and 8 of the ergonomists' joint statement.

40. The crucial question which I have to address is whether the defendant's breach of regulation 4 had any causative effect. If the defendant in or before May 2002 had set about devising a plan to comply with regulation 4, the defendant would have taken into consideration the following three facts:

(i) The claimant only used the keyboard to a moderate extent in relation to her work on renewals: see part 4 above.

(ii) The claimant was entitled to a one hour break during the day. The claimant could take this break at lunch time. Alternatively the claimant could take a 45 minute break at lunch time plus a further break or breaks totally 15 minutes at other times: see the judge's findings at page 4 of the judgment, which were open to him on the basis of Mr Burton's evidence.

(iii) As the judge found at pages 4 and 18 of the judgment, the claimant had a number of other tasks to do during the day which did not involve keyboard work. Examples of such tasks were making telephone calls, dealing with post and general administration. The judge was entitled to make these findings on the basis of the claimant's evidence and the evidence of Mr Burton.

41. In my view, the claimant's daily routine was such that it was in practice interrupted by such breaks or changes of activity as would reduce her workload on the display screen equipment.

42. There was some discussion at the hearing as to whether, in effect, the defendant had inadvertently complied with regulation 4. I was initially attracted to that analysis. I have, however, come to the conclusion that that analysis is not correct. Regulation 4 required the defendant to plan the activities of the claimant in a particular way. The defendant did not plan the claimant's activities at all, but instead left the claimant to her own devices at an office some distance away from her manager. The correct analysis is that the defendant was in breach of regulation 4, but that breach had no causative effect. If the defendant had set about devising a plan as required by regulation 4, such plan would not have required any material change to the claimant's existing routine.

43. I turn now to the second ground of appeal. The judge concluded that the defendant had not been negligent for the reasons set out on pages 28 –33 of the judgment. I would summarise the judge's principal reasons as follows. The amount of typing which the claimant did each day in connection with renewals was modest and not such as to cause a reasonable employer to foresee any risk of personal injury. The judge preferred the views of Mr Pearce to the views of Mr Hinckley, who took a somewhat theoretical view of the case. In cross–examination Mr Hinckley had conceded that no force was involved in the claimant's typing; that she did not adopt an awkward posture; and that her work was not unduly repetitive.

44. In respect of the period up to November, the judge's conclusion cannot be faulted. The judge's findings at pages 28–33 of the judgment are fully supported by the oral and written evidence at trial.

45. The position after November requires separate consideration. The claimant was signed off work for two weeks from 23 October. The GP diagnosed her condition as tenosynovitis. The defendant was alerted to the fact that the claimant had pain in her wrists and that such pain appeared to be related to her keyboard work. The claimant's workload on renewals was reduced after she returned to work in November, but that reduction in renewals was not sufficient.

46. There was a recurrence of the claimant's symptoms in early 2003, as described by the claimant in paragraph 11 of her witness statement and amplified in cross–examination on day one. The judge accepted that there was a recurrence of the claimant's symptoms in early 2003: see the second paragraph on page 21 of his judgment.

47. Mr Burton was cross–examined about these matters on day two. That cross–examination included the following passage on pages 108–109 of the transcript:

"Mr Porter Yes? Thank you. And once she was signed off of course, you knew that she was being signed off because of the GPs diagnosis of tenosynovitis.

Mr Burton Yes××.

Mr Porter All right, but what matters is what you knew, rather than what he pleaded and you knew that it was tenosynovitis. And did you know at that stage that was potentially a work related upper limb disorder?

Mr Burton No, I did not; no.

Mr Porter You did not? You still did not know after she had been signed off sick with a diagnosis of tenosynovitis that that might be connected with work?

Mr Burton I did not, at that stage that I received that doctor's note, no.

HHJ Dixon Did you know what tenosynovitis was or had you an idea of it?

Mr Burton I did not, no.

HHJ Dixon So you did not know if it was anything to do with her work or if she had contracted some disease or had an accident at home or what. It could have been anything.

Mr Burton Yes that is right; I did not know.

Mr Porter Okay. Would this note have been submitted to personnel and passed to you, or submitted to you and passed to personnel? What would have happened?

Mr Burton Yes, it would have been sent in for my attention and I would have passed it on to personnel or human resources.

Mr Porter So once you had seen it, it would have gone to personnel and someone in the personnel department would have seen it.

Mr Burton Yes.

Mr Porter And we know that the Claimant returned to work on a reduced workload, or a different workload anyway, In November and you have described how she was doing project work and audit work?

Mr Burton Yes.

Mr Porter Had anyone in the personnel department or anyone else explained to you what tenosynovitis was and what the complications were?

Mr Burton No.

Mr Porter No. So that no doubt is how it came about that by Christmas time you had her back to doing some renewal invitation work.

Mr Burton Yes.

Mr Porter Yes. And that before any advice had been sought from an occupational health physician or a doctor, was it not?

Mr Burton Yes.

Mr Porter And she ended up going into 2003 doing 20 to 30 renewals a day, did she not?

Mr Burton If that is the figure recorded, then yes.

Mr Porter Well it is the figure that she has given and I have not yet heard anyone challenge that, so do you accept that that is what happened?

Mr Burton Yes, that is probably about right.

Mr Porter Do you remember that she got a return of the symptoms, and it became worse again?

Mr Burton Yes.

Mr Porter You do recall that?

Mr Burton Yes."

48. In cross-examination Mr Warwick expressed the view that it would be reasonable in such a situation for the employer to seek medical advice before returning an employee to her original work.

49. In my view, after the claimant's return to work in November it was or ought to have been apparent to the defendant that the claimant was an employee particularly vulnerable to WRULD from moderate use of the keyboard. In those circumstances the defendant was in breach of its duty of care to the claimant in causing or allowing her quite soon after her return to work to process renewals at the rate set out in Mr Burton's exhibit "RB7". (Mr Waite who is counsel for the defendant makes the comment that the entry in exhibit "RB7" in respect of November 2002, which shows a high number of renewals in that month, must be incorrect. I agree with that observation.) It was foreseeable that this would lead to personal injury.

50. In relation to the second ground of appeal, I would uphold the judge's decision in respect of the period up to November 2002. I leave on one side the position in December, when no recurrence of the claimant's symptoms appears to have occurred. In my view, however, the defendant is liable in negligence for the recurrence of the claimant's symptoms which occurred in January 2003.

51. On 24 February 2003 the defendant consulted the claimant's GP, Dr Dinpala. The doctor advised the defendant to "minimise repetitive tasks". This advice appears to have had no impact on what happened in practice. In my view the defendant's breach of duty continued until the claimant's employment was terminated in June 2003.

52. I turn now to the third ground of appeal. The claimant here challenges the judge's conclusion that the defendant's breaches of regulations 2, 6 and 7 of the 1992 Regulations had no causative effect. In relation to regulation 2, I agree with the judge's conclusion. Up until November 2002 the defendant undertook no analysis of the claimant's workstation. However, it is clear from the evidence that if any analysis had been undertaken, it would have led to the conclusion that the claimant's workstation was satisfactory. The defendant did undertake such an analysis in November 2002 and so at that time the defendant's breach of regulation 2 came to an end.

53. I turn now to regulations 6 and 7. The defendant at no time complied with its obligation under these regulations to provide information and training to the claimant about how to use her workstation without suffering personal injury. In respect of the period up to November 2002, I agree with the judge's conclusion that these breaches had no causative effect. Even if the defendant had provided proper training and information, no-one would have expected the claimant's moderate use of the keyboard to be causing personal injury.

54. In respect of the period after November 2002, the position was transformed for the reasons which I have set out above. If the defendant had provided proper

information and training to the claimant, it would at once have become apparent that the claimant's keyboard use needed to be further reduced. I therefore conclude that the defendant's breaches of regulations 6 and 7 caused the recurrence of the claimant's symptoms in early 2003. If the defendant had provided proper information and training in and after November 2002, the keyboard use by the claimant would have been substantially less than 25–30 renewals per day. The consequence would have been that the recurrence of the claimant's symptoms in January 2003 would not have occurred.

55. The fifth ground of appeal is that the judge erred in rejecting the claimant's fallback argument. The claimant's fallback argument was that the recurrence of the claimant's symptoms in early 2003 was caused by the defendant's negligence and breach of the 1992 Regulations. This ground of appeal succeeds to the extent set out above and for the reasons which I have already stated when addressing the second and third grounds of appeal.

Part 6. Conclusion

56. For the reasons set out in part 5 above, this appeal is allowed in part. The claimant is entitled to damages, not in respect of all the injuries pleaded but only in respect of the recurrence of her injuries in and after January 2003.

57. It would be wasteful of costs to remit this case to the trial judge for a further assessment of damages. I therefore propose that each party should submit brief written submissions on the extent to which the judge's assessment of damages stands or requires adjustment in the light of this court's decision on liability and causation. This court will then deal with quantum of damages (if not agreed) on the date when this judgment is handed down.

58. Finally, I express my gratitude to counsel on both sides for the clarity of their skeleton arguments and oral submissions.

Lord Justice Dyson

59. I agree

Master of the Rolls

60. I also agree