Claim No. H90MA033

IN THE HIGH COURT OF JUSTICE

KING'S BENCH DIVISION

MANCHESTER DISTRICT REGISTRY

Before David Allan KC sitting as a Deputy High Court Judge

B E T W E E N:

PHJ
(A Protected Party by her Litigation Friend
SGL)

Claimant

- and –

HMA

Defendant

Winston Hunter KC and Michael Lemmy
(instructed by Simpson Millar
Solicitors) for the Claimant
and
James Todd KC (instructed by Weightmans LLP)
for the Defendant

Hearing dates 9-13, 16-17 October 2023, 7th December 2023

J U D G M E N T

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1. On the 14th March 2016 the Claimant, PHJ, who was then 32 years old, was struck by a vehicle driven by the Defendant, as she was crossing a road in the centre of Bradford. She suffered multiple injuries which included a severe head injury. Primary liability for the accident is admitted in the Defence but there is a dispute as to whether

the damages should be reduced by reason of contributory negligence. There are also many issues between the parties relating to quantum.

2. The accident happened at 5.12pm at the junction of Hall Ings and Bridge Street. The Defendant was driving a Toyota HiAce minibus along Hall Ings in a north easterly direction. The road is subject to a 30 miles per hour speed limit. The Claimant was walking along the pavement of Bridge Street. It was still daylight and the weather was fine and dry. The junction of the two roads was governed by traffic lights. At the point where the Claimant was crossing Hall Ings the road consists of two lanes and then a pedestrian crossing refuge, followed by a further lane before a pedestrian reaches the pavement. The Defendant's vehicle had turned onto Hall Ings from Channing Way, which is about 115 metres from the junction with Bridge Street. The Toyota HiAce approached the junction from the Claimant's right and from the far side of the junction. The Claimant had walked across one lane of Hall Ings and had reached the middle of the second lane when she was struck by the Defendant's vehicle. The force of the impact was such that she was propelled some 31 metres along Hall Ings. As a result of the accident the Defendant was convicted of causing serious injury by dangerous driving and was sentenced to a term of imprisonment.

3. The happening of the accident was captured by CCTV cameras. The films have been analysed by accident reconstruction experts: Mr. Peter Sorton, instructed on behalf of the Claimant, and Mr. Robert Seston, instructed on behalf of the Defendant. In addition to their lengthy written reports they have provided a joint statement and gave oral evidence, although Mr. Sorton was not cross-examined. There is only one point of difference in the views they express. It can be seen from the CCTV film that when

the Claimant reached the junction, she did not pause before starting to cross Hall Ings. Mr. Sorton maintained that the quality of the film did not allow one to determine whether the Claimant looked to see if there was traffic approaching from her right. Mr. Seston contended that one can conclude from the film that the Claimant did not look to her right before starting to cross Hall Ings.

4. The reconstruction experts are agreed on the following details. As the Defendant approached the junction the traffic lights in his direction changed from green to amber. When this change occurred the Defendant's vehicle was some 42 to 50 metres from the stop line and 58 to 66 metres from entering the junction. The amber phase on the traffic lights lasted for 3 seconds. The lights changed to red as the Defendant's vehicle was crossing the stop line. The Defendant's vehicle was accelerating as it approached the junction and continued to accelerate across the junction. When the vehicle passed the stop line it was travelling at about 33mph. When the vehicle struck the Claimant it was travelling at about 45mph. When the Claimant stepped off the pavement the lights had been showing amber for about two seconds. The red figure was displayed on the lights in the direction of the Claimant. A silver car travelling in the opposite direction to the Defendant's vehicle was slowing to a halt at the lights. A group of seven pedestrians had crossed ahead of the Claimant. In a photograph at paragraph 133 of Mr. Sorton's report those pedestrians can be seen standing at the pedestrian refuge at the moment before the Defendant's vehicle struck the Claimant. There was nothing to obstruct the Defendant's view of the Claimant as she crossed the road. When asked in a police interview why he had not seen the Claimant crossing the road the Defendant stated that he was looking in his rear view mirror. The reconstruction experts agree that had the Defendant's vehicle been travelling at 30mph

it would have passed behind the Claimant and would not have struck the Claimant, even in the absence of any braking. Alternatively, at 30mph and upon the traffic lights changing to amber, the Defendant could have stopped his vehicle without emergency braking.

5. Section 1 of the Law Reform (Contributory Negligence) Act 1945 provides that:

> "(1) Where any person suffers damage as the result partly of his own fault and partly of the fault of any other person or persons, a claim in respect of that damage shall not be defeated by reason of the fault of the person suffering the damage but the damages recoverable in respect thereof shall be reduced to such extent as the court thinks just and equitable having regard to the claimant's share in the responsibility for the damage..."

The burden of establishing contributory negligence rests on the Defendant. Where the court is satisfied on a balance of probabilities that contributory negligence is established, then the apportionment exercise has been described thus:

> "There are, as has often been held, two aspects to apportioning responsibility between claimant and defendant, the respective causative potency of what they have done, and their respective blameworthiness..." per Hale L.J. in **EAGLE v. CHAMBERS [2003] EWCA Civ. 1107**, at paragraph 10.

Mr. Winston Hunter KC on behalf of the Claimant submits that contributory negligence is not established and the accident was wholly the fault of the Defendant. Mr. James Todd KC, on behalf of the Defendant, accepts that by far the larger share of liability rests with the Defendant but contends that the Claimant failed to take reasonable care for her own safety and that an appropriate share of liability to be attributed to the Claimant would be 20%.

6. In support of the contention that the Claimant has failed to take reasonable care for her own safety, Mr. Todd KC relies on the guidance in the Highway Code:

> "Rule 21

> At traffic lights there may be special signals for pedestrians. You should only start to cross the road when the green figure shows. If you have started to cross the road and the green figure goes out, you should still have time to reach the other side, but do not delay. If no pedestrian signals have been provided, watch carefully and do not cross until the traffic lights are red and the traffic has stopped. Keep looking and check for traffic that may be turning the corner. Remember that traffic lights may let traffic move in some lanes while traffic in other lanes has stopped."

One knows that pedestrians often do not wait for the green figure to appear before starting to cross a road as evidenced in the present case by the seven pedestrians crossing ahead of the Claimant. If a pedestrian chooses to cross when the red figure is being displayed, then the Defendant contends it is incumbent on the pedestrian to keep a careful lookout.

7. I have had the opportunity of viewing the CCTV film, both as a continuous film and broken down into still photographs. The Claimant stopped to look in a shop shortly before reaching the junction. She has walked at a shallow diagonal towards the pavement edge. The angle was such so that her body was slightly turned in the direction from which the Defendant's vehicle was approaching. One cannot discern from the CCTV film any definite turn of the Claimant's head to the right. If the Claimant had looked to the right there was no obstruction that would have prevented her from seeing the Defendant's approaching vehicle. When the Claimant stepped off the pavement the Defendant's vehicle was about 50 metres from her. The reconstruction experts agree that the Claimant would not have been able to determine the status of the traffic signals governing the stop line which the Defendant's vehicle was approaching. The experts agree that in respect of traffic travelling in the opposite direction the Claimant would have been able to see the status of the traffic signals governing this traffic, albeit the colour of the lights reflected within the cowlings.

8. My conclusions are as follows:

(i) The traffic lights governing the Defendant's vehicle began to change when the Defendant was a sufficient distance from the stop line to have brought his vehicle to a halt without difficulty.

(ii) The Defendant has decided to "jump" the lights and to achieve this objective he has accelerated into and across the junction.

(iii) To compound the risk to other road users he has chosen not to look at the road ahead. His failure to do so was inexplicable and highly dangerous.

(iv) He has performed this reckless manoeuvre in a busy city centre when there were large numbers of pedestrians about, some of whom were in the process of crossing Hall Ings.

(v) As the Claimant approached the junction she became aware that the traffic lights were changing. She is likely to have seen a silver car travelling in the opposite direction to the Defendant slowing so as to stop at the lights.

I am unable to conclude whether the Claimant has seen the Defendant's approaching vehicle. In any event she has assumed that traffic was stopping because the lights were changing. This was a reasonable conclusion and she could not be expected to anticipate that a driver would choose to act as the Defendant did.

(vi) In the above circumstances I conclude that the accident resulted entirely from the deliberate, highly dangerous act of the Defendant and that the allegation of contributory negligence against the Claimant is not established.

THE INJURIES

9. The Claimant sustained the following injuries:

(i) a very severe traumatic brain injury (TBI) and a hypoxic brain injury secondary to cardiac arrest;

(ii) fractures of the occipital condyle and C1 vertebra;

(iii) pneumothoraces of the lungs;

(v) multiple rib fractures on both sides with a florid segment on the right and subcutaneous emphysema;

(v) multiple liver lacerations;

(vi) multiple comminuted pelvic fractures extending to the acetabulum on the right;

(vii) comminuted displaced fractures of tibia and fibula in both legs;

(viii) a comminuted fracture of the right clavicle.

EVENTS FOLLOWING THE ACCIDENT

10. The Claimant suffered a cardiac arrest at the scene of the accident. She was air lifted to Leeds General Hospital and suffered a further cardiac arrest at the hospital. A CT scan of the head on admission revealed bilateral traumatic subarachnoid haemorrhages especially in the right frontal, temporal and parietal lobes, intraventricular haemorrhage and blood around the brain stem. The Claimant was admitted to the intensive care unit. An intracranial pressure bolt was inserted and a tracheostomy performed. Her leg fractures were fixed by nailing and screws.

11. The Claimant remained in intensive care until the 14th April 2016 when she was moved to a neurosurgical ward. She remained an inpatient at Leeds General until the 6th June 2016 when she was transferred to a rehabilitation unit at Chapel Allerton Hospital. On the 20th October 2016 she was transferred to Daniel Yorath House for

further rehabilitation. She was finally discharged home in April 2017 to her flat in Leeds.

12. The attempt at neurorehabilitation support in the community was not successful. Given the effect of her head injury the Claimant was unable to appreciate her need for rehabilitation. She was reluctant to engage with professionals, save that she did attend some appointments with Dr. Todd, a clinical neuropsychologist. In the community her mental state declined, particularly in August 2018. On the 9th September 2018 she was arrested under Section 136 of the Mental Health Act 1983 and admitted to the Becklin Centre in Leeds under Section 2 of the 1983 Act. She was discharged on the 1st October 2018. However, her mental health deteriorated again in January 2019 with increasing signs of paranoia and psychosis. She was readmitted to the Becklin Centre on the 26th March 2019 with a history of deteriorating mental health over the previous 8 weeks. The admission was under Section 3 of the 1983 Act and the grounds for admission were paranoia with severe breakdown of mental health. On the 21st August 2019 she was transferred from the Becklin Centre to York House in York under a deprivation of liberty safeguarding order. She was discharged home on the 15th January 2020. Shortly after her discharge a multidisciplinary team (MDT) was put in place under a case manager. Since January 2020 the Claimant has at times, particularly in 2021, suffered some deterioration in her mental state but she has not required admission as an inpatient, either voluntarily or under compulsion pursuant to the 1983 Act. To assist in the delivery of therapies a flat was provided for the Claimant in a city centre location but the Claimant did not give up the tenancy of her own flat.

13. The medical experts agree that as a result of her head injury the Claimant lacks capacity to conduct litigation and manage her financial affairs, and this will be a permanent state of affairs. There is a good deal of agreement as to the effect of the head injury. Much of the disagreement relates to the Claimant's condition before the accident. It is contended on behalf of the Defendant that in the absence of the head injury the Claimant would have required care and assistance because of her mental state and that as a result there should be a reduction in the damages to be awarded for both past and future care. In support of this submission the Defendant relies on the Court of Appeal's judgment in **REANEY v. UNIVERSITY HOSPITAL OF NORTH STAFFORDSHIRE NHS TRUST 2015 EWCA Civ. 1119**. It will therefore be necessary for me to consider in some detail the Claimant's history and condition prior to March 2016.

CLAIMANT'S LAY WITNESS EVIDENCE

14. In support of the Claimant's claim, reliance is placed on a number of lay witnesses. Some of those witnesses gave oral evidence, namely:

NPT, the Claimant's sister;
EAP, the Claimant's mother;
SGL, the Claimant's partner;
Jenny Locke, the Claimant's case manager from 2020 to 2023;
Dr. David Todd, a clinical neuropsychologist who has treated the Claimant since late 2017.

In addition, reliance is placed on behalf of the Claimant on witness statements from the following:

Hazel Clerkin, an occupational therapist who treated the Claimant from 2020 to 2023;
Carol Varley, who took over as the Claimant's case manager from Jenny Locke in 2023;
Olanike Akinnodi, a rehabilitation support worker, who worked with the Claimant for several months in 2023.

CLAIMANT's APPLICATION FOR PERMISSION TO RELY ON A FURTHER STATEMENT AND FOR RELIEF FROM SANCTIONS

15. At the outset of the trial an issue arose as to a further statement from SGL. Mr. Winston Hunter KC, on behalf of the Claimant, made an application to rely on a statement from SGL dated 4th October 2023. Mr. James Todd KC, on behalf of the Defendant, opposed the Claimant's application. I ruled in favour of admitting the further statement and I said I would give reasons for my decision in the main judgment, which I now do. In the further statement SGL says that he was diagnosed as suffering from type 2 diabetes in about 2010. This condition was related to weight problems. SGL is 5feet 4inches tall and his weight has fluctuated between 26 to 29 stones. In an attempt to control his weight and on the recommendation of his GP, SGL underwent gastric sleeve surgery in 2015. Initially this was successful and SGL's weight reduced, but then increased again and further surgery for a gastric bypass was performed in 2020. Again, surgery was initially successful but SGL's weight has increased and is now about 25 stones. He has been informed that no further surgery is feasible. Exhibited to the statement are letters from Imperial College Healthcare NHS Trust confirming the information regarding the gastric surgery and that further surgery is not an option.

16. The importance of the information in SGL's further statement lies in the fact that he provides much support and supervision for the Claimant. In his absence the cost of care and support will greatly increase. His health and life expectancy are very relevant to the calculation of damages for future care. The application to admit the further statement from SGL was supported by statements from Mr. Matthew Clayton, the Claimant's solicitor. He states that the information regarding SGL's health, weight

and treatment had only recently come to light. Witness statements were originally to be served by 28th January 2022 and this date was extended to 7th March 2022. By an Order dated 6th June 2023 further witness statements were permitted if served by 7th July 2023. In seeking to serve and rely on SGL's statement of the 4th October 2023 the Claimant was in breach of an order and so had to apply for relief from sanctions pursuant to CPR 3.9 which provides:

> "(1) On an application for relief from any sanction imposed for a failure to comply with any rule, practice direction or court order, the court will consider all the circumstances of the case, so as to enable it to deal justly with the application, including the need –
>
> (a) for litigation to be conducted efficiently and at proportionate cost; and
>
> (b) to enforce compliance with rules, practice directions and orders.
>
> (2) An application for relief must be supported by evidence."

17. Applying the test laid down in **DENTON v. T.H. WHITE LTD. 2014 EWCA Civ.906** the first stage is to consider the seriousness of the breach. To serve a witness statement just before trial, a statement containing highly relevant evidence which might have a significant impact on the value of the claim, is a serious breach. The reason for the breach is that the Claimant's representatives were unaware of the matters relevant to SGL's health until shortly before serving the further statement. Given SGL's pivotal role in the care of the Claimant, enquiries should have been made earlier to ascertain his state of health. However, given that six medical experts were to be called to give oral evidence and would have the opportunity to comment on the impact of SGL's diabetes and obesity in relation to his health and life expectancy, I decided it would not be unfair to the Defendant to allow this further statement to be admitted. The diabetes and obesity affecting SGL are matters of fact

which should be taken into account when assessing the appropriate award for future care.

PRE-ACCIDENT CIRCUMSTANCES OF THE CLAIMANT

18. The Claimant had a troubled family life which seems to have centred on the behaviour of her father. He suffered from alcoholism and mental health problems, described as a bipolar disorder. In the Claimant's medical records there is reference to the Claimant having defective hearing from an early age. When the Claimant was 4, in 1988, she was referred to a speech therapist because of delayed speech and language development. At the age of 5 she underwent operations for bilateral myringotomy (creating a hole in the ear drum to allow fluid to escape), tonsillectomy, adenoidectomy and the insertion of grommets. Thereafter the references to hearing problems cease. From the medical records there does not appear to be further concern regarding developmental problems during the Claimant's childhood.

19. In February 1995 there is the first reference to ulcerative colitis and this is then a recurring condition troubling the Claimant. From early 1998 there are many references in the records to eczema particularly affecting the face, which must have been most distressing for a teenage girl. Despite ongoing problems with colitis and eczema the Claimant seems to have progressed normally through primary and secondary schools. Her GCSE results were modest, achieving Cs in two subjects and lower grades in other subjects. She then attended a further education college where she pursued a 3 year course, achieving an NVQ in health and social care. This enabled her to obtain a place on a degree course in health sciences in Leeds but she

then transferred to Manchester Metropolitan University to study nutrition, commencing this course in September 2004.

20. The Claimant's father left the family home in 2004. In the following year he attacked a relative, was arrested and was subsequently sectioned under the Mental Health Act 1983. On discharge from hospital he was in a residential home in Manchester. He was visited by the Claimant who had arranged accommodation in Manchester so that she could pursue her degree studies. She organised a student loan and supplemented her income by returning home to Leeds at weekends and carrying out a job at a supermarket. The first reference to stress induced anxiety is in January 2007 when the Claimant was in what should have been the final year of her degree course. The GP records indicate the Claimant was suffering stress due to her university studies. She was finding it difficult to concentrate, was not eating well and was becoming socially withdrawn. In the following months there are further references to anxiety and depression. The Claimant failed her end of year exams and decided to have a year out before resuming her studies. She went on a trip to India, visiting members of her extended family. While abroad she was prescribed some medication for anxiety which she felt did not help. When seen by a psychiatrist in March 2008 her symptoms were said to have improved. She was not felt to have any psychotic or mood disorder. Her history suggested she might have had a moderate to severe depression. She experienced a frightening incident in 2008 working at Tesco when a customer threw a bottle at her.

21. The Claimant returned to university in September 2008. In October 2008 her symptoms of depression were said to be in partial remission. She completed her final year and passed her exams but only achieved an ordinary degree.

22. Following completion of her degree in 2009, the Claimant returned to live with her mother and sister in the family home in Leeds. While at university the Claimant had developed an online friendship with SGL, a man who was nearly 10 years older than her. For several years they communicated online and by phone. During this time SGL was working full-time in London. They eventually met in person in late 2011 and a romantic relationship began. The Claimant's sister, NPT, did not approve of this relationship and there was friction and tension in the family home. In 2010 and 2011 the Claimant seems to have been reasonably well, although there are some references to anxiety in the records. An entry in the GP records in February 2011 describes the Claimant as sleeping well, socialising and being happy with life. In November 2011 there is a reference to the Claimant having good and bad days. The notes refer to a long history of anxiety, being unable to cope and getting depressed sometimes. In late 2012 she was attending sessions provided by a mental health service aimed at helping her manage her anxiety and depressive symptoms. In March 2012 the Claimant moved out of the family home. In June 2012 she is described as feeling depressed and unable to cope with a job at Poundstretcher.

23. Having left the family home there followed a period of great difficulty for the Claimant regarding her housing. This undoubtedly had an adverse effect on her mental health. She was initially in a property at Bracken Court, Leeds. From about the middle of 2012 she was at a property in Leeds provided by Touchstone, which

was established to help vulnerable people. It is described as a charity providing mental health and wellbeing services, particularly for people from black and minority ethnic backgrounds. The accommodation provided by Touchstone for the Claimant was intended to be short-term. Support was offered to assist individuals to secure more long-term accommodation. The Claimant was also seeking support from her GP practice. There are extensive records relating to this support which in particular was provided by Rehan Majeed, a health professional. The Claimant's problems of finding permanent accommodation were compounded by the fact that in January 2013 she signed an agreement for a tenancy of a flat in Crossgates. Having taken the tenancy she failed to move into the flat. It is clear from the medical records that the reason for changing her mind was fear of being subject to racism in the area of Leeds where the flat was located. Arrears of rent accumulated and problems arose regarding her housing benefit. She was threatened with eviction and there is reference in the records in April 2013 to SGL stopping the Claimant from harming herself. With extensive support from Mr. Majeed and others the Claimant secured a short-term tenancy in a transitional housing unit (THU) at Cottingley Court. This was for a period of 6 months from July 2013. Agreement was reached on the payment of the rent arrears. This brought about an improvement in the Claimant's mental state, although she remained very anxious. In August 2013 a GP record describes her as being very worried at the prospect that her tenancy would expire in six months.

24. In September 2013 the Claimant is described as not being ready to engage with work. In this month she made an application for employment and support allowance. The basis of the application was that she was suffering from an anxiety disorder which affected her day-to-day living. In the application the Claimant complained of

confusion, inability to make decisions and feeling agitated all the time. When her anxiety disorder was acute it prevented her from carrying out everyday tasks.

25. The Claimant was given support and advice regarding obtaining a long-term tenancy. Eventually she was successful in securing the tenancy of a flat at 48 Holtdale Road, Leeds, in March 2014. She still has the tenancy of this one-bedroom flat up to the present. In the Spring of 2014 the Claimant was continuing to seek help with her mental health. In May 2014 a GP record states that the Claimant was seeking more emotional and psychological support. At this time it was suggested to the Claimant by Mr. Majeed that she had made a lot of progress in her mental health compared to her condition 12 to 18 months before. In August 2014 it is recorded in the GP records that the Claimant was doing well in her new flat. She had started voluntary work again and had attended for a job interview. She was working in a charity shop for one day a week for three hours.

26. In November 2014 SGL began living with the Claimant in the flat in Holtdale Road. From March 2015 the Claimant was working as a volunteer teaching assistant at centres in Leeds and Harrogate, helping pupils with English and maths. This was for one day a week for 1 to 5 hours, depending on how the Claimant was feeling.

27. In April 2015 the Claimant attended a weekend course which was designed to improve her social confidence. The Claimant felt that people judged her, and her anxiety created difficulty in dealing with people. It seems that at this time SGL was suggesting the Claimant might have Asperger's Syndrome or bipolar disorder. The Claimant was seen by a community psychiatric nurse who concluded that the

Claimant did not require the services of the community mental health team and instead the Claimant should focus on her voluntary work.

28. In August 2015 the Claimant was seen by a psychiatrist, Dr. Pearson who, following a consultation, wrote a lengthy letter to the Claimant's GP. Dr. Pearson observed that the Claimant did not present as being particularly anxious. She was not restless or agitated. There was no evidence of perceptual abnormalities or psychotic symptoms. There was an absence of acute depression or suicidal ideation. Dr. Pearson's conclusion was that there was no indication for a role for mental health services at that time.

29. What is described as a gate assessment was carried out in February 2016. It was noted that the Claimant was volunteering in a charity shop one day a week. She was having difficulty when coming into contact with people. She was very sensitive to criticism. She felt supported by SGL. It was recorded that she had always been an anxious person who struggled socially.

MEDICAL EXPERT EVIDENCE
(All the medical experts gave oral evidence except the orthopaedic surgeons)

Neurological Experts

30. Dr. Liu, a consultant neurologist, was instructed on behalf of the Claimant. He interviewed and examined the Claimant in October 2021 and also interviewed SGL. Dr. Crawford, consultant neurologist, was instructed on behalf of the Defendant. She examined and interviewed the Claimant as long ago as March 2018, which was prior to the Claimant's lengthy spell in hospital after being sectioned under the Mental Health Act 1983. SGL repeatedly expressed the view to Dr. Crawford that the

Claimant had recovered from her injuries and her residual difficulties were long-standing.

31. The joint statement of the experts reveals considerable agreement so far as the neurological effects of the accident are concerned. They agree that the Claimant suffered a severe brain injury, both traumatic due to the collision and hypoxic due to cardiac arrest. They agree that the Claimant's neurological impairments will not improve. Her cognitive and behavioural difficulties will be affected by alterations in her mental state and psychiatric status. There are some physical impairments with mild ataxia leading to some incoordination of upper limbs and an abnormal gait. There are significant persistent cognitive problems with impact on memory, attention, and processing. They agree there are frontal lobe deficits and behavioural issues. They note an effect of pre-accident problems but in relation to those they defer to the neuropsychology and neuropsychiatry experts. The neurologists agree that at times there will be a worsening of her cognitive performance due to her mental health difficulties.

32. Dr. Liu's examination of the Claimant was more recent and followed the Claimant's lengthy stay in a mental hospital. Dr. Liu has greater experience than Dr. Crawford as to the care and treatment of brain injured individuals following discharge from hospital. He identified a long-term need for ongoing clinical support from medical experts in neurorehabilitation, neuropsychiatry and neuropsychology. He identified a need for support workers with specialist training in respect of brain injury. He stressed that novel, unexpected events and activities will always pose difficulty for the Claimant. For this sort of activity and any multitasking she will require supervision,

prompting and assistance. Her thinking is quite rigid and she is very poor at initiating activity. The neurologists agreed there is an increased risk of epilepsy and a reduction in life expectancy of 3.5 years. They further agreed that when the Claimant is in her seventies there is a risk of premature physical deterioration and that normal ageing will be more challenging for her. Dr. Liu describes how the Claimant is often impatient, irritable and frustrated. She has a lack of empathy and a failure to recognise emotions in others. A further consequence of the brain injury is fatigue which affects the Claimant more mentally than physically. Her lack of insight results in a failure to appreciate her cognitive problems and an inability to recognise when her mental health is deteriorating.

Neuropsychological Experts

33. Professor Wang, a consultant clinical neuropsychologist, was instructed on behalf of the Claimant and carried out an assessment in May 2021. Professor Powell, a consultant clinical neuropsychologist was instructed on behalf of the Defendant and assessed the Claimant when she was still an inpatient at York House in November 2019.

34. The joint statement of the experts reveals considerable agreement as to the organic effects of the accident. They agree the Claimant sustained a very severe traumatic brain injury and suffered two episodes of cardiac arrest causing cerebral hypoxia. They further agree that pre-accident there was no history of head injury or developmental difficulties, but there was a non-specific psychiatric history of significant proportions. The main difference between the experts was in the evaluation of that pre-accident psychiatric history. They agree that pre-accident the

Claimant's intellectual ability was in the average range. She had endured a difficult adolescence with problematic family relationships. There had been no firm psychiatric diagnosis pre-accident. Intermittently the Claimant had problems coping with life. The experts agree that there was no clear trajectory towards remunerative employment.

35. Professor Wang states that pre-accident the Claimant was able to live independently, did not require supervision, had intact mental capacity and engaged in constructive voluntary activity. On the other hand, Professor Powell notes the Claimant was troubled by stress, panic disorder, depression, difficulty sleeping, hearing her own voice in her head, paranoia, had issues with comprehension and had an inability to make appropriate decisions. He believes there were significant limits on her ability to live independently and that SGL acted as a support worker.

36. During the assessment by both experts, the Claimant undertook psychometric testing. The results of such testing were similar and reliable. There was evidence of general intellectual decline and significantly reduced speed of processing information. Memory was substantially impaired in respect of both immediate and delayed recall. There was evidence of executive dysfunction associated with left frontal brain damage. Professor Wang emphasises that the cognitive difficulties will have exacerbated the Claimant's pre-existing mood disorder and rendered treatment for that condition far more challenging.

37. The experts agree on the valuable role played by the multidisciplinary team (MDT) since March 2020. The team has consisted of a neuropsychologist, Dr. Todd, a case

manager, an occupational therapist, a speech and language therapist and a physiotherapist. More recently there has been the introduction of a support worker. It is accepted that the MDT has prevented the need for further periods of inpatient treatment following psychiatric episodes. When a decline in the Claimant's mental health occurred in August/September 2021, the MDT was able to arrest the decline and the Claimant's mental health gradually improved.

38. A further point of disagreement between the experts is as to the extent of the input which will reasonably be required from the MDT in the future. Professor Powell sees the MDT provision moving to a maintenance regime, save for periods when the Claimant's mental health goes into decline. Professor Wang considers there is a need for a continuing, more extensive role for the MDT.

39. Professor Wang views the deficits now observed in the Claimant's functioning as being overwhelmingly attributable to the effects of the accident. Absent the accident the Claimant would have been capable of independent living and employment. There would have been no requirement for any professional care. The anxiety and depression which had affected the Claimant, particularly in 2012 and 2013, would have been treatable. He views the deterioration in this period as closely connected to the issue of accommodation. He has seen no convincing evidence of autistic spectrum disorder or Asperger's. In terms of the need for care, assistance and supervision, Professor Wang states there is a qualitative difference between what the Claimant required before and after the accident.

40. Professor Powell places much greater weight on the Claimant's difficulty in coping with life before the accident. He considers the Claimant had a combination of social communication difficulties and personality issues. This had much in common with autistic syndrome disorder, even if there was no diagnosis of such a condition. He believes the Claimant would always have required some support from her partner and/or statutory services. She is unlikely to have achieved significant earnings. He views the Claimant as requiring an enhanced version of the type of support she would have needed in any event. He accepted that during psychotic periods the Claimant will require extensive care, but at other times he saw no need for 24 hour care, nor could he see such extensive care ever being required. He saw no evidence that the relationship between the Claimant and SGL was brittle and he thought the relationship would survive.

41. In oral evidence the experts maintained the views expressed in their written reports. Professor Wang explained that the relationship between the Claimant and SGL was complex. He noted that at times SGL over-emphasised the Claimant's abilities, and at other times over-emphasised her dependence. This inconsistency of approach posed challenges for the MDT. What one has seen since 2020 are improvements resulting from the Claimant's engagement with the MDT. The underlying organic condition is unchanged. If the MDT were only to have minimal involvement, then one would lose the opportunity to maximise the quality of the Claimant's life. There would also be the risk of failing to detect a deterioration in the Claimant's mental state given that she does not possess the insight to appreciate when her mental state is worsening. Professor Wang accepted that at present there was no need for an expansion of the provision by the MDT, but that might change if the Claimant should deteriorate.

42. Professor Powell, in answer to questions in cross-examination, said it was not correct to say one needed a diagnosis of a psychiatric condition pre-accident. One can underperform cognitively for purely psychological reasons. He described the Claimant getting an ordinary degree as gross under-performance. Professor Powell accepted that he had failed to mention the effect that the Claimant's ulcerative colitis and eczema is likely to have had on her performance at GCSE and her later education. He conceded that most people would have suffered stress as a result of the accommodation problems faced by the Claimant, living in temporary housing, with rent arrears accumulating and the threat of eviction proceedings. He remained of the view that the Claimant's psychological problems had continued for a sufficient time before the accident to conclude that such problems would have continued to date and into the future in the absence of the accident. Professor Powell accepted that in considering the Claimant's ongoing psychiatric disability there were two elements. Firstly, an exacerbation of the anxiety and depression which affected her pre-accident, and secondly, an organically based personality disorder and delusional disorder stemming from the head injury.

43. In forming his view about the likely continuation of the relationship between the Claimant and SGL, Professor Powell said that he had appreciated the age difference between the couple, but had not been aware of SGL's excessive weight. With a BMI of over 50, Professor Powell acknowledged that SGL was classified as morbidly obese. It carried a risk of disability and had an impact on mortality. Professor Powell conceded in his oral evidence that there was a significant risk the couple might

separate, although the chance of the relationship surviving would be increased if the care burden placed on SGL was not too great.

Neuropsychiatric Experts

44. Dr. Moore, a consultant neuropsychiatrist, was instructed on behalf of the Claimant and carried out an assessment of the Claimant in June 2020. Dr. Jacobson, a consultant neuropsychiatrist, was instructed on behalf of the Defendant, and carried out assessments of the Claimant in November 2020 and July 2021. The experts discussed the case in August 2022 and following this discussion produced a joint report. There were many points of agreement but also some points of disagreement. The main areas of dispute were in relation to the type of life the Claimant would have been capable of in the absence of the accident, and the extent to which the Claimant will reasonably require therapy and support in the future.

45. Dr. Moore and Dr. Jacobson agree on the neuropsychiatric consequences of the brain injury. The Claimant has an organic personality disorder or personality change due to the brain injury. Dr. Moore classifies the condition as a neurocognitive disorder with behavioural disturbance. Professor Jacobson agrees with this diagnosis. They further agree that the head injury has resulted in three episodes of psychosis. Two of the episodes required admission to hospital and the third was less severe and was dealt with in the community by the MDT. The experts agree as to the Claimant's persisting neuropsychiatric problems, namely low mood, social anxiety, excessive daytime fatigue, poor motivation and cognitive and balance problems. Further, the Claimant has suffered from recurrent depressive episodes.

46. At the time of Dr. Jacobson's first report dated 11th August 2021, he was of the opinion that pre-accident the Claimant suffered from a developmental/language disorder: Asperger's Syndrome or an autistic condition. Having seen additional evidence, and in particular statements from the Claimant's mother and sister, he revised his view. If the evidence contained in those statements was accepted, in particular that the Claimant had no obvious speech and language problems after the age of 5 and no impairment of social functioning, then it is improbable that she had any of those above conditions. Dr. Moore rejected the possibility of these conditions, commenting that there was no evidence of childhood problems such as interpersonal difficulties or the rigid behaviours and routines seen in autism or Asperger's Syndrome.

47. The experts agree that the witness evidence from family members indicates that the Claimant was independent in all domestic activities, and there was no evidence of any cognitive deficit. Dr. Jacobson considered that the Claimant had required some emotional and practical support. He relied on the fact that the Claimant had lived in supported accommodation for a period and required help from housing key workers. Dr. Moore raised questions regarding SGL's relationship with the Claimant. He suggested the possibility that SGL was responsible for the deterioration in the Claimant's mental state in 2012 and 2013, but no other expert advanced this view. In the absence of the accident, Dr. Moore opined that the Claimant would have been able to live independently and would have been able to work full-time until retirement age. Dr. Jacobson considered that the Claimant would have required support from time to time and possibly for longer periods when depressed or under stress. She would have had continuing personality difficulties, fluctuating anxiety and a substantial risk of

major depression. In terms of employment, Dr. Jacobson believed the Claimant would have remained in voluntary work or intermittent low paid work. There was the risk of her becoming chronically unemployed.

48. As to the position now, the experts agree that the Claimant requires neuropsychiatric and neuropsychological input for the future. In terms of the multidisciplinary rehabilitation, the experts agree that the Claimant has entered what is termed the "maintenance" phase, but do not agree as to what it should consist of. Dr. Moore is of the view that the Claimant will require a high level of support indefinitely due to the extent of her cognitive and neurobehavioural impairments. Dr. Jacobson does not consider the Claimant requires regular occupational therapy indefinitely, only that an occasional top-up may be required. The experts agree that the cessation of support worker and therapy input contributed to the Claimant's psychiatric deterioration in 2018 and 2019 which culminated in her being sectioned. The experts agree that the Claimant's care requirements when not psychotic are difficult to estimate given the presence of SGL who has been seen by the treating team as over-protective. Dr. Jacobson considers that the level of independence demonstrated by the Claimant when not psychotic does not suggest a need for 24 hour care in the absence of SGL. Dr. Moore believes the Claimant will need a very high level of professional support for the rest of her life due to her behavioural and cognitive impairments. As to the details of a care package, the experts agree to defer to the care experts although they still offer opinions on the subject. Dr. Moore believes that in the absence of SGL, 24 hour professional support will be required. Dr. Jacobson has provided more detailed estimates of care requirements which have varied as further evidence has become available.

49. The experts agree that further psychotic/behavioural episodes will occur. Dr. Jacobson thought on average such episodes will occur on a biennial basis. Dr. Moore knows of no scientific basis on which to predict the frequency of such episodes.

50. Both experts consider there is a risk of the relationship between the Claimant and SGL breaking down. In their joint report Dr. Jacobson estimated this risk at 40 to 60%. In a further report dated 28th July 2023 he changed his assessment of the risk in the light of evidence of the Claimant and SGL getting on well. He suggested the risk of breakdown was in the region of 30 to 50%. Dr. Moore did not suggest a level of risk.

51. In relation to the Claimant's capacity, the experts agree that she lacks capacity to manage her property and affairs and is unlikely to regain this capacity.

52. Dr. Moore, in his oral evidence, faced careful questioning concerning the preparation of his reports. His first report dated October 2021 referred to him seeing a review of a list of identified medical reports and statements. He explained that the review was prepared by his wife who is a neuropsychologist. He did not read the documents himself before preparing his report. In his second report dated 31st March 2022 he stated that he had been sent further evidence and there was set out a long list of medical records, witness statements and expert reports. There is no reference in Dr. Moore's second report to him seeing a review. However, it transpired that he had not read those documents before compiling his second report. He had relied on a review of the documents compiled by his wife. At the very least this report should have

made clear that Dr. Moore was relying on a review of the documents, rather than reading the documents himself. The report should also have identified who carried out the review and their expertise. Given the vast number of documents in a case such as the present one, one can understand, on the basis of time and cost, using a suitably qualified person to read documents. One might have expected Dr. Moore to have read at least the most important documents for the purpose of forming his opinion. Dr. Moore stated that prior to giving evidence he had read all the clinical records.

53. When Dr. Jacobson gave evidence he was questioned about his estimates of the extent of professional care which the Claimant will reasonably require. He accepted that he had never had to devise a care package. He had occasionally been involved in meetings when the care requirements of an individual had been discussed, but the last time he had assisted with such an issue was about five years ago.

54. Dr. Jacobson was asked about the relationship of the Claimant and SGL and the risk that they might separate. When giving his estimates of risk he was not aware of the weight issue affecting SGL. He said that he was very cognisant of the health problems created by excessive weight and the impact on life expectancy. He referred to a double digit reduction in life expectancy due to SGL's obesity.

Orthopaedic Experts

55. Mr. Hamilton, consultant orthopaedic surgeon, was instructed on behalf of the Claimant and examined her in August 2017. Mr. Hodgkinson, consultant orthopaedic surgeon, was instructed on behalf of the Defendant and examined the Claimant in

January 2022. These experts prepared a joint report in July 2022. There is very little difference in the opinions they express regarding the orthopaedic injuries sustained by the Claimant and as a result these experts were not required to give oral evidence.

56. The experts agreed on the following:

(i) The comminuted fracture of the right clavicle was treated conservatively and had healed satisfactorily within about three months. The Claimant will have regained normal function and mobility of her right shoulder and arm within 12 months. Any ongoing symptoms after this time would have been fairly minor and intermittent and unlikely to cause functional impairment.

(ii) The multiple rib fractures on both sides healed satisfactorily within about three months and the Claimant will have reached the end stage of her recovery after nine months.

(iii) The compound fractures of the left tibia and fibula will have healed within four to six months. The tibial fracture was stabilised with an intramedullary nail. Symptoms from these fractures will have continued to improve during the two years following the accident.

(iv) The fractures to the right tibia and fibula will have healed within about six months and most symptoms attributable to these fractures willl have resolved within about two years.

(v) The multiple pelvic fractures healed satisfactorily within three to six months of the accident and symptoms attributable to these fractures will have resolved within about 18 months.

57. The experts are agreed that there is no indication for any further orthopaedic treatment. There is no evidence of any rapid onset of arthritis at any of the fracture sites. However, in respect of the pelvic fractures, the fracture of the right superior pubic ramus entered the medial aspect of the floor of the acetabulum and so has theoretically increased the risk of premature onset of osteoarthritis of the right hip joint. Such risk is fairly small and the likelihood is that no treatment will be necessary other than treatment which may be required as part of the normal ageing process.

58. The intra articular fracture of the right tibial plateau has slightly increased the risk of premature osteoarthritis of the right knee joint, but the risk is small and any progression of arthritis would occur slowly.

59. The experts have viewed surveillance film footage taken in April 2022 and are agreed that from an orthopaedic point of view the Claimant has made a very good physical recovery following excellent orthopaedic treatment.

60. The only difference of view between the experts is that Mr. Hamilton considers there is a very slight risk of premature osteoarthritis in the right acromioarticular joint as a result of the fractured clavicle. Mr. Hodgkinson does not consider there is an increaed risk.

Evidence of the Care Experts

61. Mrs. Maggie Sargent was instructed on behalf of the Claimant to value the gratuitous care provided by members of the Claimant's family, and to assess her future

reasonable requirements for the provision of commercial care and case management. Ms. Sally Gooch was instructed to carry out a similar exercise on behalf of the Defendant.

62. Mrs. Sargent has extensive relevant experience over many years, not only as an expert assessing care costs but in the provision of case management and care packages in the private sector. She is a director of a national care consultancy and case management company. Her company has some 50 case managers across the country. She case manages clients in the Midlands area. She is part of a community rehabilitation project that provides therapy, care and rehabilitation. She has a particular interest in the case management and care of brain injured individuals. Ms. Gooch has many years experience working as a nurse and health visitor. Her CV reveals that she has undertaken many different roles in the healthcare sector. However, her experience of case management and care in the private sector, and the actual management of care packages, is much more limited than that of Mrs. Sargent.

63. Mrs. Sargent's assessment relied on remote interviews with the Claimant and SGL in April and May 2021 as well as speaking to the case manager, Ms. Jenny Locke. In September 2021 Mrs. Sargent visited the Claimant at the independent living flat in Wellington Street, Leeds. In October 2021 she had discussions with the case manager, Jenny Locke, and the occupational therapist, Hazel Clerkin. She also had further discussions with the Claimant, the Claimant's mother, and SGL. In August 2022 Mrs. Sargent had a further conversation with the Claimant's mother, and in September 2022 she spoke to Ms. Locke again. In addition she took into account

extensive documentation relevant to the case and updated information from Ms. Carol Varley who has replaced Ms. Locke as the case manager for the Claimant.

64. Ms. Gooch carried out a remote assessment of the Claimant in September 2020. SGL and Ms. Locke were present during that assessment and both contributed to it. She has never met with the Claimant in person, nor has she had any discussions with those involved in the care of the Claimant, save for the remote discussion which took place in September 2020. It is apparent from her reports that Ms. Gooch has considered a very large quantity of documents which she refers to extensively.

65. The care experts have arrived at vastly different assessments of the value of gratuitous care and the Claimant's reasonable care needs in the future. In arriving at her assessment Mrs. Sargent has relied on her own expertise, but also on the evidence from the members of the MDT and in particular that provided by Ms. Locke. Of course Ms. Locke is not an expert witness, but she has been the Claimant's case manager from early 2020 until 2023. She has provided two detailed statements and gave oral evidence. She has provided a good deal of information concerning the Claimant's condition in early 2020 after the Claimant had recently been discharged from York House. She deals with the challenges posed by the Claimant who was initially reluctant to engage with the MDT, and the slow progress that has been made during the following three years, complicated by the restrictions imposed during the pandemic.

66. Having carefully considered Ms. Gooch's extensive written reports and her oral evidence, I do not find that she has undertaken an objective and fair assessment of the

value of gratuitous care provided by family members, nor of the commercial care which the Claimant requires now and will require for the future. I have reached this conclusion for the following reasons:

(i) Although differences between the medical experts exist, as set out previously, there is broad agreement as to the consequences of the head injury in terms of profound cognitive and psychiatric effects. Ms. Gooch's reports place little emphasis on this agreed medical evidence, but instead highlights references in the medical records to an excellent recovery from the head injury. This is often due to self-reporting by the Claimant although the Claimant is incapable of appreciating the extent of her cognitive disabilities. There was also a failure on the part of SGL to accept the consequences of the brain injury. These are undisputed matters which Ms. Gooch fails to recognise. In her report dated 19th August 2022 she quotes a record of the 12th May 2016: "Her partner considered that she was back to her old self." Ms. Gooch refers to a record of the 5th July 2016 indicating that PHJ had made an excellent recovery from her brain injury. In relation to a record of the 2nd March 2020 Ms. Gooch states "PHJ had mild cognitive dysfunction but was functioning at a 'relatively high level'." In relation to a visit to the GP on the 19th June 2017 Ms. Gooch states "Her GP considered that she had no remaining obvious cognitive deficits and that her short and long-term memory appeared to be working well". The psychometric testing of Professor Wang and Professor Powell produced broadly similar results. The results of Professor Powell's tests found that both immediate and delayed memory were substantially reduced. Professor Powell commented on the results: "Her recovery has plateaued at a very low level."

(ii) Ms. Gooch gave the impression in her reports and oral evidence of trying to minimise the difference between the Claimant's pre-accident and post-accident condition. This is illustrated by her assessment of past gratuitous care in the period in 2018 and 2019 when the Claimant's mental state deteriorated and she developed a psychosis. This resulted in an admission to the Becklin Centre in September/October 2018 and then again from March 2019 to August 2019, followed by a transfer to York House and eventual discharge in January 2020. The behaviour of the Claimant due to brain injury induced psychosis was extremely challenging for SGL and the Claimant's mother. When assessing the extent of gratuitous care provided between September 2018 and January 2020, Ms. Gooch allows nothing for most of this period and a maximum of two hours a day gratuitous care for 25 weeks. When making no allowance, Ms. Gooch states in her report: "I understand that her presentation in this period would not have been any different absent the collision." When asked in cross-examination about her approach to assessment during this period of deterioration of the Claimant's mental state resulting in the Claimant being sectioned, Ms. Gooch stated that it was her understanding that the symptoms of psychosis would have occurred in any event. It was pointed out to Ms. Gooch that the agreed view of the expert neuropsychiatrists was that the psychosis was due to the head injury. Ms. Gooch's response was that her understanding came from a reading of all the records and that she was entitled to have a clinical opinion. I am afraid the only conclusion I could draw from this exchange was that Ms. Gooch, in her efforts to equate the pre and post-accident position, was prepared to reject agreed expert medical opinion in favour of her own interpretation of the records.

(iii) In making her assessment, Ms. Gooch has chosen to ignore the witness evidence provided by the Claimant's mother, SGL and the members of the MDT, particularly Ms. Locke. EAP explains in her witness statement that during the Claimant's lengthy period in hospital she and the Claimant's sister, NPT, would visit nearly every day. When the Claimant was moved from intensive care to a neurological ward she and NPT would provide care that was not being provided on the ward. They helped feed the Claimant, who was not capable of feeding herself. For the period in hospital up to October 2016 Ms. Gooch thought it reasonable to allow one hour of gratuitous care a day for travelling time. At no time from the happening of the accident up to the present does Ms. Gooch allow more than two hours a day for gratuitous care. Ms. Gooch was asked in cross-examination about the period from late 2018 to March 2019, which was the period between the two admissions to hospital. Ms. Gooch agreed that looking after the Claimant during this period would have been extremely challenging. It was pointed out to Ms. Gooch that even during this period her assessment never exceeds two hours a day despite family members having to be constantly vigilant to protect the Claimant from herself. In fact the Claimant attempted to jump from a first-floor window. Ms. Gooch's initial response was to say she did not have enough information to allow more than two hours a day. When it was suggested that her assessment was untenable, she replied she could have said she was unable to quantify the time spent.

(iv) Ms. Gooch confirmed in evidence that her only assessment of the Claimant was in September 2020. Given the amount of documentary material she had, she did not think it necessary to visit the Claimant in person. She was asked

about her observation in her report that throughout a long online assessment the Claimant was able to concentrate without any apparent difficulty. Ms. Gooch did not refer in her report to Professor Powell's finding on testing that the Claimant's attention score was at the first percentile and classed as deficient.

(v) In respect of future care needs, Ms. Gooch asserted in her reports that the Claimant was unlikely to accept support worker provision. In fact such provision was established in 2023. Ms. Gooch, in her updated report of August 2023, still stated that on the balance of probabilities the Claimant will not tolerate a support worker on a regular basis, and so she made no allowance for the cost of a support worker under her scenario one. In the event that the Court finds the Claimant will accept a support worker, she allows the cost for 12 hours a week. The statements of the current case manager, Carol Varley, explain that the Claimant has a support worker for 21 hours a week. Ms. Varley states the Claimant has engaged well with this support. The Claimant has tolerated a change of support worker and the Claimant has established a good rapport with the new support worker. Ms. Gooch did not seek to amend her report or reconsider her opinion when she gave evidence but the Defendant, in closing submissions, did not seek to argue for a reduction in the support worker hours.

(vi) Ms. Gooch has provided an assessment in the event that the Claimant is no longer living with SGL. She allows for case management of 60 hours per annum plus a contingency of 30 hours for life in the event of a crisis or major event. For a support worker she allows 24 hours per week plus a contingency for life of 35 hours a week on 5 occasions for 6 weeks on each occasion. Ms.

Gooch states that this assessment is on the basis of costing for the additional care the Claimant would need as a result of injuries sustained in the collision. She has left out of the assessment the care which she considers the Claimant would have required in any event in the absence of the accident. However, she does not say what that care would have consisted of. It therefore remains unclear what Ms. Gooch considers the Claimant's overall care needs would be in the absence of SGL.

(vii) Having regard to the matters set out above, I am unable to rely on the evidence of Ms. Gooch.

SHOULD PAST AND FUTURE CARE COSTS BE DISCOUNTED?

67. The Defendant contends that the Claimant's damages for past and future care should be reduced by reason of her pre-accident condition and the care she would have needed in the absence of the accident. The reduction sought is one of 25%. In support of this argument, the Defendant relies on the Court of Appeal's judgment in **REANEY v. UNIVERSITY HOSPITAL OF NORTH STAFFORDSHIRE NHS TRUST 2015 EWCA Civ. 1119.** In that case a woman developed transverse myelitis resulting in her being paralysed below the mid-thoracic level. While in hospital she developed pressure sores which resulted in her permanent disability being greatly increased. The defendant admitted liability for the pressure sores and their consequences. The trial judge concluded that the claimant was entitled to full compensation for all her care, physiotherapy and accommodation costs. The Court of Appeal held that this approach was wrong in principle. The defendant was liable to compensate the claimant for her condition only to the extent that it had been worsened by the negligence. Lord Dyson M.R. stated, at para. 19:

> "It did not injure a previously fit and able-bodied person. It injured a T7 paraplegic and who, as a result of her condition, already had considerable care and other needs. It was (rightly) common ground that if the defendants' negligence caused Ms. Reaney to have care and other needs which were substantially of the same kind as her pre-existing needs, then the damage caused by the negligence was the additional needs. On the other hand, if the needs caused by the negligence were qualitatively different from her pre-existing needs, then those needs were caused in their entirety by the negligence."

The judgment makes clear that whether a claimant can recover compensation from another tortfeasor for the loss already sustained is irrelevant.

68. The judgment of Lord Dyson considers the earlier case of **SKLAIR v. HAYCOCK 2009 EWHC 3328 (QB)**. In that case the claimant suffered from Asperger's syndrome and obsessive compulsive disorder. He lived a mainly independent life but required supervision from his father who, by the date of trial, was over 80. As a result of being struck by a car the claimant suffered physical injuries which greatly reduced his dexterity and mobility. He now required care 24 hours a day. The defendant contended that in the absence of the accident the claimant would have required extensive care once his father was no longer able to look after him. The true loss, it was argued, was the difference in the level of care now needed. The reasoning of the trial judge for rejecting the defendant's argument was disapproved by the Court of Appeal in **REANEY,** although the actual decision could be supported:

> "...the decision can be justified as based on an issue of causation although that is not how it was analysed by the judge. The care regime required after the accident could properly be described as qualitatively different from that which had been previously needed (and would have been needed in due course). But for the accident, the claimant would have required general supervisory care of an essentially independent life. This was to be contrasted with his need for personal support in a 24 hour care regime as a result of the accident." (Lord Dyson para. 32)

69. The Defendant submits that the care needs of the Claimant pre and post-accident were similar, although clearly greater as a result of her severe head injury. The Defendant accepts that the expert evidence does not provide an arithmetical basis for making a reduction. In support of a broad-brush approach, the Defendant draws an analogy with cases where the court has had to apportion losses between two tortfeasors, in particular in **RAHMAN v. AREAROSE 2000 EWCA Civ. 190** and **XP v. COMPENSA TOWARZYSTWO SA 2016 EWHC 1728**.

70. It appears to be accepted by the Defendant that, apart from anxiety and depression, the Claimant was not diagnosed as suffering from any developmental or psychiatric condition pre-accident. Reliance is placed on the evidence of Professor Powell. There was not a diagnosis as a result of what Professor Powell describes as ASD (Autistic Spectrum Disorder) symptoms or personality type symptoms. The Claimant was diagnosed with anxiety and depression and Professor Powell maintains that psychological disturbance can adversely affect neurological performance so that one can underperform cognitively for purely psychological reasons. The Defendant submits that when one looks at the care needs the extent is greater because of the head injury, but save during the episodes of psychosis the needs are very similar.

71. In response the Claimant relies on the evidence from her mother and sister that during childhood, while the Claimant frequently suffered from ulcerative colitis and eczema, the medical records do not suggest any psychological or psychiatric condition. There is no reference to speech or language problems after the age of 5. The first reference to any stress related condition was in 2007 when the Claimant was 23 and in what should have been the final year of her university course. It is accepted that over the

next five years there are entries in the records referring to stress and mood related symptoms. During this period, up to 2012, the Claimant was independent and engaged in social activities. In 2012 the Claimant left the family home and encountered a lengthy period of housing difficulties. The Claimant accepts that during the two years up to 2014 her mental health deteriorated. She suffered from periods of low mood, anxiety and low self-esteem. Relying on certain parts of SGL's oral evidence, it is asserted on behalf of the Claimant that she was still living an independent life and did not have significant mental health problems. Housing was the major cause of her mental health turmoil. By mid-2014 she had been provided with a flat which became her permanent home. SGL began living with the Claimant in this flat in late 2014 and there was an improvement in her mental health.

72. The Claimant submits that the medical issue as to the significance of the Claimant's condition pre-accident is a psychiatric one. Reliance is placed on Dr. Moore's evidence that absent the head injury the Claimant would not have required care and support. Dr. Jacobson accepts no support was required in respect of any cognitive deficits. Whilst he suggested some support may have been required from time to time when the Claimant was depressed or under stress, this bears no resemblance to the Claimant's post-accident disability and consequential needs. It is contended on behalf of the Claimant that the Defendant has failed to identify any significant medical need pre-accident and has been unable to articulate exactly what needs required care and assistance or the extent of any such needs, and so has to rely on a general request for a discount.

73. Earlier in the judgment I summarised the pre-accident circumstances of the Claimant (paragraphs 18 to 29). Having considered the detailed records, including those referred to in the Defendant's chronology annexed to the closing submissions, I have come to the following conclusions:

(i) During her childhood the Claimant had to cope with unhappy family circumstances, largely due to her father's alcoholism and serious mental illness. She also had to cope with frequent episodes of ulcerative colitis and eczema which no doubt resulted in many absences from school. She had early problems with her hearing and language development. She had treatment and those problems seem to have been overcome after the age of 5. As a girl of average intelligence but suffering with the identified health problems, it is not surprising that she did not excel academically. She did succeed in going to a further education college and obtaining the qualifications necessary to gain entry to a degree course at a university.

(ii) At university in Manchester she led an independent life, organising her finances and accommodation with the benefit of a student loan. She supplemented her income by returning home to Leeds at weekends and undertaking a part-time job at a Tesco's store.

(iii) In what should have been the final year of her degree course in nutrition, she was affected by stress and feeling depressed and anxious. This seems to have been linked to struggles with her studies and she failed her final year exams. She chose to have a gap year during which she travelled to India. During the gap year she continued to struggle mentally and complained of hearing voices in her head.

(iv) On returning to university in September 2008, her mental state improved and she was noted to be coping reasonably well with her course work. She completed her course although only achieving a pass degree.

(v) After completing her degree she returned to live at home, but then went to India in December 2009 and stayed for six months. In the period up to 2012 she was troubled from time to time by anxiety and her life seems to have been quite restricted. She had formed an online relationship with SGL. Her sister strongly disapproved of this relationship and this led to friction between the sisters.

(vi) The Claimant left the family home in March 2012. Housing difficulties led to a marked deterioration in her mental health and very frequent visits to her GP practice. In 2013 she required extensive support from healthcare workers. Her anxiety disorder was such that she struggled to cope with everyday life.

(vii) A turning point came in March 2014 when she obtained the tenancy of the Holtdale Road flat. In August 2014 she was reported to be doing well in her accommodation and had started voluntary work.

(viii) In November 2014 SGL joined the Claimant at the Holtdale Road flat. She continued to complain of anxiety and panic attacks. In 2015 she undertook voluntary work in a charity shop. In April 2015 she attended a weekend course which was intended to improve her social confidence. At this time SGL was suggesting that the Claimant may have Asperger's syndrome or bipolar disorder. An assessment by a community psychiatric nurse concluded that the Claimant did not require the assistance of the community health team, and the Claimant should focus on her voluntary work.

(ix) There was a detailed assessment by a psychiatrist, Dr. Pearson, in August 2015 who did not find that the Claimant was suffering from any mental illness and concluded there was no role for mental health services.

74. From 2007 the Claimant was a person troubled by anxiety and periods when she felt depressed. For approximately two years her mental health problems increased and this was very much linked to her housing difficulties. Once she was settled in her Holtdale Road flat, her mental health improved and in the months before her accident, whilst she felt low at times, there was no evidence of mental illness. In the absence of the accident the likelihood is that the Claimant would have continued as she had done in the months before the accident. She is likely to have been quite reliant on SGL for emotional support. She would no doubt have felt depressed from time to time. This state of affairs should be contrasted with the position following the severe brain damage. The Claimant has quite profound cognitive difficulties affecting memory, information processing, and attention. She has been prone to develop psychotic episodes leading to prolonged spells in a psychiatric hospital. Since 2020 she has not required inpatient treatment, but this is only as a result of intensive input from a therapy team who have used their various skills to keep the Claimant living in the community. The Claimant will require some continued input from this team and from a support worker skilled in working with brain damaged individuals. This is a care need qualitatively different to the needs which the Claimant would have had in the absence of the accident.

75. It would, in any event, have been an unsatisfactory position to have determined a reduction in the award for care by in effect plucking a percentage out of the air. If a

reduction in the reasonable care costs to be awarded is to be contended for, there is at least an evidential burden on a defendant to provide some evidence to enable an estimate to be made of an appropriate deduction. Failing such evidence, there is an obvious risk that the principle of compensating a claimant for their full loss, but no more, will be breached. I doubt whether an analogy can be drawn with the approach in **RAHMAN v. AREAROSE LTD.** where the problem was not the assessment of the Claimant's loss, but how to divide that loss between two tortfeasors. In determining the aetiology of the claimant's severe psychiatric injury, the medical experts had given their views on the causation of the different aspects of the injury. This did not allow for the distribution of causative responsibility with any degree of precision. In order to arrive at a just result a broad-brush division of responsibility was justified. In the present case, in the absence of evidence estimating care requirements pre-accident, it would be difficult to justify a broad-brush approach that was little more than a guess.

SURVEILLANCE EVIDENCE

76. The surveillance of the Claimant consists of film on five consecutive days from the 11th to 15th April 2022. I have viewed an edited version, which does not reveal the Claimant carrying out any activity not referred to in the expert and lay witness evidence, save that it did emerge that the Claimant had spent some nights on her own without SGL being present. The further statement of SGL explained that on occasion the Claimant has stayed at the therapy flat while he stayed at the Holgate Road flat. They contacted each other last thing at night and again in the morning after therapy was completed. The film mainly consists of the Claimant walking around Leeds city

centre, often with SGL or a support worker, and sometimes on her own. When on her own she always uses a pedestrian crossing and waits for the green figure to appear.

DAMAGES FOR PAIN, SUFFERING AND LOSS OF AMENITY

77. Reference is made by both parties to the Judicial College Guidelines 16th Edition. The Claimant relies on the category termed moderately severe brain damage A(b) where the range is £219,070 to £282,101. Further awards are suggested on behalf of the Claimant for the pelvic injuries, leg injuries and scarring. Some adjustment is made to reflect overlap, and the total claimed is £300,000. The Defendant relies on a different category in the Guidelines, namely, moderate brain damage A(c)(i) where the range given is £150,110 to £219,070. The Defendant contends for an overall figure of £210,000. The introduction to the 16th Edition states that the figures suggested are up to date to September 2021. Since that date, inflation has been a little over 20%.

78. Whilst acknowledging the mental health difficulties the Claimant suffered from before the accident, an important feature of the present case is the psychiatric injury with serious episodes of psychosis and the substantial risk of further episodes. The Claimant suffers from an organic personality disorder adversely affecting her behaviour in a number of ways. The Claimant suffered extensive injuries in addition to the brain injury. Fortunately the Claimant has made a good recovery from her many fractures. Taking all these aspects into account, an appropriate award for general damages is £275,000.

79. I have not referred to the small risk of epilepsy, which is to be dealt with by an award of provisional damages. There will be interest on the award at 2%p.a. from date of service.

PAST LOSSES

Past Gratuitous care

80. I accept the description of the jurisprudential basis for the award of gratuitous care set out in the Claimant's closing submissions. It is intended as a sum which will enable a claimant to make reasonable recompense to those who have provided care and support. Although care experts provide an assessment based on a number of hours and an hourly rate, the award is akin to a jury award. For the reasons I set out above, I do not feel able to rely on the assessment of Ms. Gooch. In contrast, I place considerable weight on Mrs. Sargent's assessment. I accept her use of the aggregate hourly rate as opposed to the basic hourly rate relied on by Ms. Gooch. I accept the view of Cotter J. in **SCARCLIFFE v. BRAMPTON VALLEY GROUP 2023 EWHC 1565 at para 234** that the basic rate is appropriate when care is provided, or largely provided, during ordinary working hours. I do not accept that such a description applies to the present case.

81. A further issue is what allowance, if any, should be made for care during the lengthy periods which the Claimant has spent in hospital. I accept that where a hospital visit simply consists of social chat, then this does not amount to compensatable care. However, that is not a valid description of what has occurred in the present case. I accept the evidence of family members as to the frequency of their visits to the Claimant in hospital, the shortcomings that sometimes occurred in hospital care, and

the importance which their visits had in providing both practical care and emotional support.

82. In cross-examination Mr. Todd K.C. established that Mrs. Sargent had not made any allowance for periods when the Claimant was being provided with a support worker, both for a short period before her admission to Becklin House in March 2019 nor during 2023 when support worker provision built up to 21 hours a week.

83. The figure contended for in the final revised Schedule of Loss is £170,603, which is based on Mrs. Sargent's assessment less a 25% discount for the non-commercial nature of the care. My conclusion is that Mrs. Sargent's assessment of hours is a little overstated. Allowing for this and the factors referred to above, I assess the appropriate net sum up to the 9th October 2023, after deducting 25%, as £145,000 plus £10,000 for the relatives' travelling expenses making a total of £155,000.

Past Commercial Care

84. This figure is agreed at £18,179.

Past Case Management Costs

85. These costs are agreed in the sum of £85,995.

Therapies Past Costs

86. The sum claimed in the Schedule of Loss is £174,831. The Counter Schedule concedes £164,201. The item disputed is a sum of £10,630 for electronic gem therapy. It is stated in the Counter Schedule that there is no scientific basis for such

therapy. The therapy does not have the support of any expert evidence adduced in the case, nor any evidence to support a beneficial effect or even the reasonableness of relying on such therapy. I therefore disallow this claim and assess the reasonable therapy costs at £164,201.

Past Accommodation Costs

87. These costs are agreed at £58,965.

Past Transport and Travel Costs

88. The sum claimed is £37,428, and the Counter Schedule allows £2,500. The figure which appears in the summary document of the Claimant's final submissions is £57,428, but I take this to be a typographical error. The revised Schedule of Loss claims the cost of purchasing a vehicle at £18,919 and running costs of £3,821. In addition the cost of travel to visit the Claimant in hospital is claimed and estimated at £14,733.

89. A VW Tiguan was bought in November 2020. The idea may have been that this vehicle would be used by a support worker to drive the Claimant about. In fact the car has only been driven by SGL. Sometimes this has been for his own use, and sometimes for the benefit of the Claimant. I understand that only half the running costs have been claimed. The Claimant is now only able to use public transport to a limited extent on short journeys that she is familiar with. Given that the car has been partly for the Claimant's benefit and partly for the private use of SGL, I allow half the cost of the car and the running costs claimed, namely £13,281. A reasonable sum for the travelling costs incurred visiting the Claimant is £10,000 but as a matter of legal

principle this should be awarded under the past gratuitous care claim. The loss was incurred by the relatives who are not parties to the claim. The objective of the gratuitous award is to enable the Claimant to make a reasonable payment to relatives for the care, assistance and support they have provided. In determining what is a reasonable sum it is appropriate to take into account the expenses the relatives incurred in providing the gratuitous care. This means the amount allowed for past transport costs is £13,281.

Past Deputyship Costs

90. On the issue of deputyship costs, the Claimant relies on the evidence of Katherine Peterson, a consultant solicitor with Slater Heelis LLP and a professional deputy of many years' experience. The Defendant relies on the evidence of Emma Gaudern, managing director of EMG Solicitors Ltd. who has also acted as a professional deputy for many years. In their joint statement they reached agreement on reasonable figures for deputyship costs for years 1 to 4, namely a sum of £54,394. In respect of year 5, they provided two estimates with a difference of about £4,000 depending on the extent of the Claimant's care package, namely £35,479 and £31,508. This resulted in a claim for the Claimant in the Schedule of Loss of £89,873.80. In the Counter Schedule the Defendant accepted a sum of £85,902.82. However the further report of Ms. Peterson dated August 2023 has updated the figures to take account of the assessed costs for year 4 of the deputyship up to July 2022 and estimated costs to the date of trial based on work in progress. I accept the figures in Ms. Peterson's report of August 2023 at Appendix 2 and this produces a past sum for deputyship costs of £87,240.72.

Past Loss of Earnings

91. The Claimant carried out part-time work when at university, but from 2009 to 2016 any paid work seems to have been very limited indeed. She undertook voluntary work on one or two days a week. There is reference to the Claimant applying for a paid job in the period before her injury, but it does not seem to have been a concerted effort. The neuropsychology experts agree that 'there was no clear trajectory' towards remunerative employment. The Schedule of Loss assumes regular part-time work averaging £10,000p.a. The Counter Schedule denies that the Claimant would have achieved any earnings from March 2016 up to date. My conclusion is that in the absence of the accident, the Claimant would have undertaken a mixture of occasional part-time paid work and voluntary work. A reasonable estimate of total net earnings during this period is £25,000.

Miscellaneous Costs

92. A claim is made for miscellaneous expenses, namely £1,500 for food and other expense and £2,500 for clothing. The claim is denied and I am not aware of any evidence to support such a claim.

FUTURE LOSSES

Future Care and Case Management Costs

93. A key factor when considering the future care of the Claimant is the presence and role of SGL. The relationship has endured for many years. The injuries to the Claimant have placed the relationship under great strain at times. SGL has been inconsistent in his view of the Claimant's disabilities. For the treating team of professionals, not only has it been a challenging case because of the Claimant's needs and behaviour, but in

addition coping with the demands of SGL has also been challenging. The parties are agreed that the approach to assessing the cost of future care should assume the continued presence of SGL. Where the parties differ markedly is in the assessment of the extent of commercial care required. Further, it is contended on behalf of the Claimant that the risk of the breakdown of the relationship between the Claimant and SGL should be catered for by a further award.

94. For the reasons already outlined, I am unable to rely on the opinion of Ms. Gooch on the reasonable costs of future care. It is noteworthy that in the Defendant's closing submissions Ms. Gooch's assessment was not fully adopted. By the end of the trial, both parties were adopting a two-stage approach to the cost of future care. The first stage is up to the Claimant's 60th birthday during which time SGL will be capable of contributing to the care of the Claimant, and a second stage after 60 when a contribution cannot be assumed. This is a sensible approach given that SGL is nearly 10 years older than the Claimant, and given the serious concerns regarding his health.

95. Mrs. Sargent's recommendation is that professional support in the form of an experienced rehabilitation assistance with neuropsychiatric experience should be increased to about 40 hours a week. This should enable case management to be reduced from its present level, which costs about £25,000 a year, if not more. Mrs. Sargent recommends 160 hours per annum of case management in the first year, reducing to 120 hours per annum thereafter. Mrs. Sargent regards an expansion of support as essential to enable the Claimant to engage in a broader range of activities and so improve her quality of life. Mrs. Sargent also regards it as essential that the Claimant should fully engage with her therapy team rather than seeking out

alternative therapies such as electronic gem stones. Expanded support will enable a rehabilitation assistant to attend therapy appointments with the Claimant which will encourage her full participation in such therapy. My conclusion is that the assessment of Mrs. Sargent is broadly supported by the medical evidence from Dr. Liu, Professor Wang, and Dr. Moore. I accept her recommendations for the provision of care up to the time the Claimant is 60. The total cost in the first year, including case management, is £109,005, and thereafter £94,622p.a. This is costed on the basis of agency care. The Claimant's tendency to fall out with those providing care, assistance and therapy means that directly employing staff is unlikely to be successful. Mrs. Sargent's costings assume that SGL will provide about 30 hours of assistance a week.

96. From the age of 60 Mrs. Sargent, as well as relying on her own expertise, relies on the opinion of Professor Wang that absent a partner the Claimant will not be able to live on her own:

> "Her cognitive deficits would act as a constant barrier to safe decision making, she would not be able to sufficiently use her executive skills and her memory deficits would quickly impact on her confidence. In addition to her cognitive deficits it is very likely that her anxiety and mood would overwhelm her in terms of decision making leading to a downward spiral in her functioning. I do not consider that these deficits could be addressed by some form of remote support even if this was possible. PHJ's domestic support will need to balance her need for supported community activity with periods of domestic engagement in terms of ordinary activities for which she will need support. I would anticipate that PHJ would be able to spend some periods of the day alone provided the same is part of a planned regime with good understanding between PHJ and those supporting her."

In the absence of a partner, Mrs. Sargent proposes agency care of 14 hours a day which can be used flexibly to support the Claimant during the day and night as required. The case management required would be 140 hours per annum. The annual cost of this package would be £180,622p.a. I accept the opinion of Professor Wang

on this aspect of the case and the opinion of Mrs. Sargent on the reasonable future care needs of the Claimant.

97. There remains a risk that the relationship between the Claimant and SGL does not endure. Dr. Jacobson considered various studies and initially assessed the risk of relationship breakdown at 40 to 60%. He later revised this assessment to 30 to 50%. None of the other medical experts felt able to place a percentage on the risk of breakdown. In his written reports Professor Powell was quite bullish in his views as to the likelihood of the relationship surviving. In his oral evidence he conceded he had not been aware of the weight and diabetic issues concerning SGL. Professor Powell accepted that these issues gave rise to a risk of disability and impacted on mortality. He continued to believe that the relationship was sustainable but there was a significant risk of breakdown.

98. Given that the care costs in the absence of SGL will be much higher than the costs during the period when he is present, the Claimant seeks an award to allow for the risk of relationship breakdown before the Claimant is 60. This would be similar to the award in **CROFTS v. MORTON 2009 EWHC 3538** where an award was made for the risk that a marriage might not survive. The Defendant denies that any such award should be made. However, on this issue I prefer the evidence of Dr. Jacobson to Professor Powell. That being the case, there is a very real risk the relationship will breakdown or that the health risks faced by SGL will become manifest. I assess the risk of SGL no longer being there to support the Claimant at 40%. The calculation of the appropriate lump sum to compensate for that risk is:

£180,622-£94,622 = £86,000 x 21.03 x 40% = £723,432.

99. In respect of the award for future care and case management costs, the Claimant seeks an order for periodical payments. The Defendant is neutral on the issue. Applying the provisions of CPR 41.7 I conclude that the form of award for future care and case management costs which best meets the Claimant's needs, having regard to the factors set out in Practice Direction 41B, is an order for periodical payments.

Future Accommodation Costs

100. The Claimant seeks to recover the cost of either the purchase or rental of a larger home. The Defendant contends that the Claimant's present home at 48 Holtdale Road is suitable for her reasonable needs, and so disputes that any additional costs for accommodation need be incurred. Both sides rely on the evidence of an accommodation expert: Mr. Steven Woodley was instructed on behalf of the Claimant, and Mr. Keith Miller was instructed on behalf of the Defendant. In addition, the parties rely on other expert evidence in support of their submissions on this head of loss.

101. The first issue to be determined is whether the Claimant's present home does meet her reasonable needs and will continue to do so in the future, having regard to the impact and permanent effect of her injuries. 48 Holtdale Road is a small one bedroom flat. From the measurements in Mr. Woodley's report and the photographs, one can see that all the rooms are small. It is necessary to consider the Claimant's long-term accommodation needs. If there is likely to be a requirement for a support worker to stay overnight, then the present flat is clearly inadequate. Having accepted the evidence of Mrs. Sargent, and rejected the evidence of Ms. Gooch, the Claimant will

need to have accommodation in which a support worker can stay in the future. This may be required in the near future if there is a decline in the Claimant's mental state, or if the relationship with SGL does not continue, which may happen at some stage. The facility for a support worker to stay overnight may avoid a future admission to a mental hospital. The risk of relationship breakdown and the risks to SGL's health may require a support worker to stay overnight, sooner rather than later.

102. The Claimant's requirement for therapies led to the provision of the two bedroom flat in Wellington Street, Leeds, on a temporary basis. The costs relating to this flat are not in dispute. The Holtdale Road flat remains unsuitable for the delivery of the therapies. The use of public spaces is not a reasonable alternative.

103. My conclusion is that it is reasonable for the Claimant to be provided with a long-term suitable property now.

104. The next issue is whether it is reasonable for the Claimant to purchase or rent an alternative property. In the absence of the accident the Claimant may well have continued to live in a rented property. However, to achieve the rental of a suitable alternative property is likely to result in the Claimant having to move several times due to lack of secure tenure. This will be disruptive for the Claimant and harmful to her mental state. Further, the additional costs involved in several moves between rental properties will result in a claim far greater than allowing for the purchase of one property. I therefore conclude that it is reasonable for the Claimant to purchase rather than rent.

105. The next issue is what type and size of property is it reasonable to purchase on the Claimant's behalf? Mr. Woodley and Mr. Miller have both considered this issue. Mr. Woodley has concluded that the Claimant's reasonable needs require the purchase of a three bedroom bungalow with garden, and the construction of an ensuite shower room for the Claimant. In the event that the court holds it is reasonable for the Claimant to purchase a property, then Mr. Miller recommends purchasing a two bedroom two bathroom property which can be either one or two storey.

106. The Claimant's present home is a ground-floor flat and although her physical disability is modest, I accept that given it is a property for life and given the impact of the disability of the Claimant in later years, I conclude that it is reasonable for the Claimant to have single floor accommodation. The property should have:

(a) facilities for a support worker to stay overnight;

(b) additional space to accommodate the Claimant's therapy needs;

(c) a large enough kitchen so that a support worker can assist the Claimant in improving her meal preparation skills;

(d) a shower room provided as an ensuite facility.

Given the above requirements, it would be reasonable for the Claimant to have a three bedroom bungalow with a family bathroom and one bedroom with an ensuite shower room. Mr. Woodley has allowed for the cost of an extension to provide an ensuite bathroom. However, I note that one of two properties for sale, particulars of which are annexed to his October 2022 report, already has an ensuite shower room plus family bathroom. The two-bedroomed properties annexed to Mr. Miller's report all have one bedroom with an ensuite shower room. One of the claims made on behalf of the Claimant is for a property finder fee of £5,040. I conclude that a suitable

bungalow can be found for the Claimant with one bedroom already having an ensuite bathroom. In these circumstances the building of an extension and the disruption that it would involve can be avoided.

107. In respect of the acquisition of a three bedroom bungalow, I allow the following costs:

Relocation costs	£1,500.
Property finder fee	£5,040.
Suitability report	£5,000.
Purchase costs	£2,000.
	£13,540.

In respect of additional running costs, Mr. Woodley's total is £4,484p.a. The gardening at £900p.a. is excessive when one of the benefits of a bungalow is that the Claimant will be able to do some work in the garden with her support worker. I note that Mr. Miller allows £2,155 for a two-bedroomed property, but this is based on a flat with a service charge. I would allow £3,500p.a. and with a multiplier of 45.68 years it gives a loss of £159,880.

108. As to the cost of a three-bedroomed bungalow, I have had regard to the cost of properties in both Mr. Woodley and Mr. Miller's reports and a reasonable price would be £300,000. The **SWIFT v. CARPENTER** calculation is as follows:

Purchase cost £300,000.
Claimant's remaining life expectancy 43.25 years
SWIFT reversionary interest:
£300,000 x 0.11743 = £35,229.
Value of life interest £300,000 - £35,229.
= £264,771.

109. The assessment for the accommodation claims is:

SWIFT v. CARPENTER calculation	£264,771.
Property acquisition costs	£ 13,540.
Additional running costs	£159,880.

£438,191.

Future Costs Of Aids And Equipment

110. In **MUYEPA v. MOD 2022 EWHC 2648** Cotter J. at paragraph 295 stated:

> "The evaluation of damages for care and equipment is not just a question of a requirement simpliciter, including on a theoretical and/or limited or occasional basis, rather of a reasonable requirement. Damages will not be recoverable if the cost is disproportionate to the benefit. The requirement of reasonableness is used to qualify and filter suggested requirements and there is no entitlement to have funding for a wish list of all care and expenditure which could conceivably provide any benefit."

I have adopted this approach to the claim for aids and equipment.

111. In respect of this claim, the Claimant relies on the evidence of Mr. Nicholas Holland-Smith who is an occupational therapist and also works as a case manager. His first report is dated November 2021 and followed remote assessments in September and October 2021. There was limited evidence available to Mr. Holland-Smith at this time. In this report he stated: "I have estimated possible items in the schedule of aids and equipment based upon my experience from similar brain injury cases". His second report is dated September 2022. He had not had further contact with the Claimant, but he was in possession of much more extensive expert and lay witness evidence and records. He had also spoken with the case manager, Jenny Locke, in May 2022. In his oral evidence he said that by the time of his second report he had seen the surveillance evidence. In that second report the schedule of aids and equipment remains the same as in his first report and the report again refers to possible items. In both of his reports Mr. Holland-Smith referred to the fact that he had not had the opportunity to observe or assess how PHJ functions in the kitchen when preparing a snack or meal. He recommended that the treating occupational

therapist, Ms. Clerkin, video cooking sessions and/or provide a detailed observational assessment so that he could identify and recommend appropriate aids in the kitchen. He was not provided with such material.

112. In October 2022 Mr. Holland-Smith produced a joint report with the expert instructed on behalf of the Defendant, Ms. Jill Ferrie. He did not revise his schedule of recommended equipment at this stage. In cross-examination he accepted that his recommendations were still provisional.

113. In August 2023 Mr. Holland-Smith met with the Claimant and SGL at the Wellington Street flat. In a letter dated 29th August 2023 Mr. Holland-Smith described his recent meeting with the Claimant. He noted having received further expert reports, but stated there had not been any significant change since the joint discussion with Ms. Ferrie in October 2022.

114. In a report dated 16th October 2023, produced shortly before he gave evidence, Mr. Holland-Smith provided an amended schedule of aids and equipment in which some items had been deleted and adjustments made to others. It is this amended list which forms the basis of the claim for aids and equipment in the revised Schedule of Loss. It is unclear why Mr. Holland-Smith only provided a revised list of aids and equipment part way through the trial, and why this was not done following his face-to-face meeting with the Claimant. It was clearly unsatisfactory for him to produce a joint report which was still provisional.

115. Ms. Ferrie is an occupational therapist with extensive experience in the area of neuro-rehabilitation. Her main report is dated September 2022. A curious feature of that report is that it contains numerous references to a medical report dated July 2017 by Dr. Kemp, consultant neurologist. Ms. Ferrie seems to have been unaware that Dr. Kemp was not a Part 35 expert, even though it was apparent from the documents available to her that Dr. Kemp had not prepared a joint report with Dr. Crawford, the consultant neurologist instructed on behalf of the Defendant. Ms. Ferrie had available the three reports of Dr. Liu together with the joint report of Dr. Liu and Dr. Crawford. In the main body of Ms. Ferrie's report there is not a single reference to Dr. Liu's findings and opinion, and only a brief reference to him in an appendix. Listening to Ms. Ferrie being cross-examined on this matter, I had concerns as to whether Ms. Ferrie's assessment was fair and objective. The only equipment which she supported was a dosette box and grab rails.

116. When considering whether items of equipment are reasonably required, I have had regard to evidence provided by experts in addition to that provided by the occupational therapists. I accept the findings of Dr. Liu that on examination he found that the Claimant had mild right upper limb weakness with a decreased range of movement at the right shoulder. There was mild right lower limb weakness. In the lower limbs there was a decreased coordination which was worse on the left. She had an asymmetric gait with everted feet which were both flat. Dr. Liu and Dr. Crawford agreed that due to the brain injury the Claimant was at risk of physical worsening in her seventies concerning her gait and balance. They agree that normal ageing will be more difficult for her because of her executive dysfunction. The jointly instructed physiotherapist, Ms. Nicola-Jayne Keech, refers to the Claimant having some very

mild residual physical difficulties relating to balance, motor planning and proprioceptive awareness which are likely to be the result of her injury. There is also a report dated 25th August 2023 from a jointly instructed ophthalmologist, Mr. Durnian, in which he concludes the Claimant has light aversion and jerky smooth pursuit eye movements due to brain injury. He noted that in the optometrist records in April 2023 the Claimant was struggling with crossing roads due to inability to judge distance, direction or speed of travel. Mr. Durnian states that the Claimant's current visual difficulties are light aversion and difficulties judging distance, particularly in the case of fast moving cars.

117. The claim on behalf of the Claimant for aids and equipment amounts to £82,493. The response of the Defendant is that the Claimant does not require aids and equipment, save for a small number of minor items and the claim is valued at £5,000. The most expensive item in the Claimant's list of equipment is a powered scooter. Mr. Holland-Smith, in his main report, concluded that the Claimant is unlikely to require a wheelchair but should the chronic fatigue persist then the need for a powered scooter would be a reasonable requirement. The medical evidence suggests that fatigue is primarily a mental issue rather than a physical one. In any event Mr. Holland-Smith does not address the issue of whether the Claimant's cognitive difficulties would mean that on safety grounds a powered scooter should be ruled out. The medical evidence indicates that despite the Claimant expressing a wish to learn to drive, cognitive defects will make it unsafe. Mr. Holland-Smith concedes that the Claimant does not require a powered scooter, now or in the immediate future. I am not convinced that she will ever be safe to use one.

118. In support of a profiling bed and mattress, Mr. Holland-Smith, in the joint report, said he had taken into account PHJ struggling with her lower back and right hip and she would need a profiling bed if she were to lose power and function in the lower back and hip. The orthopaedic evidence does not support such a risk. The joint evidence of the neurologists refers to a risk of physical decline when the Claimant is in her seventies, but the risk is unquantified. The need for the bed and mattress is not made out.

119. Mr. Holland-Smith accepts in the joint report that the Claimant has no present need for a recliner armchair. He says he has taken into account her lower back and gait difficulties and how this will affect the Claimant over time. The medical evidence does not support a lower back problem due to the injuries. Nor does the medical evidence suggest the Claimant's impaired gait requires a recliner armchair. I disallow this item.

120. The Claimant is capable of operating a mobile phone. Given her cognitive difficulties, she is capable of benefiting from simple technology. I would therefore allow the Panasonic smart home, smart door entry and video door bell.

121. Mr. Holland-Smith recommends a thermostatically controlled shower unit. Given the Claimant's cognitive difficulties, a shower unit which can be pre-programmed at a set temperature has an obvious advantage and I would allow this item. I cannot see that the Claimant's cognitive problems or mild physical problems would justify a wall mounted shower chair. I would allow instead a shower stool. The grab rails are agreed and I allow the cost suggested by Mr. Holland-Smith. The Claimant's mild

physical disability does not justify the claims for a bath sponge, shoe horn, foot and body wash, handi grabber or soap dispenser.

122. The Claimant is keen on walking, despite her impaired gait. She has recently suffered a stress fracture in her foot. She is likely to benefit from using walking poles.

123. There are claims for a number of kitchen items. It is hoped that with increased support the Claimant will improve her cooking skills. Mr. Holland-Smith recommends an adjustable sink unit and refers to the Claimant's ongoing fatigue and such a unit will enable her to sit. The fatigue is primarily mental and such a unit is not justified. For safety reasons an induction hob and cookware are reasonably required. The Claimant's mild physical disability does not justify the need for a specialist oven. For safety reasons I allow the non-spill mug and water boil alert. The Claimant's mild physical disability does not justify the claims for a hot cup, Dycem roll, cooking basket or mini food processor.

124. Mr. Holland-Smith states that if the Claimant's mild physical disabilities do not improve, then he supports the provision of a bidet seat and I accept his evidence on this point.

125. The award for aids and equipment is as follows:

Item	Initial Cost	Replacement Period	Total Cost
Panasonic			
smart home	£134.99	6 years	£ 1,044.
smart door entry	£159.99	10 years	£ 742.
video door bell	£327.00	8 years	£ 1,896.
shower unit	£241.51	10 years	£ 1,121.

shower stool	£ 59.98	8 years	£ 348.
grab rails	£100.00	5 years	£ 928.
walking poles	£ 39.99	5 years	£ 371.
induction hob	£499.00	10 years	£ 2,315.
induction cookware	£149.00	10 years	£ 691.
non-spill mug	£ 14.95	2 years	£ 347.
water boil alert	£ 4.79	4 years	£ 56.
bidet seat	£452.97	6 years	£ 3,503.
installation costs	£250.00	6 years	£ 1,933.
toilet support rail	£242.40	10 years	£ 1,125.
			£16,420.

Future Cost Of Therapeutic Support

126. The final Schedule of Loss seeks to recover the future cost of neuropsychiatry, neuropsychology, occupational therapy and physiotherapy. The future requirement for these therapies is not disputed by the Defendant, but the extent and cost of such therapies that are reasonably required is in issue. The Claimant, in addition, seeks to recover the cost of future MDT meetings, and this cost is disputed by the Defendant.

127. I received evidence from a number of witnesses who have been part of the Claimant's MDT. In particular I had written and oral evidence from Dr. Todd, a clinical neuropsychologist, who has been treating the Claimant since December 2017. I also had written and oral evidence from Ms. Jenny Locke who was the Claimant's case manager from early 2020 to 2023. I had written evidence from Ms. Carol Varley, who is the Claimant's current case manager and has extensive experience of case managing clients with acquired brain injury. Finally, there was a detailed statement from Ms. Hazel Clerkin, an occupational therapist, who undertook regular sessions with the Claimant from 2020 to 2023.

128. What became clear from the evidence of the above witnesses is that the needs of the Claimant due to her acquired brain injury are complex. The continuation of her cognitive deficits and mental health problems means that working with the Claimant is very challenging. Progress has been made, but the Claimant has limited 'carry over' because she struggles to retain information and requires frequent prompting. Since early 2020 the Claimant has not required admission to a mental hospital, either voluntarily or under section. When her mental health deteriorated in 2021 the MDT were successful in arresting that deterioration.

Neuropsychiatry

129. In the joint statement of the neuropsychiatrists, Dr. Moore recommends 12 to 16 hours of neuropsychiatric assessment and treatment in the first year, followed by 6 to 8 hours in the second year, and then a lifelong contingency of 2 to 4 hours per annum. Dr. Jacobson recommends 4 to 6 treatment sessions per annum for 5 years, two sessions per annum for 6 to 8 years, and then a contingency of 6 courses of assessment plus 4 treatment sessions. Relying upon Dr. Moore's opinion, the Claimant seeks to recover the cost of 14 hours in the first year, 7 hours in the second year, and 3 hours a year thereafter, all at £500 per hour. The Counter Schedule relies on Dr. Jacobson's opinion, and contends that a treatment session costs £200 and an assessment costs £800.

130. The Claimant has been in receipt of treatment from a neuropsychiatrist under the NHS. The intention is that she should receive such treatment privately. Given that she is relatively stable at the present time, I doubt she will require the number of hours provided for by Dr. Moore in the first two years. However, given the

seriousness of her mental health problems, there should be an annual provision for life. Reasonable provision would be 6 hours a year for two years, and then 3 hours a year for life. Dr. Moore gives an estimate of £400 to £500 per hour for treatment by a neuropsychiatrist. Dr. Jacobson's estimate in 2021 was £400 per hour. I conclude that £450 per hour is a reasonable cost for treatment by a consultant neuropsychiatrist. The assessment is:

2 years x 6 hrs. x £450 per hour	=	£ 5,400.
3 hours x £450 x 44.4	=	£59,940.
	Total	£65,340.

Neuropsychology.

131. There is agreement for the need for neuropsychological treatment for life. There is agreement that a reasonable hourly rate is £275 per hour. Based on Professor Wang's evidence, the Claimant seeks the cost of an initial input of 20 sessions, and thereafter 12 sessions per year. The Counter Schedule, relying on Professor Powell's evidence, contends that treatment should consist of a maintenance programme of 6 sessions a year. Dr. Todd's evidence is that he had been providing treatment on a fortnightly basis, but since the beginning of 2023 has reduced the frequency of sessions to once a month. Professor Wang states that he supports this level of input. Given the history of the Claimant's mental health problems, I accept this evidence but I do not see the need for an initial increased level of input. The award is:

12 sessions p.a. x £275 = £3,300 x 46.4 = £153,120.

Occupational Therapy

132. Based on the recommendations of Mr. Holland-Smith, the claim is for 8 hours per month for 2 years at £110 per hour plus travel costs, and then 20 hours per annum for

life at £110 per hour. Based on Ms. Ferrie's assessment the Counter Schedule allows for a total of 36 hours of occupational therapy at £90 per hour plus travel time and mileage. In addition a contingency of 60 hours plus travel time and mileage is allowed and the cost of a functional assessment. Whilst there has been a good deal of input from an occupational therapist since 2020, Mr. Holland-Smith comments in the joint report of a future need for an occupational therapist to assist PHJ in setting up a suitable long-term home, ensuring it is appropriately equipped and all risk assessments and coping strategies are in place for the support workers to carry over and maintain. Ms. Ferrie questions whether there will be any functional gains.

133. I note that the neuropsychiatrists disagreed on whether the Claimant required occupational therapy indefinitely. Dr. Moore was of the view that the Claimant required a high level of OT support indefinitely because of her neurobehavioural and cognitive impairments. Dr. Jacobson was of the opinion that the Claimant has had excessive therapy, and once what he describes as the maintenance phase is reached, the Claimant is likely to require only top-up rather than indefinite sessions.

134. The statement of the present case manager, Carol Varley, reveals that the Claimant is currently having OT 2 hours a week and the hourly rate is £95 per hour. I am satisfied from the evidence provided by members of the MDT that whilst it has at times been difficult to get the Claimant to engage with OT, it has been valuable in improving her independence and quality of life. Further progress appears possible and an occupational therapist has an important role in establishing the Claimant in a new home. After a further two years, I would anticipate occupational therapy being used on a contingency basis. I therefore allow 8 hours a month for 2 years at £95 per

hour, and thereafter a contingency of 200 hours at £95 per hour, making a total of £37,240.

Physiotherapy

135. The recommendations are provided by the jointly instructed expert, Ms. Nicola-Jayne Keech, a chartered physiotherapist. There is no dispute as to those recommendations, save for gym membership at £550p.a. The Counter Schedule contends that this is expenditure that would have been incurred in any event, either on gym membership or other sporting or leisure activity. Ms. Keech recommends a gym which also has a facility for aquatic exercise. I accept there will be additional expenditure. I fail to understand why Ms. Keech has limited this recommendation to age 70. I would allow the claim as set out in the Schedule of Loss at £2,260 x 46.4 = £104,864.

MDT Meetings and Liaison of Experts

136. The Schedule of Loss seeks a sum of £6,000p.a., comprising 4 meetings a year of the MDT, each meeting lasting 2 hours. This claim is resisted in its entirety. The benefit of having meetings of the treating professionals is established by the evidence. Ms. Locke refers to the MDT having collectively developed approaches to the therapy and treatment of the Claimant, so that there has been a consistent rehabilitation plan. One can readily see that it is essential for the treating professionals to agree on an approach and to learn from the experience and views of other members of the MDT. The intention is that this should continue. Carol Varley states that one of the functions of a case manager is to facilitate regular multidisciplinary team meetings.

137. Where evidence is lacking, is the required frequency of such meetings and the likely cost. I anticipate that such meetings will usually be conducted remotely. Doing the best I can, it seems reasonable to have such a meeting every 6 months at a cost of £1,500 per meeting. This produces a total cost of £3,000p.a. x 46.4 = £139,200.

138. The award for therapies is as follows:

neuropsychiatry	£ 65,340.
neuropsychology	£153,120.
occupational therapy	£ 37,240.
physiotherapy	£104,864.
MDT meetings	£139,200.
	£499,764.

Future Transport Costs

139. The cost of a car at £20,000 is claimed, with a replacement period of 5 years and an annual mileage of 10,000 miles. Running costs of £4,176 p.a. are claimed plus fuel costs of 9.40pence per mile. The Counter Schedule denies that the Claimant requires a car, and allows the cost of taxis calculated at a total cost of £50,000. Mr. Holland-Smith supports the provision of a car, and Ms. Ferrie denies the requirement for costs in this regard.

140. As noted above in relation to past costs, the car that has been purchased is driven by SGL. The Claimant's ability to use public transport is very limited. She is incapable of learning to drive because of cognitive deficits. SGL uses the car, both to drive the Claimant about and for his own use. This is likely to continue while SGL remains living with the Claimant. There is the risk referred to above of the relationship breaking down. In addition to this risk, there will come a stage due to the age difference and SGL's health, when they are no longer together. It is reasonable at that

stage for the Claimant to have a car which is driven by a support worker. The present arrangement whereby SGL drives the Claimant, is likely to continue for some years. It is therefore reasonable to allow part of the cost of a car for the immediate future, and the full costs in the long-term, on the basis that in the absence of the accident the Claimant is unlikely to have owned a car. I have therefore allowed half the costs for the immediate future, and the full costs in the long-term, but with lower running costs and mileage than claimed in the Schedule of Loss. On the basis of a vehicle costing £20,000. with a replacement period of 5 years and a mileage of 10,000, half of which is attributable to the Claimant's reasonable need:

Immediate future	13,400 x 4.23 x 0.5	=	£ 28,341.
Running costs	4,176 x 23.2 x 0.5	=	£ 48,441.
Fuel costs	9.40p x 10,000 x 23.2 x 0.5	=	£ 10,904.
Long-term future	13,400 x 4.23	=	£ 56,682.
	3,000 x 23.2	=	£ 69,600.
	9.40p x 5000 x 23.2	=	£ 10,904.
		Total	£224,872.

Future Deputyship Costs

141. The medical experts are agreed that the Claimant lacks capacity to manage her financial affairs, and will not recover that capacity. There is agreement that the Claimant requires, and will always require, the services of a professional deputy.

142. Ms. Peterson and Ms. Gaudern produced a joint statement in October 2022. Where there were differences in their estimates of costs, they were able to reach a compromise on all matters save for one item, which is the frequency of change of the Claimant's Will. Ms. Peterson allows for a change of Will every 10 to 15 years, whereas Ms. Gaudern would allow for one further Will. Given that the general management costs of deputyship will be affected by the extent of the commercial care

arrangements, and given the dispute between the parties on the appropriate extent of those arrangements, Ms. Peterson and Ms. Gaudern agreed to produce two estimates of costs, one on the basis of an extensive care package, and the other on the basis of limited support. Following the joint statement Ms. Peterson produced a further report in August 2023, and Ms. Gaudern a further report in September 2023. Ms. Peterson took the opportunity to clarify the costs of years 4 and 5 of the deputyship. She notes a change in the security bond arrangements which was introduced in April 2023. A security bond has to be purchased by the deputy as an insurance policy to guarantee the obligations of the deputy to the protected person. Ms. Gaudern noted the same change in her further report. Given the extent of agreement between Ms. Peterson and Ms. Gaudern, they were not required to give oral evidence.

143. In the light of the conclusions I have reached on the extent of the appropriate care package, I shall adopt the compromise costs of Ms. Peterson and Ms. Gaudern under their scenario 1, rather than what they term their light touch costs for general management of the deputyship. In relation to the one issue which continued to divide them, a compromise is appropriate and I allow the cost of two further Wills.

144. Having regard to the joint statement of Ms. Peterson and Ms. Gaudern, and the figures which appear in the Schedule of Loss and Counter Schedule, the allowed costs are as follows:

Management costs of deputyship:		
Year 6		£ 24,532.
Years 7 and 8 £24,532.24 x 2.01	=	£ 49,310.
Thereafter £15,299.99 x 43.39	=	£663,866.
Contingency fund		£ 40,000.
Appointment of replacement deputies		£ 15,000.
One-off costs:		
pre-nuptials £5,300.		

Winding up £900.	£ 6,200.
Further Applications	£ 6,400.
Statutory Will after settlement	£ 18,432.
Subsequent statutory Wills (2)	£ 26,290.
Ordinary Will	£ 3,150.
Total	£853,180.

I appreciate that there may be an application for a combination of a periodical payments order and a lump sum.

Future Loss of Earnings

145. A claim is made on the basis of net earnings of £20,640p.a. and a reduced multiplier of 16.96. The basis of the claim is that the injuries have destroyed the Claimant's earning capacity. It is accepted that the Claimant's ability to work pre-accident was affected by anxiety and episodic depression. It is contended that the Claimant would probably have worked part-time, or full-time with periods of reduced working. The Defendant argues that the Claimant was very unlikely to have obtained remunerative employment and a nominal figure of £25,000 is conceded.

146. In **BLAMIRE v. SOUTH CUMBRIA HEALTH AUTHORITY 1992 EWCA Civ. 20**, a claimant appealed against a lump sum award of £25,000 for future loss of earnings and pension, arguing that the trial judge should have calculated the future loss by the established multiplier/multiplicand approach. The Court of Appeal held that the trial judge, on the material before him, was entitled to conclude that the multiplier/multiplicand measure was not the correct one to adopt. There were too many imponderables for the judge to be bound to take the conventional approach.

147. In **IRANI v. DUCHON 2019 EWCA Civ. 1846** a claimant was 26 when injured in a road traffic accident. On appeal it was argued that the trial judge was wrong to have

made a **Blamire** award for future loss of earnings, but should have made a conventional award based on the adoption of a multiplier and multiplicand. The Court of Appeal stated that the general method of assessment of future loss of earnings is to use the multiplier/multiplicand methodology, and the current Ogden Tables and guidance. This method is to be preferred to the broad-brush approach of awarding an overall lump sum figure after consideration of all the circumstances. The conventional method should be adopted unless the court is driven to conclude that there is no real alternative to a **Blamire** award. The fact that there are uncertainties does not justify abandoning the conventional approach. There will be no real alternative if there are too many imponderables or insufficient evidence for a judge to make the findings necessary to support the multiplicand/multiplier approach.

148. In the present case, the Claimant had not established any pattern of employment in nearly seven years from leaving university up to the date of the accident. The Claimant had achieved a degree, but had not utilised that qualification in pursuit of a career. Her mental health was such that ongoing anxiety and periods of depression made any type of regular employment difficult to achieve. I accept Dr. Moore's evidence that the conditions affecting the Claimant's mental health were amenable to treatment, although the treatment she had received between 2009 and 2016 had only achieved limited success. I find that absent the accident the Claimant would have been able to work and achieve modest earnings, although her fragile mental state may well have resulted in lengthy absences from work. However, the lack of any settled employment history before the accident and uncertainty regarding the Claimant's mental state in the absence of the accident, creates so many imponderables that the

multiplier/multiplicand approach is inappropriate. The alternative is a **Blamire** award, and I assess the appropriate sum at £100,000.

Future Cost of Holidays

149. A claim is made, relying on the evidence of Mr. Holland-Smith, for additional costs of support when travelling abroad, both when travelling with SGL and without him. A claim is also made in respect of a UK holiday when travelling with a support worker. The claim is calculated on the basis of one foreign holiday every 4 years, and a domestic holiday in the other years. The Counter Schedule accepts that at some point in the future the Claimant may go on holiday with a support worker.

150. Prior to the accident the Claimant did go on some trips abroad, several times travelling to India and other destinations. In 2023 there was a proposal for the Claimant to have a trip to Amsterdam with a support worker, but without SGL. However, there was insufficient funding available. It seems to me very unlikely that if the Claimant is going on a trip abroad with SGL that she will agree to a support worker travelling as well. The Claimant is not capable of travelling abroad on her own, nor of holidaying on her own in the UK. There will come a time when she will not have SGL to accompany her on holiday. It is also reasonable that the Claimant may want to take a short break either in the UK or abroad without SGL, as in the proposed trip to Amsterdam when she will require the assistance of a support worker.

151. While SGL is her partner, any trips abroad or in the UK with a support worker are likely to be short and occasional. For this period it is reasonable to allow an average annual additional cost of £2,500p.a. For the period when the Claimant is without a

partner, it is reasonable to allow increased costs of £5,000p.a. Assuming the Claimant is without a partner for 50% of her lifetime, the calculation is:

23.2 x £2,500	=	£ 58,000.
23.2 x £5,000	=	£116,000.
	Total	£174,000.

Domestic Assistance

152. A claim is made for domestic support at £2,160p.a. This is based on the report of Mr. Holland-Smith who states that he has provided for domestic support during periods of severe fatigue. He has calculated the cost at £15 per hour for 6 hours a week for 24 weeks per annum. The Counter Schedule allows a contingency sum of £25,000 in case a cleaner should be required in the future.

153. The medical evidence does not support the notion that the Claimant is prevented by fatigue from carrying out ordinary cleaning jobs in the home, and she has the assistance of SGL. In years to come he will not be around. On the medical evidence there is a risk that the Claimant's physical disabilities will increase and she is likely to find the ageing process more challenging because of her injuries. It is therefore reasonable to provide a contingency for cleaning costs in the future, which I assess at £40,000.

Personal Care Activities

154. Based on the report of Mr. Holland-Smith, claims are made for the cost of a hairdresser, chiropody and nail care, aromatherapy and hypnotherapy. Confusingly, Mr. Holland-Smith's report refers to a one-off package of 10 sessions of hypnotherapy, but then refers to an annual cost. Similarly, the report refers to a one-

off allowance for aromatherapy, but then refers to an annual cost. My conclusion is that the medical evidence does not provide any support for either hypnotherapy or aromatherapy, and no award is made.

155. Mr. Holland-Smith states that due to impaired upper limb function, it has not been possible for PHJ to maintain her hair, nails and eyebrows, and she has had to visit necessary specialists. In fact there is no past claim for such expenses. PHJ is likely to have used a hairdresser in the absence of the accident. She may well have gone to a salon for her nails and eyebrows. The orthopaedic evidence does not provide any support for the need for such services because of impaired upper limb function. The joint statement of the neurologists agreed that PHJ has been left with a mild ataxia, leading to incoordination of the upper limbs. On examination Dr. Liu found there was mild right upper limb weakness with decreased range of movement around the shoulder. I accept Dr. Liu's findings and there should be a modest award for additional costs relating to hair, nails and eyebrows, which I assess at £10,000.

156. **SUMMARY**

Pain, suffering and loss of amenity		£ 275,000.
Interest at 2% p.a. from service		
Past losses:		
Gratuitous care and assistance		£ 155,000.
Commercial care		£ 18,179.
Case management costs		£ 85,995.
Therapies		£ 164,201.
Accommodation costs		£ 58,965.
Transport and travel costs		£ 13,281.
Deputyship costs		£ 87,240.72
Loss of earnings		£ 25,000.
	Total	£ 607,861.72
Future losses:		
Care and case management		

PPO to age 60:	
year 1	£ 109,005.
thereafter	£ 94,622.pa
PPO from age 60	£ 180,622.pa
Lump sum	£ 723,432.
Accommodation	£ 438,191.
Aids and equipment	£ 16,420.
Therapeutic support	£ 499,764.
Transport	£ 224,872.
Deputyship costs	£ 853,180.
Loss of earnings	£ 100,000.
Holidays	£ 174,000.
Domestic assistance	£ 40,000.
Personal care activities	£ 10,000.

157. It may be necessary for me to hear an application regarding periodical payments. Subject to that matter, I would be grateful if the parties would endeavour to agree terms of an appropriate Order.