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Case No: TLQ / 13 / 0433

IN THE HIGH COURT OF JUSTICE
QUEEN'S BENCH DIVISION

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 01/04/2015

Before:

MR JUSTICE FOSKETT

Between:

JAMES ROBshaw
(a child by his mother and Litigation Friend
SUZANNE ADAMS)

Claimant

- and -

UNITED LINCOLNSHIRE HOSPITALS NHS
TRUST

Defendant

Susan Rodway QC and William Latimer-Sayer (instructed by **Shoosmiths LLP**) for the
Claimant
Neil Block QC and Nicola Greaney (instructed by **Browne Jacobson LLP**) for the **Defendant**

Hearing dates: 13 – 20, 22 & 23, 26 – 28 January 2015
Further written submissions based upon initial draft judgment sent to parties on 18 March 2015:
23-31 March

I direct that pursuant to CPR PD 39A para 6.1 no official shorthand note shall be taken of this Judgment and that copies of this version as handed down may be treated as authentic.

JUDGMENT

Mr Justice Foskett:

Introduction

1. The Claimant, James Robshaw, was born on 9 December 2002. He is currently very nearly 12 years and 4 months of age. It is not disputed that his birth was negligently mishandled at Lincoln County Hospital, Lincolnshire, with the result that he sustained significant brain damage leading to serious disabilities.
2. Liability for negligence has been admitted and judgment for damages to be assessed was entered on 31 January 2013.
3. The hearing of the assessment of damages took place before me over 11 days. At the commencement of the trial, whilst there had been agreement on certain issues, there was a very significant gap between the claim advanced on James' behalf and the valuation put upon it by the Defendant. During the trial the gap narrowed, but not to the extent that the whole claim was settled. As it is, I have had to consider important issues such as life expectancy, accommodation (including whether the property already acquired should be demolished and something put in its place or whether it should be extended) and some aspects of the care regime as well as some, frankly, trivial issues such as whether there should be a cord operated curtain track in James' new home.
4. Agreement had been reached before the trial, subject to the approval of the court, on the appropriate award of damages for pain, suffering and loss of amenity in the sum of £290,000. That indicates the severity of the brain damage. There is no doubt that James' disabilities are severe and that he has complex needs. The means by which those needs are to be met lie at the heart of the differences between the parties. There is, unfortunately, a material dispute as to his life expectancy, the Defendant's case being that James will live to age 53, the case advanced on his behalf being that he will live to age 70-71.
5. Recorded in the Appendix to this judgment are those areas where agreement had either been reached before the trial or where agreement was reached during the trial.
6. I should say that the predictions of the parties about the length of the trial were somewhat pessimistic although those predictions were made before the gap between the parties narrowed and certain events occurred that shortened the trial. James' advisers thought the trial might last 20 days and the Defendant's advisers thought it might be nearer 15 days. In fact, as I have indicated, the trial lasted 11 days, of which 10 were devoted to the evidence, lay and expert, and one day to final submissions. The initial pessimism may have been borne of the knowledge that there were 91 files of documents copied for the hearing and so many potential areas of disagreement at the outset of the trial to which apparently James' team were put to proof. I merely observe that it is unfortunate that such substantial time estimates had to be given for a "damages only" hearing because, inevitably, accommodating such a lengthy hearing in the list is less easy than one of more manageable proportions.

Accommodating the availability of all witnesses is also problematic in such circumstances.

7. As it is, the fact that so little has been agreed has led to a very lengthy judgment.
8. As it was, the Defendant sought an adjournment of the trial at its outset because the expert paediatric neurologist who reported for James, Dr Colin Ferrie, was unfit to attend the trial and the Defendant submitted that it was unfair that it should be deprived of the opportunity to cross-examine Dr Ferrie. The James' advisers contested the need for the adjournment. I rejected that application and the trial started on the following day. If Dr Ferrie had been present, the trial might have been extended by one day or thereabouts. His absence has not rendered resolution of the life expectancy issue (see paragraphs 33 - 137 below) impossible (though it has made it more difficult) nor has it caused the trial to be unfair from the Defendant's perspective. At the end of the day, the issue of life expectancy is to be determined by the court, not by the experts, on the basis of all the evidence received.

The form of the award

9. It is accepted by both parties that the award of damages should be paid partly by way of a lump sum and partly as periodical payments. In particular, the award for future care and case management should, it is agreed, be paid by way of annual periodical payments and that any periodical payments should start on 15 December 2015 (which is the usual date for payments by the NHSLA). It is further agreed that there will need to be a *pro rata* payment in respect of any heads of loss awarded by way of a periodical payments to cover the period from the date of trial (to which date past losses have been calculated) and 14 December 2015.
10. The extent to which other heads of loss might appropriately be dealt with by way of periodical payments will have to await the outcome of my assessment of the multiplicands for the other continuing losses in the light of James' needs. James will require sufficient free capital to meet his accommodation needs, to pay for items of equipment that will need to be changed periodically (e.g. wheelchairs, adapted vehicles and eye-gaze equipment) and to provide an adequate contingency fund. The parties have invited me to hand down a judgment determining the level of James' needs and the appropriate multiplicands after which submissions can be made on the appropriate form of award in the light of independent financial advice which will then be commissioned. I have been content to approach the case on this basis. The other factor that the parties will need to know before being able to advance this aspect of the case is my conclusion on the life expectancy issue because the appropriate multiplier (or multipliers) will depend upon that conclusion. This judgment is, therefore, the judgment that contains all my conclusions on the disputed items. The final judgment giving effect to these conclusions will be handed down in due course.
11. This is a case where substantial interim payments have been made totalling £1,718,487.60 (inclusive of repayment to the CRU of £18,487.60). This has

enabled, within the limits of the present rented family accommodation (which is agreed to be inadequate for James' needs), the implementation of an interim care and other support regime over the 3 or 4 years or so prior to the trial. I will say more about that in due course.

12. I can say that where agreement has been reached by the parties on any issue I am able to give my approval to the agreement.

James' disabilities

13. Before turning to his family situation I should set out briefly the nature of James' disabilities. In view of the dispute there is about his capacity to improve his function in the future, I will for present purposes merely record the general nature of his disability.
14. He sustained a hypoxic ischaemic encephalopathy during his unnecessarily prolonged birth and was subsequently diagnosed with motor developmental delay, cerebral palsy and learning difficulties. His cerebral palsy affects all four limbs (and he is thus described as quadriplegic or tetraplegic) and is dyskinetic in type, with prominent dystonia and athetosis, characterised by frequent involuntary writhing movements. James attended the first day of the trial and I was able to observe for myself that which is also shown on the videos prepared for the trial and described by the witnesses, namely, frequent jerky arm and hand movements, in particular. It should, perhaps, be observed that this attendance at court would have been either an exciting or anxious time for James and it is possible that I saw rather more movements of this nature than in a calmer setting. However, for reasons that will emerge, this is an ongoing feature of his presentation that does add complexity to the picture.
15. He does possess a high level of retained intellect and insight, but equally has significant communication problems. At present he communicates using an eye-gaze augmentative and alternative communication (AAC) system which I will describe in greater detail later (see paragraph 204). It is not difficult to appreciate and sympathise with the frustrations to which this particular combination of disabilities must give rise.
16. Fortunately, James is continent and ordinarily he can and does indicate when he wants to go to the toilet. The process is not without its complications however.
17. James wins the highest praise from everyone he meets. Mrs Julia Ho (see paragraph 225 below) described him as "a very active, quite exceptional, young man." That seems to be borne out from all other sources.

The family setting and the Claimant's mother

18. James' mother (who has been referred to throughout as 'Mrs Adams') was born in 1966 and is now aged 48. She was first married in 1988 to Paul Adams who was in the RAF. They separated in January 1996 and divorced later that year. Subsequently she met James' father, Graham Robshaw, in 2001. They had not lived together permanently prior to James' birth because

he worked away during the week and she stayed with her parents during the week. They shared weekends together at his property. Her pregnancy was unexpected, but nonetheless something about which they were both pleased at the time and which, at that stage, heralded a permanent relationship together. However, without going into details, Mr Robshaw found James' disabilities difficult to cope with and he and Mrs Adams separated in April 2005. I have not had the advantage of seeing and hearing from Mr Robshaw, but I understand that he and James see each other twice a week and that this is something that James enjoys. Mr Robshaw plays no direct role in James' daily care.

19. I will say a little about Mrs Adams and her close family and their involvement in her life and that of James. Her family are based in and around Lincoln.
20. There can be absolutely no doubt about the strength of the support that her family has given to Mrs Adams personally over the period since James was born and of the love and affection they show to James. It is not easy to find the words adequately to re-create on paper the obvious bonds that exist between them all and I will not try. The general flavour will, I trust, emerge from what follows. All I will say is that having seen Mrs Adams, her brother, her father and James in court together briefly on the first day of the trial, the empathy between them all was palpable. I will return to Mrs Adams herself later, but her father and brother were immensely impressive, good-humoured and caring men who were plainly proud of their family's achievements and who wanted the best for James and Mrs Adams. I am sure Mrs Adams' late mother was of a similar disposition. Mr Neil Block QC, Leading Counsel for the Defendant, paid tribute to them all handsomely by describing them as "a fantastic family". He was right to do so.
21. Superimposed upon some physical problems that Mrs Adams possesses (and to which I will return below), she has suffered very considerable anxiety and stress leading to some psychological difficulties over the last few years. Unfortunately, it will be necessary to say a little about those matters because they have an impact on certain aspects of the claim, both for past losses and for future expenses. However, there can, in my view, be no doubt at all that she has faced more than her fair share of misfortunes. It is to be hoped that the future will be somewhat brighter for her once this case is over and she and James have moved to the property that will accommodate his needs and the care regime that is recognised to be necessary. For reasons that will become apparent, I will have to make some assessment as to whether, and if so to what extent, it is likely that her difficulties will continue in the future.
22. From childhood Mrs Adams had problems with her left knee which were eventually diagnosed as having been caused by a congenital problem with her hips which put stress on the joints, causing her pain. In October 1990 she underwent bi-lateral femoral rotational osteotomies with a view to straightening the top part of her legs. She was in hospital for six weeks and there was a substantial rehabilitation period. Although this improved matters considerably, by May 2004 (and thus when James was eighteen months old) she was advised to undergo further surgery. It had been intended that she should be in hospital for 7-10 days, but following her development of MRSA

she had to remain in hospital for six weeks and there was a significant period of recovery thereafter during which her parents took substantial responsibility for looking after James. There was some assistance once a week provided by Social Services, but little more than that. It was not until December 2004 that she was able to start helping look after James again and, as already indicated above, in April 2005 she and Mr Robshaw separated.

23. As will be appreciated, during that period and in the years that followed, James continued to grow and become stronger with the result that handling him in the context of his vigorous athetoid movements became more and more difficult. As a result of that, in September 2008 Mrs Adams injured her left shoulder when lifting him and putting him into his car seat. The problems associated with her shoulder have been ongoing since then.
24. During the three year period after Mrs Adams' discharge from hospital in 2004, she and James remained with her parents in their property. The bedroom and bathroom they used was upstairs and carrying James up and downstairs, given his athetoid movements and increasing weight, was a major problem. The property was not wheelchair accessible either. She needed to find a bungalow. Her father bought out the half share of Mr Adams in the former shared home and that property was then sold to realise money for Mrs Adams. Her brother, Mr Darren Chafer, re-mortgaged his property and lent her £40,000. With that generous assistance, and with her father paying all the conveyancing and removal costs, she acquired a bungalow in Lincoln (1 Graveley Close) in May 2007 for £136,000. After that was acquired she repaid her brother at the rate of £300 per month which was increased to £440 per month when the property was rented out in December 2011 (to which I will refer further below). Although the property was a bungalow it was not really suitable for James but it was all she could afford at the time. Mr David Reynolds, the Defendant's accommodation expert, described it as "a rather small two-bedroomed bungalow". Dr Lewis Rosenbloom, the Consultant Paediatric Neurologist instructed by the Defendant, described it as "somewhat cramped". Mrs Adams' witness statement sets out the problems that I need not rehearse in detail. She said, and I have no doubt as to its accuracy, that it was "incredibly hard coping with the situation" and that she "constantly felt tired and drained and everything felt hopeless." She said she often had little sleep.
25. Although the proceedings were not issued in this case until 20 August 2012, litigation had plainly been in contemplation for a much longer period (Dr Rosenbloom having examined James for the first time in October 2007). Following the payment of an interim payment, a case manager (Amanda Beesley) was appointed and her first task was to see if more appropriate accommodation could be found. Another property in Lincoln was found into which Mrs Adams and James moved in July 2011. It was a larger bungalow than the one from which they moved and it had a level access and doors wide enough for a wheelchair, but there were a number of difficulties with it. However, the most serious difficulty that she ran into was one with the neighbours who complained about the large number of people (mostly support workers, therapists, family members and others) who were visiting the property. Mrs Adams said, and again I do not doubt it, that she was caused

very considerable stress and worry during the eighteen month period they were there. They were given notice by the landlord and had to leave.

26. Amanda Beesley found another property (a chalet bungalow) into which they moved in December 2012. Mrs Adams remains there with James and says that, though it is not ideal, it is better than the previous properties. Her bedroom and bathroom is upstairs and downstairs is a bedroom for James and another bedroom for the carers. It is, however, accepted by all parties to be unsuitable in the long term.
27. I have recounted this history to demonstrate the pressures to which Mrs Adams has been exposed over at least ten years or so, superimposed upon which has doubtless been the constant flow of experts reporting on the case for litigation purposes. It would doubtless have taxed someone of a less anxious disposition than hers.
28. If all this was not enough, her mother died in late 2013. The video clips I have seen include passages showing the inter-reaction between James' grandmother and James and his grandmother's fondness for him is clear. Needless to say, not merely did Mrs Adams have to support herself through the shock of losing her mother, but she will have had to guide James through it also, together with offering her father, Mr Terry Chafer, support also.
29. Finally, of course, a few days before the long-awaited trial for the assessment of damages, in which so many items are contested, she learned of Dr Ferrie's situation.
30. As I have said, these are pressures that would have tested the resilience of anyone. When Mrs Adams gave evidence, I could see the tension she felt as she grasped her hands together in the witness box (something Mrs Hazel Tuckfield also noted when she visited Mrs Adams and James in September 2014: see paragraph 172 below) and she was on the verge of tears on one or two occasions. However, she answered all the questions, sensibly, coherently and intelligently and with evident and entirely understandable concern for James. Mrs Beesley, who probably knows her better than most at the moment, described her as "an intelligent lady with many skills". She described her also as "brave". Her solicitor, Mrs Denise Stephens, who also acts as James' Deputy, described her as a "very kind, loving and intelligent woman". I agree entirely with each aspect of those assessments. I sense that James already knows how lucky he is to have a mother such as Mrs Adams. I think that his appreciation of that will grow as time moves on.
31. It is now some while since she worked, but prior to the birth of James she had worked as a medical secretary, an administrative assistant, as an administrative officer with the CAB and as a legal secretary. Her hope is that she will be able to get back to some form of employment when this case is finished and she and James are settled in proper accommodation with a full care package for James.
32. Because it may impact on the future case management and/or Deputyship costs, I will have to make some assessment of the role Mrs Adams will play in

James' life in the future and her ability to be a little more decisive than has been the case over the last few years - which has had an effect on the level of those costs hitherto. I will return to that aspect later (see paragraphs 443-446).

Life expectancy

33. I should turn immediately to the vexed issue of life expectancy. It is most unfortunate that the dispute should exist and having to determine it is always an invidious task for a court. Whilst the welcome introduction of the ability of the court to make periodical payments orders in cases of this nature has lowered the profile of the issue in a number of cases, as the editors of *McGregor on Damages*, 19th ed., 2014, remark somewhat ruefully at paragraph 38-103, "the issue is still with us". Dr Rosenbloom made much the same point in his article in 'Clinical Risk' entitled 'Estimating life expectancy in children with neurological disabilities' in 2004 (see paragraph 62 below). In this particular case it is, of course, doubly unfortunate that I have not been able to witness what would, in effect, have been an informed debate on the issue between two acknowledged experts in the field who have arrived at different views.
34. Dr Rosenbloom expressed his regret that Dr Ferrie was unable to be present and it was obvious that each had mutual respect for each other's opinion. I do not recall seeing previously a passage such as that which follows in a memorandum recording the areas of agreement and disagreement between experts (and indeed Dr Rosenbloom confirmed that he had never introduced such a passage into a joint statement previously), but Drs Ferrie and Rosenbloom said this at the conclusion of their memorandum dated 6 July 2014:

"Against the background that both Dr Ferrie and Dr Rosenbloom are experienced experts who prepare reports for both Claimant's and Defendant's advisers they would wish to bring to the attention of those instructing them and to the Court that the differences between them, especially so far as their life expectation estimates are concerned, are much greater than is usually the case.

Dr Ferrie's estimate is to age 66 years. Dr Rosenbloom's estimate is to age 53 years.

The reasons for our differences are detailed in this minute and following extensive, constructive and mutually respectful discussion we are not able to reconcile them further.

In spite of the extent of the difference between us we each accept that the other's estimate is reasonable whilst preferring our own.

We agree therefore that there is a wide range of possible projected life expectancy for James and that this is between 53 and 66 years in total."

35. As already recorded (see paragraph 4 above), the case in fact advanced on James' behalf on the basis of the evidence given at the trial (which is said to have demonstrated material improvements in his abilities since Dr Ferrie and Dr Rosenbloom discussed matters in July 2014) is that I should conclude that the predicted life expectancy should be to age 70-71.
36. By way of background, it should be noted that Dr Ferrie's first report dated 8 September 2012, based upon his assessment at the time, contained the opinion that James was likely to survive "to around 70 years of age", but that assessment expressly did not take into account "any adjustment the Court might consider appropriate to take into account the likely benefits which are likely given his success in the litigation." That latter comment was directed to the suggestion that the Court might make a further "modest upward adjustment" to his own estimate to reflect the advantageous position that James would enjoy in comparison with others who would not have access to substantial damages and the benefit of very high standard 24/7 care. Dr Ferrie's approach at that time was that James had the ability to roll/sit and get around by scooting, but would not be able "to fully feed himself", but would "gain sufficient self-feeding abilities such that for the purposes of [the 2008 Strauss paper: see paragraph 41 below] he could be considered as self-feeding."
37. In a further report dated November 2013 Dr Ferrie maintained that opinion for the reasons that will appear in paragraph 51 below. He modified his view downwards slightly (in other words, survival to age 66) in the light of his discussion with Dr Rosenbloom for the reasons mentioned in paragraph 52 below. That was his last recorded view on the position and I have, of course, received no direct evidence that he had changed his view back to survival to age 70 or thereabouts in the light of developments since July 2014 or indeed in the light of the new statistical material to which I will refer below (see paragraph 42). However, I have effectively been invited to conclude that this would have been his view had he heard all the evidence I heard and that such a view would have been correct. I will return to that contention in due course, but for the present will make the following observation on the differences between the two expert views as recorded in the memorandum.
38. The task of trying to reconcile or choose between opposing views that are recognised by respected experts in the field to be "reasonable" is even more difficult than choosing between two views that each opposing proponent regards as unreasonable or unsustainable. I do not know whether that passage in the memorandum was a subtle, coded message to the parties or the court simply to "split the difference" bearing in mind the long-established view that whatever assessment of life expectancy is made it will be proved to have been wrong. However, whatever the temptation, I do not think that a court can perform its role conscientiously by approaching the issue in that way: unlikely though I suspect it may be in this particular case, it could result in a significant over-payment of compensation with public money, on the one hand, or a significant degree of under-compensation for a very seriously disabled young man with, on whichever view is adopted, many years ahead of him, on the other. Nonetheless, it offers some comfort if it should be the case that I

conclude that neither view is wholly consistent with the evidence I have received. It is accepted on all sides that ultimately I must make an assessment based upon all the evidence that I consider goes to the issue.

39. It has been established for a long time that there is interplay between the conclusions to be drawn from certain statistical data available to the experts and the actual presentation of the individual concerned. The statistics are those derived from the data collected and published in the USA by Professor David Strauss and others (which is generally referred to as “the Strauss data”). I will say a little more about those statistics and how they are to be applied shortly, but the following interchange during Ms Susan Rodway QC’s cross-examination of Dr Rosenbloom on behalf of James illustrates the proposition in the first sentence of this paragraph:

Q. Are you prepared to accept that common sense, clinical judgment and empirical experience are relevant in seeking to predict the individual life expectancy of someone like James?

A. To the best of one's ability, yes, I do.

MR JUSTICE FOSKETT: That has always been the position, hasn't it?

A. It has indeed, my Lord.

MR JUSTICE FOSKETT: But one looks, obviously, at the statistics because they are very important, but at the end of the day the individual characteristics are matters that have to be factored in.

A. And this is something that we have always written about and always taught.

MR JUSTICE FOSKETT: That's what I had always understood to be the position

MS RODWAY: Within that clinical experience, clinical judgment can be brought to bear and is very important.

A. I think that's parts (sic) of it.

Q. Even if one can't find a paper in the literature that specifically reflects someone with James's range of disabilities, one ... overlays the statistics with the clinical assessment?

A. With caution, my Lord, and to the best of one's ability. I would not be looking for (sic) someone such as James [and] saying the described clinical characteristics are such that he shouldn't be in that group altogether, because I don't think that's an appropriate way to look at the data and to look at clinical experience.

Q. But ... we have discussed not just the aspiration, and we differ on that, where you consider that even absent aspiration now, there is still a risk in the future. But on the other side, I think we did agree that on the mobility aspect, the greater the mobility, it's an empirical judgment that that decreases the risk of lung infections because you have a lesser chance of getting respiratory load?

A. Yes.

Q. One doesn't need for that purpose to see dozens of papers written by learned authorities; you are able to say that because you see it in practice?

A. But it is also supported by the literature.

Q. Yes. A lot of it, though, Dr Rosenbloom, when one moves on to these various areas, a lot of it is common sense, isn't it? If you can cough more, if you can clear your lungs more, you are going have be a better chance than someone who is unable to do so?

A. I hope it is common sense, my Lord. It would be worrying if that which we have attempted to describe is so against common sense and then you would be looking for flaws in the argument ... [so] I agree with counsel.

40. It is this kind of approach that will have led Swift J in *Whiten v St. George's* [2011] EWHC 2066 (QB) to consider whether to make any adjustment to the figure generated by an analysis of where the claimant in that case fell within the Strauss data "to reflect individual features in [his] case": [85]. In fact she did not do so in that case, but there are examples in other cases where the life expectancy derived from the statistical data has been altered by reference to the individual characteristics of the particular claimant and his or her clinical presentation. It should be noted that Swift J considered this question after the necessary adjustment for use in the UK of the actual life expectancy rates utilised in the US: see [22]. I will return later to the way in which this factor is sought to be deployed in the present case and the issue about when any such adjustment should be made (see paragraphs 91 - 100 below). However, it is important to recall that an adjustment to UK figures is required and the manner in which it is achieved is set out in the 2008 paper at page 491. It is common ground in this case that such an adjustment is necessary and the essential manner in which it is achieved is not in dispute.
41. In an endeavour not to extend unduly what is necessarily a lengthy judgment, I would respectfully adopt and rely upon the full and detailed description of the background to the Strauss data and its development set out in *Whiten* at [19]-[38]. It has not been questioned in this case and, in my view, it sets out clearly the history up to and including what is generally referred to as "the 2008 paper" (i.e. Strauss DJ, Brooks J, Rosenbloom L, Shavelle RM. 'Life expectancy in cerebral palsy: an update': *Developmental Medicine and Child Neurology* 2008; 50: 487-493). Dr Ferrie and Dr Rosenbloom took the 2008

paper as the relevant starting point to apply to this case at their meeting in July 2014.

42. The judgment in *Whiten* was given in August 2011. There has been a further contribution to the learning on this topic by the same authors with the addition of Linh Tran and Yvonne Wu in the form of articles published in 2014 in *Developmental Medicine and Child Neurology* entitled ‘Recent trends in cerebral palsy survival’. Part 1 related to “period and cohort effects” and Part 2 to “individual survival prognosis”. The articles were accepted for publication on 15 April 2014 and were apparently published online subsequently although Dr Rosenbloom was unable to remember precisely when that was. I mention this only because it is very unfortunate that reference to the new study and its potential relevance to this case did not feature at the meeting between Dr Ferrie and Dr Rosenbloom on 6 July 2014 although publication must have been imminent if it had not taken place already. As I have already said (see paragraph 41), they agreed that the 2008 paper was the correct starting point. It is troubling that the existence of this new learning was, it would seem, unknown more generally (or certainly in the context of this case) until Dr Rosenbloom drew it to the attention of the Defendant’s solicitors in a letter dated 31 December 2014, about 14 days before the trial. This was too late for Dr Ferrie’s indisposition not to have intervened before he could express a view based upon the new study. As I will indicate below (paragraphs 52 - 55), his articulated view is, therefore, based upon the 2008 paper being the starting-point and upon his appreciation of James’ presentation in July 2014.
43. Although the message of the 2014 articles is, as I read them, essentially positive in relation to those cerebral palsy patients who are fed to some extent by a gastrostomy (see paragraphs 44 - 48 below), in fact the new research did not alter Dr Rosenbloom’s previously expressed view of James’ life expectancy following the joint meeting: he adhered to survival until age 53 and it is possible to see how, simply applying the new relevant table produced in the 2014 articles, he did so. I will indicate below (paragraphs 56 - 57) how he reached that conclusion.
44. According to Part I of the 2014 paper, the “study population included persons age 4 years and older with [cerebral palsy] who were clients of the California Department of Developmental Services between January 1983 and December 2010.” The total number involved in the survey was 51,923, split roughly 55% male and 45% female. The study drew attention to the fact that “[tube] feeding, most often by gastrostomy, was more common in children than in adults ... [but that in all age groups] the use of feeding tubes has become more prevalent in recent years.” In the light of the questions raised in this case about the significance of the gastrostomy that James now has (it having been inserted on 2 April 2013), it is worth noting what the authors say about the significance of tube fed cerebral palsy patients:

“Tube feeding has become much more widespread in children with CP. We found that 6% of children born in the 1980s had a gastrostomy at their first evaluation and an additional 9% had a tube inserted during the study period. Supplementary analyses

revealed that, as expected, the 6% had more severe functional disabilities than the 9% who had the tubes placed later in the study period. On the other hand, the 9% who had tubes placed after the initial evaluation had disabilities that were still worse than those of the remaining 85% who fed orally throughout the study period. This demonstrates that while tube feeding is still a marker for more severe disabilities, there has been some shift toward placement of tubes into children with less severe disabilities. Further, an increasing number of clinicians have embraced mixed tube and oral feeding, such that gastrostomy is no longer an ‘all-or-nothing’ intervention. In the present study, we were unable to make distinctions between children who were completely tube fed and those with feeding tubes who took a significant proportion of their nutrition orally.”

45. The authors also say this:

“Because tube feeding remains one of the most powerful predictors of long-term survival, it should always be considered in the survival prognosis for an individual child.”

46. The concluding paragraph of Part 1 was in these terms:

“There have been substantial improvements in mortality rates for children with CP in California. Childhood mortality rates in CP declined by 2.5% per year from 1983 to 2010, which is very similar to improvements found for children in the general population. Mortality rates in tube fed adolescents and adults have declined by 0.9% per year. The mortality ratio for orally fed adolescents and adults and adults over age 60, as compared with the United States general population, has actually increased. These trends should be taken into account for individual survival prognosis.”

47. The concluding paragraph of Part 2 was as follows:

“Survival prognosis for persons with CP should take into account age and severity of disability. The survival figures reported here are based on the most recent California population data from the Department of Developmental Services, and supersede those given for the same comparison groups in prior publications. These new figures include adjustments to reflect the observed declines in mortality rates in California. We hope that this article serves as a practical guide to prognosis to be used in planning of future care for children, adolescents, and adults with CP.”

48. It was in Part 2 that the up-to-date table of life expectancies appeared as Table III. That table replaces Table 1 of the 2008 paper referred to at [29] of Swift J’s judgment in *Whiten* and reproduced for convenience in paragraph 49 below. The new table is reproduced here:

Table III: Life expectancy: additional years (standard error) for adolescents and adults with cerebral palsy^a

Sex/Age	Cannot lift head			Lifts head or chest			Rolls/sits			Walks unaided ^b	General population
	TF	FBO	SF	TF	FBO	SF	TF	FBO	SF		
Female											
15y	14 (1.0)	18 (1.2)	–	18 (1.5)	23 (1.0)	–	27 (1.8)	37 (1.3)	48 (1.2)	55 (1.0)	66.2
30y	14 (0.9)	19 (1.2)	–	14 (0.8)	23 (1.1)	–	18 (1.8)	32 (1.2)	37 (0.8)	43 (0.7)	51.6
45y	12 (1.0)	14 (1.0)	–	12 (1.0)	17 (1.2)	–	12 (1.5)	21 (1.0)	25 (0.6)	29 (0.6)	37.4
60y	7 (0.8)	10 (1.4)	–	7 (0.8)	10 (1.1)	–	7 (0.8)	10 (0.8)	16 (0.5)	19 (0.7)	24.1
Male											
15y	14 (1.0)	18 (1.2)	–	18 (1.4)	23 (1.0)	–	27 (1.7)	33 (1.1)	45 (1.1)	52 (0.9)	61.4
30y	14 (0.9)	19 (1.2)	–	14 (0.8)	23 (1.1)	–	18 (1.7)	28 (1.1)	33 (0.7)	39 (0.6)	47.4
45y	12 (1.0)	14 (1.0)	–	12 (1.0)	17 (1.1)	–	12 (1.5)	18 (0.9)	22 (0.5)	25 (0.5)	33.5
60y	7 (0.8)	10 (1.4)	–	7 (0.8)	10 (1.1)	–	7 (0.8)	10 (0.8)	12 (0.4)	15 (0.5)	21.1

–, Results not shown because of small sample size. ^aAs noted in the text, these life expectancies do not necessarily apply to younger children. ^bLife expectancies for the 'walks unaided' groups assume that individuals in the group will remain ambulatory until at least age 60. FBO, fed orally by others; SF, self-feeds orally; TF, tube fed.

49. Table 1 of the 2008 paper was as follows:

Table I: Life expectancy (additional years) by age and cohort

Sex/age (y)	Cannot lift head			Lifts head or chest			Rolls/sits, cannot walk			Walks unaided	General population
	TF	FBO	SF	TF	FBO	SF	TF	FBO	SF		
Female											
15	13	16	–	16	21	–	21	35	49	55	65.8
30	14	20	–	15	26	–	16	34	39	43	51.2
45	12	14	–	13	16	–	14	22	27	31	37.0
60	–	–	–	–	–	–	–	–	16	20	23.8
Male											
15	13	16	–	16	20	–	19	32	45	51	60.6
30	14	19	–	15	24	–	16	31	35	39	46.5
45	12	14	–	13	15	–	14	20	23	27	32.8
60	–	–	–	–	–	–	–	–	13	16	20.4

TF, tube fed; FBO, fed by others, without feeding tube; SF, self-feeds.

50. It was that latter table that both Dr Ferrie and Dr Rosenbloom took as the framework for the assessments of life expectancy up until and including the discussion in July 2014.

51. In his report dated November 2013 Dr Ferrie had given the following as his reason for adhering to the view that James would probably survive to around 70 years of age:

“In my previous Report I estimated that James will probably survive to around 70 years of age. This estimate was based upon the likelihood that at 15 years of age he would continue to be able to roll and scoot and to be substantially self-feeding. Since I gave this estimate a gastrostomy feeding tube has been inserted. However, I do not think it would be appropriate to consider James within the Strauss cohort of those fed by gastrostomy since it is clear that the majority of his calories continue to be given orally. On the basis of the information available to me when I re-evaluated James, I no longer felt it likely that at 15 years of age he would be able to self-feed to any significant extent and that he should be considered within the cohort of subjects who roll/sit but cannot walk and are fed by others. This would equate with a significant reduction in my previous estimate of his life expectancy. However, more recent evidence indicates that James

is now obtaining a significant proportion of his calories orally and that he has rapidly learnt to use the Neater Eater. His self-feeding skills are likely to further improve and on this basis I feel that his life expectancy should be calculated (as before) on the basis that he best fits in the Strauss cohort of those who can who roll/sit and self-feed (recognising that he will not fully self-feed). Taking this and additional positive and negative factors into consideration I estimated that he would probably survive until around 70 years of age. I remain of the opinion that this is an appropriate estimation of his life expectancy.”

52. The reasons that thereafter led him to reduce this estimate to 66 years was set out in the memorandum referred to above as follows:

“Dr Ferrie now considers that James is likely to survive until 65.75 years (66 years if rounded to the nearest year). This is less than the estimates in his reports due to him now considering it appropriate to now make a bigger reduction than he originally did to reflect James's limited self-feeding skills, the presence of the gastrostomy and his acceptance that his cognitive and intellectual level and his general health are neutral rather than positive factors.”

53. Dr Ferrie arrived at the foregoing figure by the route revealed in the following two paragraphs in the memorandum:

“The approach of Dr Ferrie is that the relevant cohort for James is rolls/sits, cannot walk and self feeds. A 15 year old male with these abilities has a life expectancy according to Strauss of 45 additional years (survival to 60 years) compared to 60.6 additional years (survival to 75.6 years) in the general population. In other words the subject's life expectancy is 79% of the relevant population. The projected life expectancy of a 15 year old who, like James will attain the age of 15 years in 2017 is 74.8 additional years with survival to 89.8 Therefore if James was currently 15 years of age he might be expected to survive to 71 years of age. A correction must be made for the fact that James is not yet 15 years of age (0.25 years) and for any additional positive and negative factors to survival identified.”

“Dr Ferrie considers the most important negative factor is that he is not fully self-fed. The presence of the gastrostomy is a weak negative factor. He considers his type of cerebral palsy to be a positive factor. He considers James's success in litigation also to be a positive factor. Following further consideration and discussion, he no longer considers his intellectual abilities and general health to be positive factors. He now considers these to be neutral factors. He no longer considers that the positive and negative factors to cancel each other out. He thinks a reduction of 8 years to reflect his limited self-feeding and the presence of the

gastrostomy is appropriate. He considers that the combined 'positive uplift' should be 3 years.”

54. The starting point thus taken by Dr Ferrie (from Table 1 in the 2008 paper) was that a 15-year old male with the abilities/disabilities he identified would live until age 60. Via the route set out in the first paragraph quoted in paragraph 53 above he concluded that such a person would have 79% of the normal projected life expectancy of someone of the same age, but without the disabilities. Since that projected life expectancy (in the UK) for someone who would be 15 in 2017 would be to survive to age 89.8, the projected life expectancy for James would be 71 (i.e. 79% of 89.8). From that starting point of 71, there is a reduction of 0.25 years to reflect the fact that James is not yet 15 and the risk of him dying prior to achieving that age and a further reduction of 8 years “to reflect his limited self-feeding and the presence of the gastrostomy”, but an addition of 3 years by way of a “positive uplift”, yielding 65.75 (rounded up to 66). The positive uplift is derived in part from Dr Ferrie’s intuitive opinion that the very high standard of care that James will have throughout the remainder of his life is “likely to improve survival”. Those further adjustments to the starting point of 71 were made after the relevant conversion to the UK projected figures (see paragraph 40 above).
55. That, therefore, is the way that Dr Ferrie reached the view that survival until the age of 66 was the appropriate conclusion. In relation to feeding he treated James as “not fully self-fed” and the “presence of the gastrostomy [as] a weak negative factor”.
56. Dr Rosenbloom’s approach in his report of January 2014 was to say that he classified James as “fed by others” because his view at the time was that “it is probable that most of his nutrition will continue to be given orally”, notwithstanding the gastrostomy insertion. His approach at that stage was, using Table 1 (see paragraph 49 above), that if James were aged 15 years and was fully able to roll or sit but was “wholly fed by others” his predicted life expectancy within the US data would be for a further 32 years. He considered that reductions were required from that figure (i) because of the small risk that James would not survive to 15 years, (ii) because he had only “limited rolling and sitting abilities” and (iii) because “he will continue to be partially fed by gastrostomy”. For that combination of features he considered it appropriate to reduce the life expectation estimate by 7 years – in other words from age 47 to age 40 years. This translated to living for a further 29 years from January 2014. That required adjustment to the UK figures in the manner set out in the 2008 paper. Adopting that approach, Dr Rosenbloom noted that the projected life expectation in the UK for an uninjured 11-year old male was “close to 88 years” with the result that there was “some 13 years more” than the actual life expectation data in the 2008 paper. The proportion of that 13-year difference to apply in James’ case was the fraction derived from dividing 29 (his estimated further years of actual life expectation) divided by 49.6 (the actual life expectation of an uninjured male of his age). That came to 6 years and, accordingly, Dr Rosenbloom’s then estimate of projected life expectancy was that he would live to the age of 46 years.

57. As a result of his meeting with Dr Ferrie, Dr Rosenbloom modified his view somewhat, but there remained the significant difference between their two views as reflected above. Dr Rosenbloom's approach at that time can be seen from the following two paragraphs in the memorandum:

“94. In his report Dr Rosenbloom has made a total downward adjustment of seven years to take into account James' age, his limited motor abilities, and the particular characteristics of his feeding. Following this expert discussion and in the light of updating information he has reduced this downward adjustment to 2 years in total as is further detailed below.

For the purpose of answering this question [i.e. what discount needs to be applied to reflect James' age at the trial in January 2015] he estimates that there should be a reduction of one year because of James' age and two years because of his clinical need for gastrostomy insertion. He then now increases his estimate by one year because of James' limited self-feeding abilities. He now does not make any reduction for James' motor abilities as he regards him as average for the relevant category of sits/rolls.

...

96. [In relation to the question of how the agreed upward adjustment to reflect the UK projected mortality data is achieved] Dr Rosenbloom adopts the approach detailed in the Strauss et al (2008) paper. Using this approach he has first made the deduction detailed in his answer to Question 94 above i.e. to take into account James' age and relevant clinical factors. He now considers that these deductions amount to 2 years as has been detailed in his answer to 94 above. Then, as has been detailed in his report, he has noted that projected life expectations in the UK for uninjured 12 year old males are some 13 years more than the actual life expectation data used by Strauss et al and summarised in Table I of their 2008 paper. The appropriate proportion of this to apply in James' case is 33 (James' estimated further years of actual life expectation from January 2015) divided by 53.6 (the actual life expectation of an injured 12 year old male) multiplied by 13. This comes to 8 years.

58. As I have indicated, the 2014 papers (to which, of course, like the 2008 paper, he was a contributor) have not altered his eventual opinion, but he arrives at the age of 53 years, as set out in his letter of 31 December 2014 (see paragraph 42 above), as follows: he remained of the view that James should be regarded as “fed by others”, but in the light of the new Strauss data he should increase his estimate of James' actual life expectation by 1 year (given that there was a small increase in survival for those “fed by others”, namely, from 32 further years to 33 further years). Based on the USA data he considered James' actual life expectation to be to age 46, i.e. a further 34 years. Making the appropriate adjustment for UK figures (derived on this occasion by dividing 34 by 64.4 – the actual further years of life expectation of an uninjured 12-year old male –

and multiplying that fraction by 13), in round figures this came to 7 years. This resulted in the projected life expectation to age 53 years. In the same letter Dr Rosenbloom suggested that Dr Ferrie's new estimate in the light of the new paper would be (in round figures) to age 64. I have not, of course, had any input from Dr Ferrie on that issue.

59. The focus of the debate at the trial has been upon whether Dr Rosenbloom is correct to classify James as "fed by others" and to make adjustments from the starting-point thus generated within the Strauss data or whether Dr Ferrie was right to treat him as "self-fed" for starting-point purposes, but to make in the first instance an essentially downward adjustment to reflect the proposition that James was not "fully self-fed" (my emphasis). As will be apparent from the foregoing, Dr Rosenbloom has taken his starting-point as 33 further years of life (in the light of the 2014 papers) and Dr Ferrie took a further 45 years in the light of the 2008 paper. I agree with Dr Rosenbloom that Dr Ferrie would almost certainly have taken a further 45 years as a starting-point if he had seen the 2014 papers because the life expectancy for the self-fed cohort is the same in that paper as in the earlier paper.
60. As it seems to me, the first issue to consider is the way in which the three categories of feeding set out in the Strauss tables are defined. In the 2008 paper the categories were "tube fed" (in other words, by gastrostomy), "fed by others, without feeding tube" and "self-feeds". In the 2014 papers the categories are "tube fed", "self-feeds orally" and "fed orally by others". Given that, on at least a superficial view of the evidence (and which I will examine more closely below), James is (i) fed partly orally by others, (ii) has some (arguably limited) self-feeding capability, but (iii) is also supplied some nutrition by gastrostomy, it is immediately apparent that classifying him within one or other of the cohorts in either of the tables as defined is not straightforward.
61. Ms Rodway and Mr Latimer-Sayer have invited my attention to what has been said about these classifications by the authors of the various papers over the years. The eating skills of a cerebral palsy patient (in addition to his or her motor skills) have been seen from the outset as a significant marker for the severity of the brain damage and thus upon life expectancy. In the 1998 paper, in its introductory paragraph, it was asserted that "[the] most powerful prognostic factors for survival were ... mobility and feeding skills." In the list of characteristics given on the second page of that article the numbers of those in the overall cohort who were either "tube fed", "fed by others, no feed tube" or some "self-feeding skills" were enumerated. The group that possessed "some self-feeding skills" were said in the body of the article to include those who could only use fingers.
62. Looking at matters chronologically, it is right to observe that Dr Rosenbloom, in his 2004 article (see paragraph 33 above), said this about gastrostomy feeding:

"There has also been some controversy and confusion with regard to the relevance of the need for gastrostomy feeding to the life expectation in disabled children with cerebral palsy. Here the

issues are far more complex than whether or not a gastrostomy is in place and life expectation appears to be primarily related to the child's nutritional status. Specifically it is reasonable to anticipate that a child who has a gastrostomy but is adequately nourished and free from the risk of aspiration is likely to have a longer life expectancy than one who is orally fed but is failing to thrive and has recurrent respiratory infections."

63. I will return to that issue shortly, but so far as the definitions of the classifications in the Strauss data are concerned, the 2008 paper illuminates further what should be regarded as "self-feeding" in the following passage:

"(6) The highest functioning group considered in the study, namely "rolls and/or sits and self feeds" sometimes appears to have been misinterpreted. Because it was the highest functioning category it included individuals with a wide range of disabilities. At the lower end of the group were individuals who could roll over and finger feed but, for example, could not stand unaided and had no useful form of mobility. At the higher end were those who could self-feed with utensils and walk without support. Evidently the life expectancies in these two groups are quite different and the estimates in Table III were a composite that were too high for the first group and too low for the second.

(7) In the database we worked with there is a six-level feeding scale, ranging from fed by others (level 1) to finger feeding (levels 2 and 3) up to 'uses fork and spoon without spillage' (level 6). We used the phrase 'at least some self-feeding (SF)' in the earlier article simply to contrast levels 2 to 6 with level 1. To qualify for this the person must take a significant proportion of his nutrition by SF. We perhaps did not make it sufficiently clear that children who take only 10%, say, of their nutrition by SF would not be considered to have 'at least some SF' for our purposes."

64. It follows (and Dr Rosenbloom confirmed this in cross-examination) that children who take more than 10% of their nutrition by self-feeding are to be placed in the self-feeding category for the purposes of the Strauss tables. I will return to this later.
65. I have already alluded to the proposition that, on a superficial analysis, James does not fit neatly into any of the classifications set out in the various Strauss papers. It is, of course, to be recalled that it is acknowledged in the 2014 papers that the authors were unable to make distinctions between children who were completely tube fed and those with gastrostomies who took a significant proportion of their nutrition orally. Bearing in mind that Dr Ferrie and Dr Rosenbloom each make adjustments from the starting point that each takes, the question arises of whether there is a true starting point for someone such as James within the Strauss tables. It may well be that as the Californian data base increases, further refinements along these lines will emerge, but at present I am tempted to say that he is somewhere between the two extremes

and it is somewhat artificial to be forced to place him in one category or the other and then to make adjustments upwards or downwards.

66. I will return to this when I have considered the evidence of what James can now do and whether there is a basis for concluding that his ability to self-feed will improve in the future and/or whether the gastrostomy is to be seen as a positive or negative factor in the longer term. As to the future, it is of course, the case that both Dr Ferrie and Dr Rosenbloom are paediatric consultant neurologists who have been involved in the treatment of children. To that extent their knowledge of what occurs in relation to cerebral palsy patients in adulthood is less extensive than others who do follow matters through into the post-18 age group. Dr Rosenbloom accepted that, whilst he did follow up many of his patients to age 25 or thereabouts, he had no clinical hands-on role with adult cerebral palsy patients. In those circumstances, it does seem to me that I must look elsewhere for evidence about what the future may hold in terms of the feeding pattern for James. Indeed that may also be the case in relation to other matters.
67. The most direct and persuasive evidence (which, in the event, was largely agreed) was the evidence of the two speech and language therapists who gave evidence, Ms Kay Coombes for James and Mrs Michelle Whitton for the Defendant. Although an important role in a case such as this for experts of their discipline is to address the communication difficulties of the cerebral palsy patient, their remit covers also issues relating to eating, drinking and swallowing – both areas being features of oromotor function.
68. Ms Coombes saw James in February 2011 and again in August 2013. She has seen the videos that have been prepared. Mrs Whitton saw James in June 2013 and, whilst she had not seen the videos at the time of the joint discussion with Ms Coombes, she had seen them prior to giving evidence. To the extent that it matters, I thought both were impressive witnesses, each with a good deal of relevant experience, Ms Coombes being particularly articulate and persuasive. I felt I could rely upon their combined assessment where it was given and that where Mrs Whitton felt that she should defer to others, I felt that I could rely upon Ms Coombes as an objective and reliable appraiser of the issue in question. I will come to that assessment shortly, but I need to describe one aid to eating that James has which is useful from time to time and would, if used more frequently, enable it to be said that he self-feeds to a greater extent than at present. The aid is a “Neater Eater”.
69. Before describing it I should record one clear area of agreement between Ms Coombes and Mrs Whitton: it is that James has good skills in being able to take food into his mouth, move it around and control it in his mouth, chew it and swallow it without aspiration, regurgitation or gastrointestinal reflux. His problems are more associated with getting the food to the mouth than with processing it properly when it is in the mouth. It is getting the food to the mouth that the Neater Eater is designed to help.
70. The manufacturers describe it as an eating aid designed to enable people to use their own movements to feed themselves. It can come in a variety of forms, with varying levels of sophistication, but at its most rudimentary it constitutes

a mechanical arm at the end of which is a spoon. The user grasps the arm and uses it to bring food in the spoon to the mouth. Ms Coombes described it as “quite bulky” and that it sits on a plate fixed to the table. She said that people who use such a device say that “they feel more in control and know when the food is arriving because it is very predictable” compared with being fed by somebody who is not properly trained. She was unable to say how much they continue to be used by cerebral palsy patients because very little data exists, but she was aware of people who used them over an extended period of time. Mrs Whitton had a similar view although she was aware of people who do use Neater Eaters either for one meal a day or perhaps partially during a meal. She saw it as a matter of choice for the individual depending on their capacity to use it.

71. It is common ground that such a system (or at least the system that James currently has) does take up a fair degree of space on the dining table and the process of feeding in this way can be quite laborious. In their joint statement Ms Coombes and Mrs Whitton expressed the view that “the time it takes for James to eat using a Neater Eater ... and the limited space available in his current accommodation are likely to discourage frequent use of the Neater Eater.”
72. On any view, in the future James will be in much more spacious accommodation so it follows that one disincentive to the use of the Neater Eater will be removed or at least reduced. Ms Coombes was asked whether she saw James going on to develop self-feeding skills and, if so, how much of his calorific intake might be received by that route. Her answer is worth recording:

“The issues that I would be taking into account would be his choice. He clearly has chosen to persevere with the Neater Eater, for example. He clearly is interested in self-feeding, including taking foods directly in his hands or in a tube that stops his grasp squashing whatever he is trying to hold. So he is certainly interested in it, but it's also clear that he doesn't always choose to have oral eating. For example, at school, if there is something that he is going to miss, he wants to go out and play ... he will opt for a gastrostomy feed. The question was about how I see the future. I think that it must be part of the future that he should be enabled to exercise choice, to select priorities ... what he wants to do, but he must also be given the opportunity to feed himself as much as possible. And given the way in which his eating, drinking, swallowing regime is continuing at the moment, and bearing in mind that he is able to take drinks through a straw and so on, I don't see why he shouldn't be able to have a combination of gastrostomy feeding at his choice, really, and to ensure that he has sufficient nutrition, but also ... when there is time and space and he wants to, then he should be able to feed himself using a Neater Eater or feed himself with assistance from another person perhaps. I was asked how much he might do that It is a difficult one ... but given his developing abilities and his clear

interest in being independent in terms of meal times and in other things as well, I do not see why it wouldn't be realistic to think he could have perhaps a third of his nutrition self-fed. But it's maintaining that ability for him to choose, I think, and have the flexibility. But in terms of the safety and ability to do it, there aren't vast obstacles. It's his busy life, really.”

73. I should say that Ms Coombes and Mrs Whitton agreed that at present James received about 25% of his calorific intake via his gastrostomy. It follows that the other 75% was received either through feeding by others or as a result of such self-feeding as he undertook. There is an issue about whether using the Neater Eater would constitute self-feeding (to which I will return), but finger-feeding would also be included within that definition.
74. Mrs Whitton accepted that James had already made progress with the use of the Neater Eater and that if he is in the future supported by trained carers, has the space and is encouraged to feed himself more, he is likely to do so more in future. She said that the “chances are higher” that his hand-to-mouth co-ordination will improve and the more food will arrive at his mouth via his own use of the Neater Eater in the new regime after it has been set up.
75. I am, of course, focusing on this issue because of the debate about how to classify James’ present feeding pattern. Before trying to reach a conclusion on that issue, I should return to the question of the gastrostomy. As a matter of fact, of course, the gastrostomy is in place. However, the reasons for its insertion are, on the case advanced on James’ behalf, important. Dr Rosenbloom, I believe, accepted that the reason for its insertion is of some relevance although his general stance was that a “child who has required, and still requires, a gastrostomy ... is more severely neurologically impaired in a general sense than one who does not have a gastrostomy.” He appeared at one stage to think that it was inserted because of the risks of aspiration. However, the evidence is clear that that was not the case. A video fluoroscopy was carried out in October 2012 and Mrs Beesley, who was present, said (and it was not challenged) that what had been thought to be evidence of aspiration was an artefact. On that basis, it is clear (and Dr Rosenbloom accepted) that the gastrostomy was not inserted for that reason. The reason does appear from the letter of Head of Speech and Language Therapy at Sheffield Children’s Hospital dated 2 October 2012. The relevant part was in the following terms:

“During the solid and liquid textures we felt that we saw some trace aspiration in James’ trachea. However, this did not move and we are not clear that this was the case so will be reviewing the disc as soon as it is available to us. Following the study, I was able to discuss with James’ family, his case manager and speech and language therapist that although James is reported to love his food and reported to eat a lot of food, I felt that the effort required in eating for a prolonged period – a meal time can take up to one hour – could be using up many calories in itself. I advised James’ family that I felt that if James had a gastrostomy through which he could have most of his nutrition, he would then be able to have shorter mealtimes, focussed on food that he really

enjoyed, of textures that he could cope with easily so that he would be getting nutrition and still be able to get pleasure out of food. We discussed that we had only seen a ten minute mealtime with James where the amount of effort he expended was considerable. We have no information about James' swallow at the end of an hour and this may increase his vulnerability.

James' mum informed me that he had a friend with a gastrostomy and had been quite keen on having his food this way as well as the opportunity to enjoy small amounts of food at family mealtimes."

76. Although this letter suggested that the gastrostomy would constitute the route by which "most of his nutrition" would be received, that is obviously not the case in practice (see paragraph 73 above), but nonetheless it remains a useful, and not insignificant, means by which his nutrition is kept at the right levels. The suggestion is that it constitutes a "top up" process which Dr Rosenbloom was prepared to accept as an appropriate description.
77. It will, I think, be apparent that reaching anything like a definitive conclusion on the issue of where James stands in the Strauss tables is extremely difficult. Dr Rosenbloom and Dr Ferrie found it difficult. I cannot help but observe that an important decision that may affect whether James receives adequate compensation or whether more public money than is necessary is spent on such compensation really ought not to turn on such questions. However, I must do the best I can on the material I have.
78. Dr Rosenbloom appeared to accept that if the use of the Neater Eater was included as part of self feeding, James would probably be regarded as taking more than 10% of his nutrition by self feeding. I derived that from his answer to Mr Block in examination in chief when he said that "[if] we ignore the Neater Eater, it's my opinion that [James] doesn't take 10% of his nutrition by self feeding." It seems to follow from that that he was conceding that if the Neater Eater was not ignored, the conclusion would be that James should be in the cohort of self feeding cerebral palsy patient. However, he asserted that the reference in the 2008 paper to the 10% criterion (set out in paragraph 63 above and referred to in paragraph 64 above) "clearly doesn't include machines such as the Neater Eater." That seems to me to be more definitive than his answer to the precise question addressed at the meeting with Dr Ferrie. The question was whether in terms of self-feeding it was agreed that it included using an aid such as a Neater Eater. It was made clear that this was not an agreed issue. Dr Rosenbloom's answer was as follows:

"It is Dr Rosenbloom's experience that the use of appliances such as a Neater Eater by individuals with cerebral palsy tends to be transient and time limited. In addition it is not usual for a significant amount of an individual's nutrition to be obtained using an appliance such as this. Dr Rosenbloom does not regard the use of a Neater Eater ... as indicating that an individual self-feeds."

79. In answer to the same question Dr Ferrie had said this:

“Dr Ferrie notes that no guidance is given by Strauss on how the use of aids to feeding should be approached. In his experience the use of aids such as special cutlery and, non-slip mats is 'accepted' as being compatible with self-feeding.”

80. Obviously, I have not heard from Dr Ferrie and plainly I must be cautious about preferring a view expressed by him when I have not heard him challenged upon it, but I have to say that it makes more sense to me in, if I may so describe the process and its effect, “mechanical terms” than Dr Rosenbloom’s view. I cannot see what material difference there is in the mechanics of eating if someone uses his or her hand naturally to bring the food to the mouth and someone who does so “artificially” in the sense of being assisted by some mechanical process that has the effect of dampening hand or arm movements that would otherwise make bringing food to the mouth difficult. Neater Eaters and other devices of this nature have, on the evidence, been in existence for a good many years – and doubtless have become more sophisticated with the passage of time. I am inclined to feel that if the Strauss team had for some reason wanted its readership to exclude the use of such an aid from consideration in this context, it would have said so. I am, of course, acutely aware that Dr Rosenbloom is a distinguished member of that team, but notwithstanding that I do have to be satisfied that what is advanced stands up to appropriate scrutiny and on this issue I cannot be so satisfied. I quite accept that Dr Rosenbloom’s essential answer to all this would be that not being able to self-feed properly and the need for the gastrostomy are all markers for the severity of the brain damage, but for present I am merely addressing the relevance of the Neater Eater in relation to self-feeding.
81. To that extent, I conclude that James’ use of the Neater Eater would qualify for self-feeding within the Strauss tables. I cannot, of course, speak for the conclusion that might be reached in other cases on different evidence, but that seems to me to be the correct conclusion on the evidence I have heard.
82. However, tempting though it is to say that that conclusion settles the issue under consideration, I do not think that it does. The evidence about how much nutrition James takes from using the Neater Eater is, to my mind, unclear. I have no doubt that on some days when it is used he will receive more than 10% of his nutritional intake by that process. That seems to me to be commonsense and in line with what Dr Rosenbloom said as recorded in paragraph 76 above. However, there must be other days when he does not use it at all or very little and if follows that the same conclusion could not be reached. I have little difficulty concluding that James can indeed manage to use the Neater Eater, as Mrs Adams said, “pretty much by himself”. That was supported by Mrs Sarah Hilton-Bailey, James’ current treating physiotherapist. However, Mrs Beesley said clearly that, in the present circumstances, it is not possible for James to access the dining room table on a routine basis to use the Neater Eater. It is partly a function of the relatively cramped accommodation in the present property and partly of the difficulties that Mrs Adams, in her present psychological state, causes. She has a lot of documentary material on the table and gets very stressed if it is moved. The carers do not feel that they

can interfere with this. As I have said, I accept the evidence that James can use the Neater Eater (and indeed the short video clip supports that conclusion), but there is no convincing evidence that he uses it sufficiently regularly for it to be said that he has a consistent intake of food via this route. There were some difficulties, according to the evidence, of being able to set it up at his former school. I am not sure that I was told specifically about the arrangements at his present school, but one can imagine that similar issues would arise in a mainstream school. For my part, it seems to me more in keeping with commonsense that a person would need consistently more than 10% of his daily nutritional intake for him to be regarded, on that basis of the Strauss definition, as being within the self-feeding category and I do not think the evidence supports that conclusion as things stand.

83. For reasons that I will give shortly, I do not think that the conclusion referred to in the preceding paragraph necessarily determines that James, with his present abilities, should be seen as in the category of “fed by others” if that means he is exclusively fed by others. But it does mean that I cannot accept that, as things stand, he can properly be regarded as in the self-feeding category. Although it is correct to say that the evidence has moved on since Dr Ferrie expressed his view in July last year, I do not think that the evidence supports the conclusion that, had he been available at the trial, Dr Ferrie would have modified his view again. At all events, the issue is one for me and that is my conclusion on that issue. As I have said, however, I do not think that this necessarily means that the starting-point must be where Dr Rosenbloom says it is.
84. Before coming to that and other issues, the other question that arises is whether, in assessing where James should be classified within the Strauss data, I could or should take into account the fact that he has the ability to use a Neater Eater and that the likelihood (as is contended) that that he will use it much more when he is settled into new accommodation with a better and more intensive care regime than is presently available to him. The issue was addressed by Dr Rosenbloom and Dr Ferrie in their joint discussion and I think I should record their respective conclusions.
85. The question was whether, when assessing life expectancy, it is important that James has the ability to self-feed or that he is actually self-feeding for the majority of the time. The answer was recorded as follows:

“We are largely agreed on this point. Dr Rosenbloom considers that the latter is more important i.e. that the individual should be actually self-feeding for the majority of his intake. It is his opinion that when considering life expectation it is actual-functioning, rather than a hypothetical potential to function, that is the relevant criterion. In Dr Ferrie's opinion the most important factor to consider in most cases is how the individual receives the bulk of their calories. In other words he considers the latter to be most important. However, there may be individual circumstances which negate this. For example, an individual may be capable of self-feeding and may do so for one meal a day and at weekends but time

pressures cause most of his meals to be given to him. In this case the ability to self-feed is more important.”

86. I am not sure I can quite accept the submission made by Mr Block and Miss Greaney that this represented agreement between the experts that actual functioning, rather than hypothetical potential to function, is a more important factor when considering life expectancy if what is being suggested is that the possibility that an existing ability to self-feed, albeit not utilised regularly for whatever reason, is to be disregarded wholly for life expectancy purposes, particularly if there is good reason to believe that the ability will be more regularly utilised in the future. Dr Ferrie appears to be saying that, whilst “in most cases” the life expectancy issue will be informed by the amount of calorific intake by self-feeding, there are those cases where an unfulfilled or unrealised ability to self-feed fully on a regular basis is more important. The reconciliation between that view and the view of Dr Rosenbloom seems to me to be that, whilst the current level of actual self-feeding is more relevant to the initial placement of a person within the Strauss data, the existing ability and its potential for greater utilisation may be something calling for an adjustment to the effect of that initial classification. That is how I intend to approach this factor.
87. I understand Dr Rosenbloom to accept that the starting point itself can be adjusted in an individual case. He accepted, by reference to the 2014 tables, that for a 15-year old boy there is a 12-year “life expectancy gap” between someone at the bottom of the feeding range (i.e. “fed by others”, 33 years) and someone at the top of that range (i.e. self-feeding, 45 years) and that there was a “clear linear progression”. He agreed that it would be for the court to decide where in that spectrum James was to be placed. If that is to be determined (as I have concluded) largely by reference to existing feeding patterns, it does seem to me logical (and indeed in accordance with what the 2008 Strauss paper said) that a starting point somewhere within that spectrum should be taken rather than trying artificially to force the individual case into one end or the other of that spectrum. Whether that is merely another means of “adjustment” of the life expectancy is, perhaps, a moot point, but since there is an issue about the stage at which any adjustment for individual factors is made (see paragraphs 91 - 100 below), it seems to me more logical to alight upon a sensible starting-point and then to adjust the predicted life expectancy to reflect individual factors thereafter, particularly if some of the factors reflect the effect upon life expectancy of future changes of the individual circumstances. At all events, that is the exercise I propose to undertake.
88. I have covered a great deal of the relevant ground already and I will not repeat it. I do not think that James can be regarded now as fully self-feeding. Dr Ferrie was of that view in July (as indeed was Dr Rosenbloom) and I accept that assessment as at that time. Whatever improvement there has been since July 2014 (and I accept that there has been some improvement) I do not consider that it puts James into that category. In my view, he has the ability to self-feed (albeit not to the extent that he would, certainly at present, take in his full daily calorific needs), but that ability is currently constrained by his general living conditions. He receives about 25% of his daily calorific intake

via his gastrostomy and the balance largely by being fed by others, though he will receive some food by self-feeding, either using his Neater Eater or by finger feeding.

89. Dr Rosenbloom does not suggest that the starting-point should be influenced by the presence of the gastrostomy (since this is not a case where all feeding is undertaken via a gastrostomy) and, accordingly, I ignore it for present purposes. So the question is where in the spectrum between 33 and 45 years should the starting-point be taken? In the light of my findings, it has to be nearer at the lower end of that range than the top end, but not so low as to place James in the cohort of those who are fully fed by others. My assessment is that, within the Strauss table, the starting point should be a further 37 years from the age of 15. In other words, provided James survives until the age of 15, then by reference to the US data he would survive a further 37 years subject to any further adjustments, upwards or downwards, that are required and/or justified by his individual characteristics.
90. Counsel agreed to make the necessary calculations, but my belief was that this would mean that, provided James survived to 15, he would have a predicted life expectancy by reference to UK figures of an additional 8 years or thereabouts beyond his life expectancy if in the US (in other words, a further 45 years) subject to any of the other adjustments to which I have referred. Indeed my belief has been confirmed by the agreement referred to in paragraph 134 below.
91. Before addressing any adjustments, I need to consider the disputed issue of when those adjustments are to be made – is it before or after the conversion of the US figures to the UK figures? The Defendant contends for the former, supported by Dr Rosenbloom, Mr Block and Miss Greaney arguing that it “wholly distorts the calculation” if the adjustment is not made at this stage. The latter is contended for on behalf of James. Dr Ferrie has approached matters in this way. Each side claims that logic is on their side. Dr Rosenbloom does not think it would make much practical difference because the clinical factors that would be taken into account would be similar, but adheres to his view.
92. I have noted previously (see paragraph 40) that Swift J considered whether to make any adjustment in *Whiten* after the conversion of the US figures to the UK figures). It is right to say that no argument appears to have been put forward about the matter and equally right to say that Swift J was not particularly impressed with the approach of either of the experts in that case. She did not have the advantage of Dr Rosenbloom’s view. Whilst ordinarily I would attach great weight to the approach of a very experienced judge in this field who had the benefit of help from equally experienced counsel, I do not think I can attach quite so much weight to the approach than I might otherwise have done for those reasons. However, notwithstanding that observation, it is of particular note that the Defendant’s team in that case (doubtless instructed on behalf of the National Health Service Litigation Authority as is the Defendant’s team in the present case) took no point about this and that is something I should bear in mind.

93. The first point to note is that there is nothing in any of the Strauss papers that expressly deals with this question. In his response to the issue raised at his meeting with Dr Ferrie, Dr Rosenbloom said this:

“Dr Rosenbloom considers that adjustments for age and clinical factors should be undertaken before making any upward adjustment for projected life expectation. This is consistent with the recommendation made in the Strauss et al paper.”

94. However, he agreed when giving his evidence that there is nothing that gives express guidance on the issue in the Strauss papers. He said, however, that his own opinion was shared by his Californian colleagues. He put the matter in this way:

“ ... it is also the view of Professor Strauss and the California colleagues ... I have assumed that because the material we are working with in coming to a view is the actual US life expectation then adjusted for clinical criteria. And to me, it made sense to get as accurate a figure as we could for actual life expectation before we made the adjustment. That seemed to me, and seemed to my California colleagues, to be the logical way to go about it.”

95. He also appeared to say that the majority of his paediatric neurological colleagues supported his view and that only Dr Ferrie was an advocate of the contrary view.

96. When challenged about it by Ms Rodway, Dr Rosenbloom’s approach can be seen as follows:

Q. If you do that [i.e. make the adjustments before conversion to the UK figures], because it is already recognised that there is an increased life projection in the UK, it's unfair on the individual who is living within the UK cohort, isn't it?

A. I think in all honesty, my Lord, it depends on whether the adjustment you make before altering from US to UK projected is whether the adjustment is upward or downward, because the proportionate amount would be increased if one is making an upward adjustment and would be decreased if you made a downward adjustment. So I don't see it as being fair or unfair. It's a suggested way that seems to work in practice.

97. I am not wholly clear how such an approach can be said to have been shown “to work in practice” other than by concluding that its fruits seem to accord with the perceptions of “the right result” of some of those with expertise in the field. This seems to be something of a self-fulfilling prophecy. I do feel that there ought to be a logical answer to this issue.

98. With great respect to Dr Rosenbloom, I have not found it easy fully to understand the position he takes on the basis of the answers given.

Unfortunately, there was no recorded discussion about the issue when he met Dr Ferrie and there is nothing in Dr Rosenbloom's letter of 31 December 2014 that clarified the approach. I do not, of course, doubt his evidence that he has discussed this with his Californian colleagues, but that is no substitute for a written analysis that has been considered by appropriately qualified experts and subjected to an effective "peer review". It is very difficult for a court to make a decision on a matter like this without some clearly articulated material that it can scrutinise and evaluate. All expert opinions need to withstand logical scrutiny: *Bolitho v City and Hackney Health Authority* [1998] AC 232, 241.

99. Since the approach of the parties and of the court in *Whiten* was as I have indicated, it seems to me that (perhaps by default) the practice of making adjustments after the conversion may have developed. In those circumstances, if the Defendant in any case considers that this approach is wrong, it does seem to me that the onus of persuading another court that the approach in *Whiten* is wrong must lie on those instructed by the Defendant in a subsequent case. Dr Rosenbloom is, of course, a well-known and highly-respected expert, but, as I have indicated, merely to express an opinion without any very cogent backup is not really sufficient. If this argument is to be pursued in future it needs to be put before a court in a satisfactory fashion so that an informed decision can be made.
100. I propose, therefore, to take a cautious approach (arguably marginally favourable to James) and to assume for present purposes that the approach in *Whiten* was correct and to say, as is the case, that I have not been persuaded that it was wrong. At a very simplistic level (which I acknowledge may, on proper analysis, be wrong), there seems to me some logic in the proposition that in a case such as this the Strauss figures should be converted to the projected life expectancy in the UK to the result of which any adjustments in the light of UK experience and/or conditions should then be made because it will be that experience that will inform the assessment of the individual living in the UK and those conditions in which the individual claimant will live and be cared for. If, for example, it is the case that the standard of future care is a relevant factor in the ultimate assessment of life expectancy, it seems to me to be distinctly arguable that the standards of care with which the domestic courts are familiar should inform whatever adjustments are made and that transposing any such adjustment into the US figures before conversion is inappropriate and illogical. At all events, I propose to hold, on the basis of the evidence and arguments I have heard in this case, that that approach is the correct one.
101. What adjustments, if any, should be made in this case to the converted life expectancy of 45 years from the age of 15? It will, of course, be necessary to consider making a modest adjustment to reflect the risk that James will not survive to the age of 15. Given that it was acknowledged by Dr Rosenbloom to be a small risk, my preference would be for a modest "rounding down" of the figure finally thrown up by the calculations to which I will refer below. I have to say that working in terms of a figure after the decimal point in what is acknowledged to be the world of an inexact science seems inappropriate: none

of the Strauss tables are presented in that way. However, I will return to this at paragraphs 135-137 below.

102. It will be appreciated that no further downward adjustment is required by reason of the fact that James is still “fed by others” to a material degree: that factor was taken into account in deciding where in the “33 – 45 year spectrum” (see paragraph 89) James was to be placed by way of a starting-point. The logic, as it seems to me, is that if there were grounds for thinking that the amount of feeding by others was likely materially to increase in the future (thus giving rise to whatever increased risk is associated with that process), there might be scope for some reduction in the projected life expectancy. However, the evidence is very much the other way: as I have already said (see paragraph 88), James already has the ability to use a Neater Eater and, given his very positive approach to life and his plain wish to act and behave as much as possible as do those without disability, I have no doubt that he will increase its use once he is in his new accommodation and has the full care regime in place. For my part, that seems to me to be a factor that would require some degree of upward adjustment. I will return to the “quantum” of that adjustment later. I cannot see that there is any fundamental objection to this course because Dr Rosenbloom himself made an adjustment upwards to reflect James’ existing self-feeding skills when he revised his initial life expectancy assessment (see paragraph 57 above), although I perceive his general position to be that future improvements are irrelevant. I will deal with that particular aspect shortly.
103. In relation to the gastrostomy, Dr Rosenbloom maintained his view, notwithstanding a searching cross-examination by Ms Rodway on the issue, that this remained a negative factor and required a downward adjustment of two years. It will be recalled that Dr Ferrie in July 2014 (but without access to the new Strauss papers) regarded this as “a weak negative factor”. Some part of the 8 years by which he reduced his starting point of 71 years was attributable to this, but it can safely be assumed that it was a fairly modest part of the overall reduction.
104. James is not, of course, tube-fed in the sense that all his nutrition comes via such a route. If so, he would have been in a very different cohort of cerebral palsy patients. The extent to which he currently relies upon it is set out above (see paragraph 73). It was put in place, not because of the risks of aspiration, but for convenience purposes given the length of time eating in a more conventional way required: he is a young man and does not wish to spend too long eating in that way if there is a quicker method. It has, by all accounts, paid dividends and he has put on weight since its insertion.
105. As previously observed (see paragraph 44), the most recent Strauss paper describes the more liberal use of gastrostomies for children with less severe disabilities and the philosophy on the part of some clinicians that a “mixed tube and oral feeding pattern” was acceptable or desirable. In this kind of situation, there seems to be something of a trend away from regarding a gastrostomy as a significant constraint on life expectancy. Indeed Dr Rosenbloom’s article (see paragraph 62 above) appears to me to foreshadow the viewpoint that a gastrostomy can have a positive impact on life expectancy

in some circumstances. James is certainly a child who “is adequately nourished and free from the risk of aspiration”. On that basis, according to Dr Rosenbloom’s article, he is “likely to have a longer life expectancy than one who is orally fed but is failing to thrive and has recurrent respiratory infections.” I did not fully understand why Dr Rosenbloom thought that this consideration did not apply in James’ case.

106. Ms Rodway and Mr Latimer-Sayer invite me to say that the gastrostomy should be seen as a positive factor in James’ case: it acts as a useful top up for James’ calorific intake which is positive. However, it is, to use laymen’s language, a piece of inserted medical equipment which presumably carries its own negative impact. However, it does seem to me that the 2014 papers, when seen in the light of Dr Rosenbloom’s earlier view, do put the existence of a gastrostomy in someone like James marginally on the positive side of the equation than the negative side even allowing for the artificial nature of the intervention to which it gives rise. I will return to this later.

107. The next matter for consideration is whether some positive adjustment upwards is justified by reference to the quality of care that James’ will receive for the rest of his life. The care package is secure for the rest of his life and, whatever the precise outcome of the case, it is likely that there will be sufficient free capital (or further periodical payments) to ensure that the essential quality of the care package will be maintained and that essential equipment will be updated. Ms Rodway and Mr Latimer-Sayer submit that common sense suggests that James will have a significant advantage over other people in his cohort because of his ability to pay for good quality care, accommodation, equipment, therapies and so on. This positive feature justifies an upward adjustment of the predicted life expectancy.

108. In his 2004 article (see paragraph 62), Dr Rosenbloom said this:

“...when clinicians are asked to give an opinion on the prognosis for survival in medical negligence or personal injury litigation ... figures that are statistically derived from the epidemiological studies can and should be weighted for clinical factors. What is less certain it is whether it is appropriate to weigh statistically derived figures in relation to assumed future quality of care. Whilst it is intuitive to attempt to do this there is hitherto no supportive published evidence.”

109. That was what he said in 2004 and he maintains the same position now some ten years later. Dr Ferrie took a different view and I will turn to his opinion later. So far as Dr Rosenbloom is concerned his position can be seen from the following interchange during the course of his evidence in chief:

DR ROSENBLOOM: My view, my Lord, is that poor care is very likely to produce a reduced life expectation, if the individual is neglected, not attended to, not properly nourished, skin isn't attended to and so on. In the UK and in my own practice generally that is so exceptional that I believe it can be discarded. I have never found evidence that the converse of exceptional care

prolongs life expectation, and I think that the reason for this is that the reasons people die once you get an appropriate average standard of care relate to illnesses that would cause them to die anyway, rather than the more that they are cared for, the longer that, in statistical terms, they will live. That's my best guess.

MR BLOCK: Can I see if I have understood that. You are saying that the [Strauss paper] deals with average care?

A. Yes.

Q. And if someone has very significantly below average care, then that would be detrimental and could well result in a lower life expectation?

A. I believe that's probable, yes.

Q. But increases from the average upwards, there is no evidence that that has a positive effect on life expectancy?

A. Correct.

MR JUSTICE FOSKETT: It's somewhat counter-intuitive that, though, isn't it?

A. I have said that myself, and in the 2004 paper that is included in this I have actually used the phrase "counter-intuitive", so I wholly agree with you, my Lord. But we can't find the evidence. It's interesting that, looking at other papers on care from the United States, it does seem that people living in residential institutions where there may well be an average standard of care live longer on average than those living at home. So there is quite a lot that's counter-intuitive about this, and I think that the issue that we have to look at is quality of life, rather than longevity. And here, I have no doubt that a very high quality of care, the sort of activities that have been talked about for James, will enhance his quality of life but, let me give a crude example, they are not going to stop him dying from a heart attack or a stroke.

MR JUSTICE FOSKETT: No, I understand that.

110. In cross-examination he accepted almost all the points put to him by Ms Rodway about the life-style that James will have and the care regime to which he will be subject: points such as the 24/7 availability of trained carers who could deal with any physical problems arising from the gastrostomy and reducing the risk of any aspiration or choking whilst eating; the availability of good quality accommodation with good quality hygiene and cleanliness; access to all the equipment required to remain mobile; access to physiotherapy, speech and language therapy and any other necessary therapies; access to private medical treatment and access to private occupational therapy ensuring seating reviews; and the ability to be

transported appropriately and to take holidays. He accepted that the quality of the care received would be likely to improve the quality of James' life, but he maintained his position that there was no evidence that these factors increased longevity. He said there was no data to support it.

111. The issue was re-visited again during his cross-examination and I think it right to record the interchanges:

MS RODWAY: ... one of the features ... we differ on, is your dismissal of the improved features: good care, good socio-economic factors on expectation of life. That's something you set your face against.

A. I thought we had said earlier in cross-examination that I cannot find evidence to support that, but I agreed with his Lordship that to an extent this is counter-intuitive.

Q. Yes.

MR JUSTICE FOSKETT: I was just reflecting on this over the weekend. How would you find evidence of this? I mean, this is the age-old problem. You can't run a survey with one cohort of 12-year olds and you give them the best care in the world, and another cohort that you don't give them any care at all.

A. No, you can't, my Lord. One of my constant theses that I have looked for research funding for is to follow up individuals who have been successful litigants.

MR JUSTICE FOSKETT: Yes.

A. Funding for that has never been made available to me.

MR JUSTICE FOSKETT: No. But you indicated -- I was looking back at the transcript and I hope I quote you correctly -- that there was some evidence, I think, in the States that those who were looked after in institutions fared better than those who were looked after at home?

A. Yes.

MR JUSTICE FOSKETT: But I think you put that on the basis that those who were in institutions would have an average level of care, I think was the way you put it?

A. I believe so, my Lord.

MR JUSTICE FOSKETT: But it may be said, well, actually, those who are in institutions will be more constantly monitored than those who happen to be at home. If they happen to be at home with a first class care regime, that may be one thing, but if they are simply at home being looked after by a family with no

resources, then of course, it's rather difficult to draw such a conclusion.

A. I agree completely, and I hope that I was honest about that because, of course, the other thing that would, that could be argued was if you were in some sort of care regime you would not have regular and consistent caretakers and that could be disadvantageous. It could be argued either way, and I agree with you it could be very difficult to demonstrate what is intuitive, that the sort of care that James receives will in his case prolong his life. I understand what has been put to me. I can't support it because I don't know.

112. It is, perhaps, that last comment of Dr Rosenbloom that really emphasises his position. He does not know whether socio-economic factors (including the quality of care) make a difference because, from his perspective, there is no reliable clinical or other scientific evidence upon which he can say positively that they do make a difference. From a purist perspective that does seem to me to be a perfectly reasonable and respectable position to take. However, my concern, which was foreshadowed in one of my questions to Dr Rosenbloom, is that it is difficult to see how any statistically reliable evidence to support or refute the proposition that good care extends the life expectancy of a cerebral palsy patient will ever emerge because no ethically acceptable experiment can be set up to test it. (On reflection I think my suggested need to compare a cohort of patients who receive "the best care in the world" and those who receive "no care" is a little stark, but the point is that a statistically valid exercise in which one cohort of patients is given first-class care and another has deliberately reduced care in some areas in order to compare survival rates would not be ethical.) Whilst I do not, of course, criticise this purist perspective as such, I do not consider that it binds the court to adopting the same approach. The court is never bound by scientific certainty in these matters and Dr Rosenbloom is the first to acknowledge that the whole issue is not an exact science in any event.
113. I do not see why the court cannot, in an individual case, seek to identify the risks that exist in an individual's life if he or she is a cerebral palsy patient and then consider the life that such a patient is likely to lead in the future and to determine how large those risks in truth are likely to be in that individual's life. In some cases, of course, the best care in the world may not obviate or materially reduce those risks. But there may be other cases in which it is quite plain that the risks to life are reduced by the quality of care to be received and if that can be demonstrated as the likely scenario I cannot see any reason in logic for the court not giving effect to that conclusion in the individual case by adjusting the life expectancy thrown up in the generality of cases based upon the available statistics.
114. I will for the present leave to one side the fact that Dr Ferrie is plainly of the view that this is a legitimate approach and I will consider whether there is other thinking (or indeed authority) that supports this general approach. It is clear that there is. On the basis of a number of cases where the claimant has sustained serious spinal injuries in an accident, it has been the agreed position

of the experts that the likely quality of future care affects the life expectancy prediction. The courts have accepted this approach and, as I will indicate, in at least one case the court has adopted this approach in relation to a cerebral palsy patient. However, as it seems to me, there is no material difference between the type of disability under consideration: in each case the disability will give rise to particular risks as to mortality beyond the ordinary risks of mortality and the court has adopted the position that where those additional risks are reduced by reason of the quality of care to be received in the future, that is a legitimate basis for making an adjustment to the life expectancy prediction thrown up by reference to such statistics as are available.

115. In *Owen v Brown* [2002] EWHC 1135 (QB); [2002] All ER (D) 534 (May), the claimant, then aged 20, sustained very serious injuries in a road traffic accident, including head injuries, and was rendered paraplegic. The court had to assess aspects of his damages claim (which was being met by the defendant on a 90% basis). As Silber J said, a critical factor in assessing most of the items of future loss in the case was the claimant's life expectancy. It was necessary to consider it in detail. The opinion of the very experienced Consultant Spinal Surgeon, Mr. Brian Gardner, who reported for the claimant, was that the claimant would live until the age of 70. Dr. John Evans, the Consultant Neurologist, called as the defendant's expert on life expectancy was of the view that the claimant would live until the age of 60 although "in recognition of the difficulties of estimating the life expectancy of the claimant, he was prepared to accept that the life expectancy of the claimant could be 62.5 years."
116. In the event, Silber J preferred the thrust of Mr Gardner's evidence to that of Dr Evans, but indicated that he would have to scrutinise it carefully. I will indicate one or two matters of potential relevance in the judgment, but it is, perhaps, worth recording that Dr Evans shared the view of Mr Gardner that when assessing the life expectancy of an individual "the quality of care supplied to the individual concerned [is] significant:" [78]. One of the positive factors taken into account by Mr Gardner that would increase the claimant's life expectancy was "the financial ability of the claimant to have access to good medical care and to take advantage of medical advances." Silber J said that he regarded this as a "valid and significant point".
117. Silber J reviewed extensively the worldwide statistical material available concerning the survival of spinal injury patients to which Mr Gardner had referred and which he took into account in advancing his opinion on the life expectancy of the claimant. One passage in the judgment of note in this context is where Silber J recorded Mr Gardner's reasons for saying, as was the case, that there were better survival rates in Australia than the UK. The passage is as follows [74]:

"Mr. Gardner does not think that there is anything intrinsically different between the Australia and United Kingdom populations. He concludes that the probable reason for the better life expectancies in Australia is the better care facilities available for those with spinal injuries in Australia. Mr. Gardner points out that the United Kingdom spinal cord injury service is seriously under-

resourced. For example, 42% of United Kingdom patients with complications to their spinal cord injuries cannot gain access to specialist facilities. The claimant with the benefit of his damages award would not be constrained by these limitations and fortunately he will be able to purchase and will continue to have the benefit of very good care.”

118. The judge also recorded the following view of Mr Gardner [76]:

“Mr. Gardner stressed that in his opinion that there was a trend to increasing life expectancy for those with spinal cord injuries and that it will continue to increase for those, like the claimant who are financially able to have access to good treatment and to further improvements that will arise in the treatment of spinal injuries.”

119. Having scrutinised Mr Gardner’s evidence with care and having taken into account the guidance given by the Court of Appeal in *The Royal Victoria Infirmary and Associated Hospitals NHS Trust v. B (A Child)* [2002] EWCA Civ 348, an important case in this context, Silber J said this [88]:

“My conclusion is that Mr. Gardner's assessment of the claimant's life expectancy is correct. I strongly agree with Mr. Gardner that a significant positive factor that he correctly took into account was and is the very high standard of care that the claimant receives and will receive. The effect of the award in this case is that the claimant will be the beneficiary of very high quality care in all the areas in which he requires it.”

120. A similar approach was adopted by Lloyd Jones J, as he then was, in *Sarwar v Ali and the MIB* [2007] EWHC 274 (QB) in a case involving a claimant who became a C5 tetraplegic following a road traffic accident. It does not appear to have been disputed between the two experts called on each side that socio-economic factors could have an impact on life expectancy, though there was a difference as to the extent. By way of explanation of the following passage from the judgment, the judge’s attention had been drawn to a paper by Krause and others [23]:

“Nevertheless, I consider that there is force in the submission that such socio-economic factors are likely to have a favourable impact on the life expectancy of the Claimant. I did not understand Mr. Tromans to deny them any effect. While I am unable to accept that their impact is likely to be as dramatic as the Krause paper contends, I nevertheless consider that these favourable factors should be given weight in assessing life expectancy in the present case. In this regard I attach particular importance to my finding that the Claimant will use his award to purchase high quality care and medical services.”

121. *Burton v Kingsbury* [2007] EWHC 2091 (QB) was another case in which a young man was rendered a C4 quadriplegic in a road traffic accident. The

experts on life expectancy in that case were Mr Gardner and Mr Tromans, the former taking the view that the claimant's life expectancy of 69 years whereas Mr Tromans said it was around 62-63 years. Flaux J recorded [24] that "Mr Gardner's evidence in his report is that probably the most important determinant of life expectancy for a spinal cord injured person was the quality of care" and that he (Mr Gardner) had relied upon, inter alia, the Krause paper, to which reference was made in *Sarwar's* case, in this connection. Mr Tromans had drawn attention to two critiques of the Krause paper both of which emanated, at least in part, from Professor Strauss (the contention in essence being that the inclusion in the cohort under consideration of workers' compensation cases skewed the results in favour of suggesting greater longevity). The precise criticisms are probably not relevant for present purposes because it would seem that Mr Tromans adhered to his view that socio-economic factors could have a bearing on life expectancy, but Flaux J's conclusion, having referred to the Krause paper, is to be noted. He said this [28]:

"I accept that the different social conditions and health care arrangements in the United States (particularly the complete absence of a state run health service corresponding to the NHS) should make one cautious of placing too much reliance on the Krause study. Furthermore, there seems to me to be some force in the argument that workers compensation cases should be discounted because in an American context they represent a generally healthier segment of the population. Having said that, in my judgment, the overall point made by Mr Gardner, which he adhered to, irrespective of the workers compensation argument, that favourable economics improve life expectancy in persons with [spinal cord injury] is a valid point, which I accept."

122. He continued thus [29]:

"In the Joint Statement prepared by Mr Gardner and Mr Tromans, Mr Gardner expressed the opinion that, notwithstanding the doubts expressed about the workers compensation element of the Krause study, there is robust evidence apart from the Krause study that economics impact on longevity. I agree and consider that any suggestion to the contrary in the Strauss materials is flawed."

123. There is, therefore, a clear line of thinking, accepted in those three cases, that the future quality of care can affect the life expectancy of the spinal injury patient. There is, it would seem, some reasonably extensive statistical evidence to support the validity of this factor in spinal injury patients and, of course, people like Mr Gardner and his colleagues will see patients for many years of all ages. However, as I have said, I cannot see any logical difference between patients with that disability and those who possess disabilities associated with cerebral palsy when it comes to considering such a factor. If there was compelling statistical evidence to the contrary, a different view may have to be formed, but until then I do not see why the common sense

proposition that good and conscientious care will reduce mortality risks should not be adopted and reflected appropriately.

124. It was adopted by His Honour Judge MacDuff QC, as he then was, in the unreported case of *reasonable needs v Shrewsbury NHS Trust*, 14 June 2007. Ms Rodway and Mr Latimer-Sayer have drawn my attention to the following passages in his judgment in relation to the issue of life expectancy:

“144. For reasons which are given above, I get no assistance at-all from Professor Barnes. But, in spite of Dr Thomas’s evidence that he saw no reason to adjust the statistical result (“it is the best evidence we have”) I propose to adjust the life expectancy figure by three years in the Claimant’s favour. I hold that her expected life span is to age 40. There is just one reason for this. [She] will have the benefit of a first class care package. This undoubtedly helps to guard against the risks associated with the main risk factors. Round the clock nursing care, which [she] will have, will, for example, guard against the risks associated with skin pressure ulcers. With good care, skin ulcers should not be a problem. But if they were to occur, ameliorative nursing measures would be brought to bear, at the first sign. The risk of aspiration may also be used as an example. Good feeding, carefully supervised, should guard against aspiration. And there would be a good early warning system, with prompt and appropriate medical treatment. An epileptic seizure would be detected immediately with the proper treatment. And so on.

145. Dr Thomas accepted this. He accepted that good care will make a difference. Of course, we do not know about the care enjoyed by the average member of the California database. Some will have excellent care; some, I guess, as good as that which [she] will enjoy. Many will not. Whatever is the position, [her] care package is likely to be well above the average. Unfortunately nobody asked Professor Strauss for his observations upon this and whether he could help with hard evidence about the care given to the members of his group across the range. Nor was he asked about the effects of excellent nursing care upon the results of his analysis. I should perhaps also take account of the fact that [she] will be living in a stimulating environment with loving parents, an opportunity for “swimming” in a spa pool of her own ... and regular holidays. This might also have an impact upon her prospects.

146. In the final analysis, it is impossible to judge how far to go. Why should I assume an extra three years rather than an extra two years or some other figure? It is not something upon which I have expert evidence, and, in the end, it comes down to a judgment based upon a general feeling for the case. I cannot justify a three year uplift as opposed to any other figure. It is a decision made with the help of the judicial fingertips. I find that [her] expectation is to age 40”.

125. I infer from that extract that Dr Thomas (almost certainly Dr Neil Thomas, an experienced Consultant Paediatric Neurologist, who gave evidence in *Whiten* for the defendant) had given evidence on behalf of the defendant and had “accepted that good care will make a difference” to life expectancy. That, of course, suggests that it is not universally accepted that the issue is irrelevant. That case was in 2007 and, as Judge MacDuff said, no-one had asked Professor Strauss about the issue. (Professor Strauss had given evidence in that case by video-link.) Had they done so, one assumes the answer would have been along the lines of the following passage in the 2008 paper which was accepted for publication in December 2007:

“The effect of quality of care on life expectancy is frequently discussed, and it is sometimes asserted, without any supporting evidence, that quality of care is a critically important factor. This issue is more complex and less clear than is often assumed and the following brief discussion summarizes some of the reasons for this. Some of these points have been made at greater length in a recent review article on life expectancy after traumatic brain injury by Shavelle et al. Quality of care is a rather vague term that may refer to any or all of the following:

- (1) The expertise of the caregivers, ranging from highly qualified professionals to relatively unskilled (and low paid) staff. A complicating factor is that caregivers are often family members, who generally do not have formal qualifications but in some cases become highly skilled carers.
- (2) The accessibility of physicians and emergency services.
- (3) The quantity of care and equipment provided, which is often a reflection of the funds available.

Next, the effect of quality of care on life expectancy surely depends on what is being compared. If, for example, it is good care versus grossly inferior care, the difference in life expectancy will doubtless be large. That comparison, however, is generally not of interest. The most relevant comparison is between (1) the reasonable and necessary standard care available in most developed societies, and (2) the care expected given that the patient has a carefully prepared and well-funded life care plan.

It might be argued that the care embodied in (2) represents the best case in practice, as one cannot forecast exactly what care the patient will receive, or will choose to receive, in the coming decades.

It is sometimes asserted that quality of care is the most important determinant of life expectancy. If the comparison is between (1) and (2) above, this assertion is clearly wrong: the most important determinant is undoubtedly the severity of the disabilities. For example, literature from many countries documents that young

patients in the permanent vegetative state have mortality rates up to 500 times larger than in the general population. If quality of care is as important a determinant of mortality risk, then death rates under 'standard' care would have to be 500 times higher than they would be under (2). This is surely inconceivable.

Further, some states or countries provide services to individuals with disabilities as an entitlement. For example, California provides annual person-centered individual program plans plus provision of all indicated care. In such cases it is not clear what is the difference, if any, between (1) and (2) above”

126. Mr Block and Miss Greaney have drawn attention to that passage and have submitted that it means that “the distinction between reasonable and necessary care and a well-funded care plan is probably not relevant.” I note that they do not use the expression “plainly not relevant”.
127. I confess to finding the passage in the 2008 paper rather difficult to follow and would have valued meaningful elucidation. On a straightforward reading it does not say specifically that the quality of care is irrelevant; it suggests that the issue is “complex and less clear than is often assumed.” The passage undoubtedly challenges the view that it is a “critically important factor” in assessing life expectancy. However, the way that the issue has been advanced in the cases to which I have referred (and indeed the way it has been advanced in this case) is in a less extravagant manner than is conveyed by that expression: it is to the effect that where there is good reason to believe that the quality of future care will reduce some identifiable risks to life, then it is appropriate to reflect that in the overall assessment of life expectancy.
128. Dr Rosenbloom’s position is, as I have said, that there is no evidence to support this approach and I have already indicated my view about that (see paragraph 112 above). He also asserted many times that it is the severity of the brain damage that operates as the true constraint on survival and that all the individual features of James’ presentation are simply markers of the acknowledged severity of his brain injury. As I understood him, this viewpoint was emphasised in the context of the debate about where to place James in the Strauss data. Dr Rosenbloom would not accept, for example, that merely because James has shown no tendency towards aspiration at present his lifetime risk of aspirating is in some way diminished. However, it needs to be understood, in the context of the issue about whether an adjustment can be made to the life expectancy prediction because of anticipated good quality future care, that the relevance of the care relates to the reduction in the likelihood of the risk materialising in a way that is unheeded and thus not acted upon before death occurs. The two issues are, in my view, different.
129. Having concluded that it is legitimate to increase the life expectancy prediction in the light of the future care that will be available to James, by how much should the prediction referred to in paragraph 89 above be increased? The nature of the overall care package available to James in the future will be apparent from the balance of this judgment (and indeed is reflected in paragraph 110 above), but in summary he will have 24/7 care from 2 trained

carers with the availability of many aids and items of equipment that will enhance his mobility and ability to communicate. In addition he will have available other therapies and access to the opportunities of appropriate exercise and recreation that might be denied to others who do not have the means to access such a regime.

130. Because he does not subscribe to adjusting the prediction for this reason, Dr Rosenbloom did not put forward a figure for the adjustment on this account. Dr Ferrie had suggested a 3-year increase (against the background of an 8-year decrease because James was not to be regarded as fully self-feeding and the presence of the gastrostomy as a “weak negative factor”: see paragraph 53 above), though some part of the increase was on account of the particular type of cerebral palsy that James has. I understand that Dr Ferrie’s position in relation to that matter is that the high level of dystonic movements means that James is constantly “exercising” and, accordingly, the lack of mobility (with its associated risks) that afflicts some cerebral palsy patients does not apply to him. Dr Rosenbloom clearly disagreed with this view and, without further explanation from Dr Ferrie or some clear support in the literature, I do not think I can act upon it. Because it appears to be a somewhat novel suggestion I propose to assume that it accounted for a modest proportion of the 3-year period he advocated.
131. In *Lewis*, Judge MacDuff had no expert evidence to guide him on the amount of any adjustment to be made on account of the good future care that could be anticipated in that case (other than support for the proposition that he was entitled to make such an adjustment) and, as he said, it was a matter of judgment based upon a general feel for the case assisted by “the judicial fingertips”. I might observe that in that case the claimant was to receive 90% of the full value of her damages claim, not 100% as James will.
132. In this case I do have Dr Ferrie’s view, albeit not one tested in cross-examination. Nonetheless, his approach was to look for a modest addition on this account and it would be difficult to see his 3-year period of itself to be excessive given the lengthy life expectancy otherwise predicted for James. I have also had the advantage of a detailed analysis of the factors that do or do not constitute constraints upon survival for someone like James. Although those matters go largely to where in the statistical cohort he should be placed, they have a bearing on the impact that future care may have. Overall, I consider that adding an additional 2 years for the quality of the future care and the lifestyle to which it will give rise in this case will not operate as an injustice to either party. If anything, it may be on the conservative side.
133. Furthermore, it seems to me to be appropriate to regard the continued presence of the gastrostomy and the likely increase in use of a Neater Eater once James’ new regime is in place in his new accommodation to be factors that combine to warrant a modest uplift in the way that, had she felt there were such factors in *Whiten*, Swift J would have considered appropriate in that case “to reflect individual features in the claimant’s case.” I do not think it unreasonable to assume that Dr Ferrie included a 1-year reduction within his overall 8-year reduction for the “weak negative factor” of the gastrostomy given that Dr Rosenbloom had suggested 2 years because of the “clinical need” he then

perceived for the gastrostomy. Equally, therefore, it seems to me reasonable to add 1 year to reflect the modest positive factor to which, in my judgment, the gastrostomy gives rise combined with the positive feature of greater self-feeding in the longer term by using the Neater Eater, albeit that both aspects of James' daily feeding pattern will be watched carefully by his trained carers.

134. My overall conclusion, therefore, is that a total of 3 years should be added to the predicted life expectancy before any reduction is considered for the risk that James will not survive until 15. It is agreed by Counsel that this means that the life expectancy, subject to any such reduction, is to age 63.2¹.
135. I have mentioned the small risk that James will not survive until 15 in paragraphs 56 and 101 above. I expressed the hope that I could make a modest "rounding down" to achieve a whole-figure life expectancy because a life expectancy with figures beyond the decimal point seems to me to be inappropriate in this context. It does appear that this can be achieved.
136. Dr Rosenbloom had suggested a reduction of 1 year and Dr Ferrie had suggested a 0.25 year reduction at the time of the joint statement. Dr Rosenbloom accepted in cross-examination that it was less than a year since the trial was 6 months on from the joint meeting and James had remained well. He said "precisely what" reduction should be made was uncertain and said that "the risks are that in spite of the excellent care he receives, ... he could have an overwhelming infection from which he would die [or] that he may have an episode of status epilepticus." Those were identified as the risks, but they are, he said, "small and the downward adjustment is small because of that".
137. Against that background, I would have proposed taking Dr Ferrie's assessment, now very nearly 9 months since the joint meeting. This would indeed have reduced the life expectancy to as near to age 63 as would make no difference. If I had acceded to Mr Block's suggestion in his closing submissions that it is reasonable to adopt 0.5 years, the rounding up of the figure of 62.7 would also achieve the same result. Whichever route is adopted, the relevant age is age 63.

Epilepsy/provisional damages

138. It is accepted that James is at an increased risk of developing epilepsy. The lifelong risk of developing recurrent seizures is about 10%. The impact of developing epilepsy may be serious if the seizures are not well-controlled by medication.

¹ The starting point is 15 + 37 (see paragraph 89) – thus to age 52. Normal UK life expectancy for a 12-year old boy is a further 77.6 years – thus to age 89.6 (page 22 of Facts & Figures 2014/2015). This is 13.2 more years than the US life expectancy which is to age 76.4 (15 + 61.4 from the 2014 Strauss data: paragraph 48 above). Using Dr Rosenbloom's methodology of adding 3 to reflect the fact that the Claimant is aged 12 as at the date of trial, the Claimant is entitled to 40 (37 + 3) / 64.4 (61.4 + 3) i.e. 62.11% of the difference of 13.2 years = 8.2. The exact life expectancy calculation is therefore 52 + 8.2 + 3 = 63.2.

139. The parties are agreed that, subject to a suitable form of wording, provisional damages and variable periodical payments should be awarded to deal with increased needs in such an event

“Lost years” claim

140. It is accepted on James’ behalf that I am bound by the decision in *Croke v Wiseman* [1982] 1 WLR 71 to disallow the claims made for the loss of earnings and pension he would have enjoyed between the age of 63 and his normal life expectancy in a non-disabled state. Ms Rodway and Mr Latimer-Sayer have reserved his position in that respect should this case go further and have drawn my attention to the observations of Laing J in *Totham* (see paragraph 189 below). There is nothing further I can add to the position in this regard.

James’ likely work pattern but for his disabilities

141. It is agreed in this context that I must make findings that will enable an assessment to be made of James’ net annual loss of earnings at various stages of his working life had he been able to enjoy such a life, to include the issue of whether any deduction should be made for the costs of travelling to and from work and of work clothing. I will deal with the longer term first.

(a) earnings from age 22

142. Issues such as this are always difficult. James is only 12 and making realistic assessments for the future that might have been is yet another uncertain process. However, it is a familiar exercise where agreement between the parties cannot be reached.
143. In terms of the expert evidence on the issue, the assessments of the psychologists are relevant. In this case David Johnson, a clinical psychologist, and Albert Reid, an educational psychologist, were instructed on behalf of James. The Defendant instructed Anthony Baldwin, a consultant psychologist. Mr Baldwin discussed issues with Mr Johnson and Mr Reid separately and separate joint statements were produced. In the event, Mr Baldwin was not called by the Defendant to give evidence.
144. Mr Johnson (‘DAJ’) and Mr Baldwin agreed as follows:

“But for his injuries, what would James’ level of cognitive ability probably have been? We agree that James would probably have been of at least Average ability and capable of achieving success in at least further education level. DAJ considers that, given James has been able to perform within the Average range on some tests now ... in the context of permanent brain damage and multiple impairments, it is likely that he would have been more able in the absence of injury. DAJ considers it reasonable to suggest the potential for High Average level ability, given an undamaged brain.

But for his injuries, what kind of employment would you have expected James to have been capable of? We agree that James would have probably continued his education to at least further education level. We agree his area of study/employment would probably have been vocational, rather than professional. We agree James could have worked in a skilled occupation, with the potential to progress to managerial levels.”

145. Mr Reid and Mr Baldwin agreed as follows:

“We agree but for his injuries James could have been a young man whose general level of cognitive function would have most probably fallen within the normal average range.

In Mr Baldwin’s view he would have been capable of independent living and been capable of continuing his education at a college of further education, most probably undertaking vocational qualifications. In drawing this conclusion Mr Baldwin has reviewed the family background including the social and economic resources available to them. On balance he would have obtained vocational qualifications up to NVQ level.

In Mr Reid’s view it is likely that James would have achieved at least 5 GCSE subjects at grades A* - C including Maths and English; he could then have undertaken tertiary qualifications including a Degree leading to a vocational qualification.”

146. As I have said, Mr Baldwin was not called to give evidence which means that, subject to any concessions made by Mr Johnson and Mr Reid, their evidence was not controverted by any other evidence.

147. Mr Block and Miss Greaney accept that the consensus of the expert evidence is that James would probably have qualified for and obtained vocational employment and they also accept that there is a strong family history on Mrs Adams’ side of the family of the men working for a local engineering company originally called Ruston’s but which eventually became Siemens, having at one stage been Alsthom. Indeed that was the very clear evidence given by James’ grandfather, in particular, to whom I have previously referred (see paragraph 20 above), of that connection. He said that seven of the family had worked for Ruston’s, including his grandparents on each side, his father, his father’s brother, himself, his brother and his son who had all worked there, several as engineers. When he retired in December 1998 he was Design Group Manager for Alsthom Development Department (having been promoted over the years) and was responsible for the design and manufacture of multi-million pound projects. His brother rose through the ranks and became the chief engineer of Hawker Siddeley Power Engineering.

148. Darren Chafer, Mrs Adams’ brother, is now 46 and studied mechanical engineering at college. He has been a senior planning engineer with Siemans in their project management team since November 2012 having been promoted over the years. His current pay including bonuses is just under

£40,000 per annum gross. If he was to be promoted into the next salary band he could anticipate an annual salary increase of between £6,000 and £9,000. He gave evidence that a starting salary for an apprentice was £24,000 and for a graduate it would be £27,000.

149. There is undoubtedly a very strong tradition on Mrs Adams' side of the family to work in the engineering world and, if I may say so, of an obvious commitment to hard work that brings its rewards in terms of promotion. Although the evidence I have summarised in the last few paragraphs was necessarily focused on the male cohort within the family, Mrs Adams' own approach to work (as summarised in paragraph 31 above) mirrors that ethic. As I have said, I have not seen nor heard from Mr Robshaw. It is, of course, impossible to say, but for reasons upon which I need not dwell, it is possible that, but for James' disabilities, that the relationship between Mrs Adams and Mr Robshaw would have survived. If that was so, James would have been subject to the regular influences of his natural father as well as any that might have come from Mrs Adams and her family. So far as Mr Robshaw is concerned, it is to be noted that, whilst he started life as a lorry driver, he decided to train as a plumber and apparently has been running a successful business since then.
150. I rather think, from everything that has been said about James at his present age, that he would have been very much his own man, but it would be surprising if he had not shown the kind of determination to succeed in whatever career he chose that he is presently showing to overcome his disabilities. Had he done so, he would, I am quite confident, have had the backing of all sides of his family. Equally, of course, it is a common experience that, whilst some children will be happily content to fall into the pattern of the working life of their parents, many will want to forge their own future and feel that they have moved on. Putting together all the pieces, I sense that James would have been in that latter category.
151. Mr Johnson said that a career in engineering would have fitted perfectly well with James' cognitive abilities and I see no reason not to accept that assessment. Whether James would actually have gone into an engineering occupation is, of course, impossible to say, but my assessment is that he would not have gone into anything less than that and that, accordingly, the broad level of earnings achievable in that sphere will represent a good measure of what he would have been likely to earn over his adult working life. It is, of course, impossible to say whether James would have remained in the area of Lincoln or would have moved away. I am sure that the strong family from which he came would have operated as a magnet to draw him to remain near to what has always been his home. On the other hand, if it was necessary to move some distance away in order to better himself, I am sure he would have taken that course, particularly given all the modern means of maintaining regular contact with loved ones. If he had moved away it is possible that his earnings would have been higher than if he stayed in the relatively restricted area near to Lincoln simply because the choice of potential employers would be greater.

152. I think the suggestion of the Defendant (which has moved up from the wholly unrealistic assertion in the counter-schedule that he would have earned no more than £18,000 per annum over his lifetime) that he should be seen as earning in the medium range of the male skilled trade occupations (approximately £25,000 per annum gross) or “all male employees” (approximately £28,700 per annum gross) reflects too pessimistic an assessment of his future but for his disabilities, but the figures help inform the general picture.
153. I have been told that the 2014 ASHE average annual gross earnings for science, research, engineering and technological professionals is £44,406 (SOC 21), for mechanical engineers the average was £44,436 (SOC 2122), for electrical engineers the figure was a little higher at £47,934 and for electronics engineers the average was £44,075. The average for engineering professionals generally (SOC 2112) was £42,718 gross. In order to put these figures into context, the national average for all employees is £37,028, for plumbers and heating and ventilation engineers (SOC 5314) it is £28,317 and for large goods vehicle drivers (SOC 8211) it is £26,619.
154. Looking across that range in the light of my assessment of the likely future for James but for his disabilities, I consider that a realistic figure for his average annual gross earnings over his working life from the age of 22 would be £42,000. Counsel will doubtless agree the net effect of that. I will probably follow the example of Swift J in *Whiten* (see [124]) and make a modest deduction (measured in a few hundred pounds) to reflect the likelihood that he would have incurred some expenses in connection with his employment. However, I do not see the suggested deduction advanced by the Defendant of £3,000 per annum as “modest” in the context of this case. If James had stayed in the Lincoln area, the costs associated with his employment would undoubtedly have been small. If he had left that area they could have been larger, but in my view that would have been counter-balanced by higher earnings generally.

(b) pension benefits

155. There is a dispute about the percentage to be applied to the gross earnings to determine the amount of the claim for loss of pension benefits to which, in principle, it is agreed James is entitled. I will revisit that dispute if agreement cannot be reached in the light of my conclusions as to his future earnings prospects.

(c) earnings from 16 to 22

156. A claim is advanced on James’ behalf for the part-time earnings at weekends and holidays that it is said he would have earned. Such a claim is not disputed in principle, but there is a difference between what is claimed, namely, just over £15,000 (based upon £3,250 per annum) and the round-figure suggestion of the Defendant of £5,000 (which I am told works out at just over £1,000 per annum).

157. This claim would not have arisen, in the normal course of events, for another 4 years or so. It is common knowledge that finding reasonably well-paid part-time employment for young people is not very easy in current conditions. I have not received any evidence of what the position is in and around Lincoln. That position may, of course, have changed in 4 years' time, but I consider some caution needs to be shown here.
158. A round-figure sum of £7,500 is, in my view, reasonable under this head of loss.

Retirement age if not disabled

159. It is said on James' behalf that, but for his disabilities, he would not have retired until the age of 70. The Defendant submits that the age should be 67.
160. One is looking now (in 2015) at what would be the likely position some 50 years hence. Given the current climate, in which many people work longer than hitherto, it is difficult to believe that at least the same climate will not exist then. On my assessment of James' likely future but for his disabilities, he would not have been working in heavy, manual work or work with very considerable stresses beyond the normal stresses of everyday working life. To that extent it is, in my judgment, much more likely that he would have worked until 70 rather than 67.

The approach in law to the valuation of aspects of the claim

161. Before turning to the disputed areas of the claim, I should refer briefly to the extensive written submissions that each side has advanced concerning what is said to be the "correct" approach to determining whether any particular feature of the claim is sustainable. The submissions would seem to mirror contentions advanced in other cases over the last few years.
162. The starting-point is not in issue: a claimant is entitled to damages to meet his or her "reasonable requirements" or "reasonable needs" arising from his negligently caused disability (see, e.g., *Sowden v Lodge* [2004] EWCA Civ 1370) and should receive full compensation. The issue that may arise, it is said, is when there is a range of "reasonable" options to meet those needs. In that situation is the court permitted or obliged to choose the cheapest option or that which the claimant advances? Reference has been made to *Heil v Rankin* [2001] 2 QB 272, *Rialis v Mitchell*, 6 July 1984, *Massey v Tameside & Glossop Acute Services NHS Trust* [2007] EWHC 317 (QB), *Taylor v (1) Chesworth (2) MIB* [2007] EWHC 1001 (QB) and *A (by her Litigation Friend H) v Powys Health Board* [2007] EWHC 2996 (QB), on the one hand, and *Iqbal v Whipps Cross NHS Trust* [2006] EWHC 3111 and *Whiten* (see above), on the other. *Totham* (see paragraph 189 below) was also referred to.
163. In *Whiten* Swift J said that the approach she adopted was as follows [5]:
- "The claimant is entitled to damages to meet his reasonable needs arising from his injuries. In considering what is "reasonable", I have had regard to all the relevant circumstances, including the

requirement for proportionality as between the cost to the defendant of any individual item and the extent of the benefit which would be derived by the claimant from that item.”

164. My attention was drawn after the conclusion of the hearing to a decision of Warby J in *Ellison v University Hospitals of Morecambe Bay NHS Foundation Trust* [2015] EWHC 366 (QB) where it appears that the Defendant sought to widen the scope of what Swift J had said. In rejecting that argument Warby J said this:

“18. Ms Vaughan Jones also relied on a proposition in the same paragraph of Swift J’s judgment, that the relevant circumstances include “the requirement for proportionality as between the cost to the defendant of any individual item and the extent of the benefit which would be derived by the claimant from that item”. I accept, and I did not understand it to be disputed, that proportionality is a relevant factor to this extent: in determining whether a claimant’s reasonable needs require that a given item of expenditure should be incurred, the court must consider whether the same or a substantially similar result could be achieved by other, less expensive, means. That, I strongly suspect, is what Swift J had in mind in the passage relied upon.

19. The defendant’s submissions went beyond this, however. They included the more general proposition that a claimant should not recover compensation for the cost of a particular item which would achieve a result that other methods could not, if the cost of that item was disproportionately large by comparison with the benefit achieved. I do not regard *Whiten* as support for any such general principle, and Ms Vaughan Jones did not suggest that Swift J had applied any such principle to the facts of that case. She did suggest that her submission found some support in paragraph [27] of *Heil v Rankin*, where Lord Woolf MR observed that the level of compensation “must also not result in injustice to the defendant, and it must not be out of accord with what society would perceive as being reasonable.”

20. Those observations do not in my judgment embody a proportionality principle of the kind for which the defendant contends, and were in any event made with reference to levels of general damages for non-pecuniary loss. Ms Vaughan Jones cited no other authority in support of the proportionality principle relied on. I agree with the submission of Mr Machell QC for the claimant, that the application to the quantification of damages for future costs of a general requirement of proportionality of the kind advocated by Ms Vaughan Jones would be at odds with the basic rules as to compensation for tort identified above.”

165. I am disinclined to express any concluded view of my own on any issue of principle that may be said to arise in this general context largely because it is difficult to find any head of claim in the present case that could be affected by

the resolution of any such issue of principle. I would, however, tentatively express my agreement with Warby J's analysis of Swift J's formulation of the correct test.

166. To my mind, in assessing how to provide full compensation for a claimant's reasonable needs, the guiding principle is to consider how the identified needs can reasonably be met by damages – that flows from giving true meaning and effect to the expression “reasonable needs”. That process involves, in some instances, the need to look at the overall proportionality of the cost involved, particularly where the evidence indicates a range of potential costs. But it all comes down eventually to the court's evaluation of what is reasonable in all the circumstances: it is usually possible to resolve most issues in this context by concluding that solution A is reasonable and, in the particular circumstances, solution B is not. Where this is not possible, an evaluative judgment is called for based upon an overall appreciation of all the issues in the case including (but only as one factor) the extent to which the court is of the view that the compensation sought at the top end of any bracket of reasonable cost will, in the event, be spent fully on the relevant head of claim. If, for example, the claimant seeks £5,000 for a particular head of claim, which is accepted to be a reasonable level of compensation, but it is established that £3,000 could achieve the same beneficial result, I do not see that the court is bound to choose one end of the range or the other: neither is wrong, but neither is forced upon the court as the “right” answer unless there is some binding principle that dictates the choice. It would be open to the court to choose one or other (for good reason) or to choose some intermediate point on the basis that the claimant would be unlikely to spend the whole of the £5,000 for the purpose for which it would be awarded and would adopt a cheaper option or for some other reason.
167. I apprehend that parties have been settling cases and the courts have been deciding cases on this broad approach for many years without doing violence to the full compensation principle. Inevitably, broad-brush judgments are called for from time to time and, as I have been invited by both parties to do on occasions in this case (where so many individual items remain in dispute), the court must simply “take a view”. I will be adopting that broad approach, where appropriate, when considering certain disputed heads of claim in this case.

Future care costs

168. There is now a good measure of agreement on the future care arrangements and the disputed items upon which my decision is required are relatively few in number. They are helpfully itemised in the table prepared by Mr Latimer-Sayer and reproduced in paragraph 178 below. Before I turn to this, I do need to highlight what I consider to be an unfortunate history to what became a major concession at the trial by the Defendant.
169. It was never in dispute, of course, that James would require significant 24/7 care of some nature. Following the visit in May 2013 to see James of Mrs Hazel Tuckfield, the occupational therapist instructed by the Defendant who reported on care issues as well as other matters, she prepared a report dated 2

January 2014. By then she had seen the report of Mrs Maggie Sargent dated 4 September 2013. That report had concluded that when she saw James in June 2011 (when James would have been 8½) “one carer could cope, but that he would need to have two carers to help his mobilising in the future.” She noted that he needed “very high levels of support.” She saw him again just over two years later in July 2013 by which time, of course, Mrs Beesley had been appointed as case manager and a care regime had been put in place for just over a year so far as possible in the circumstances of the accommodation available to James and his mother. James had two carers on duty throughout the day and one sleep-in carer overnight. Mrs Sargent’s view of the future care requirements was that James required two full time carers during the day and, based on the care records, also one night time carer. She costed the night time carer on the basis that a sleep-in carer should be paid for six months a year and a waking carer for six months a year. (A sleep-in carer works 10 hours, but is paid for 6 hours. If they are woken more than two times per night they are paid more. A waking night carer works for 10 hours, is paid for 10 hours and is expected to remain awake for the whole shift.)

170. In her report of July 2014, Mrs Tuckfield agreed that James required two carers during the day although she felt some of that care was being given (and would continue to be given) by Mrs Adams and the package should be costed accordingly, certainly up until the age of 19. She agreed that he required a night sleeper. After the age of 19, she agreed that two full time carers would be required each day and that night time care was also required, though not on the same basis as suggested by Mrs Sargent.
171. At their joint discussion on 26 June 2014, whilst they differed on how the night time care was to be provided, Mrs Tuckfield and Mrs Sargent agreed that from the aged of 19 James would require two carers at all times throughout the day. As I understand their joint statement, they only disagreed about the position prior to the age of 19 on the basis that Mrs Tuckfield maintained her view that Mrs Adams would be providing part of the care regime.
172. Mrs Tuckfield visited James again on 24 September 2014. In the light of her assessment on that occasion, and having (as she said) read the carers’ notes and the case management records, she revised her opinion and said that James no longer required two carers at all times throughout the day. She suggested that two carers would be required only for certain key times during the day on a school day, with additional hours being used flexibly during the weekends and school holidays. She costed the provision of a second carer on the basis that such a carer would, on school days, be employed for two hours per day during the morning and evening routines and for one further hour per day to be used flexibly and when required. On non-school days, she suggested that the second carer should be employed for two hours per day during the morning and evening routines and then four hours per day to be used flexibly and when required.
173. Leaving aside whether this was a legitimate assessment of the situation that presented itself at the time, the net effect was to reduce the annual cost of the care package for James after the age of 19 by something like £40,000 per annum. Apart from knowing that a round table meeting did take place prior to

the hearing before me (in December 2014 having originally been scheduled for September 2014, I have been told), I do not, of course, know how the negotiations proceeded. However, this kind of changed position cannot assist. I do not, of course, suggest that an expert should not change his or her opinion if it is truly justified, but having agreed to what was in effect a full care package a few months previously, some very good reason for changing to a less “populated” package for someone presenting with James’ disabilities is a surprising step to take.

174. It was during the afternoon session of the third day of the trial that Mr Block told me that Mrs Tuckfield, having heard the evidence thus far, had now accepted that full double-up care, both day and overnight, would be required in any future care regime. At Mr Block’s request she produced a supplemental report indicating her calculations which she did. It was dated 16 January 2015. Effectively, it reinstated the position that had obtained prior to her changed position following her visit to James in September 2014. She said the reason for changing her view was that she had “now had the opportunity to read through the Manual Handling Assessment prepared by Pamela Simpson and had clarification of the number of manual handling events throughout James’ day.”
175. Pamela Simpson is a Chartered Physiotherapist and Moving and Handling Consultant. Mrs Beesley requested a manual handling assessment from her on 28 October 2014 and it was carried out shortly afterwards. Her report was dated 6 November 2014. In summary it recorded James’ height and weight and the significant involuntary movements which made him difficult to manage at times and interfered with attempts to move him. It noted that the carers and Mrs Adams did carry out standing transfers, but expressed the view that these were not safe and should not be undertaken in the future. In a waking typical day James is recorded as being transferred 22 times and when at school he is allocated 2 support workers to assist with transfers. The recommendation was that transfers henceforth should be undertaken by two people using a hoist (preferably a ceiling track hoist), with two people being required to provide assistance with James’ head/body position whilst hoisting and then with the positioning of his feet when lowering him into a chair or onto a bed. It was recorded that it took two people to re-position James in his wheelchair and to re-position or turn him at night using an “in bed” sliding system. She concluded that two people would need to be available 24 hours per day to carry out any movement, transfer or change of position that James needed or wanted. She said that the bigger James became, the worse the problem would become. She emphasised that two sleep-in carers should be available all night for the long term future.
176. Apparently that assessment was disclosed to the Defendant on or about 12 November and Mrs Tuckfield accepted that she had read it in November. If that is so, and it made the impact upon her that, according to her report dated 12 January 2015, it did, it is surprising that it took until after the trial started for that to be revealed. In fact when she was asked about it by Mr Block in chief, she said that it was Mrs Beesley’s evidence that James’ stood to use a bottle to empty his bladder (which required two carers to assist him) and the

evidence that it required two people to re-position him at night if he became untucked that led her to agree that he required double-up care, both day and night. She made no reference to the Manual Handling Assessment prepared by Pamela Simpson. When she was asked about this by Mr Latimer-Sayer she said she could not see where the 22 transfers came from and, for that reason, felt her opinion was correct at that time.

177. I regret to say that this was not a very impressive piece of evidence and it shook my confidence that Mrs Tuckfield had really focused upon James' real requirements since her visit to him again in September 2014. Whilst views might differ about her position concerning Mrs Adams' involvement in the care regime, until September 2014 Mrs Tuckfield had shared Mrs Sargent's view that James did need double-up care during the day. Not unnaturally, her shifting position has made me cautious about accepting her assessment in other respects in this particular case and one or two other suggestions that she had made that have since been abandoned (for example, that James could use a sheath to overcome the difficulties of finding an accessible toilet) have given me the sense that she does not fully understand his needs.
178. I will return to the remaining issues and to the table I mentioned in paragraph 168 above. In that table 'MS' is Mrs Sargent and 'HT' is Mrs Tuckfield:

TO AGE 19	FROM AGE 19
(i) The appropriate annual allowance for waking night care – whether this should be 8 weeks (MS) or 3 weeks (HT) per annum.	(i) The appropriate annual allowance for waking night care – whether this should be 8 weeks (MS) or 3 weeks (HT) per annum.
(ii) Team leader hours – whether should be 30 hours (MS) or 20 hours (HT) per week.	(ii) Team leader hours – whether should be 30 hours (MS) or 20 hours (HT) per week.
(iii) Team leader enhanced rate – whether £8 per hour (MS) or £4 per hour (HT).	(iii) Team leader enhanced rate – whether £5 per hour (MS) or £4 per hour (HT).
(iv) Food & other expenses – whether £3,640 (MS) or £2,600 pa (HT).	(iv) Recruitment & advertising – whether should be £2,000 pa (MS) or £1,500 pa (HT).

TO AGE 19	FROM AGE 19
(v) Recruitment & advertising – whether should be £1,500 pa (MS) or £1,000 pa (HT).	(v) Payroll – whether should be £1,200 (MS) or £750 pa (HT).
(vi) Training – whether should be £1,800 pa (MS) or £1,500 pa (HT).	(vi) Additional childcare - £67,379 (MS) or nil (HT).

(i) waking night care

179. The issue here is what annual allowance should be made to reflect the possibility that James’ will need attention more than twice a night because of an unsettled night and for periods of illness and holidays. Should it be 8 weeks, as Mrs Sargent says, or 3 weeks, as Mrs Tuckfield says, or some intermediate position?
180. There are, of course, times when James is unwell, although fortunately not too frequent. However, most of the occasions when he is disturbed at night are when he gets into an uncomfortable position or because his bedding needs adjustment. Analysis of the records (which I take to be undisputed) demonstrates that in the year from September 2013 to August 2014 there were 136 waking nights (based upon 3 or more disturbances) and, by way of example, in September 2013 there were 18 waking nights, three of which involved 5 disturbances and one night involved 6 separate disturbances.
181. The point is made by Mr Block and Miss Greaney that when James has settled into suitable accommodation with suitable equipment, including the bed and bedding, his sleep will be less disturbed and they rely also upon the combined view of Dr Ferrie and Dr Rosenbloom that most children with cerebral palsy do achieve a more settled sleep pattern as they grow up. The joint statement suggests that “with suitable training he may learn to move to a more comfortable position himself”. On that basis Dr Rosenbloom thought that “a sleep-in night carer will suffice”. However, Dr Ferrie was not wholly confident that “awake night care” would not be necessary in the future. Improvement is a possibility, but I consider it unrealistic to think that there will be any prolonged period when there are wholly undisturbed nights and when there are disturbed nights there will be those when the carers are disturbed sufficiently for higher payments to be required. The agreed position of Mrs Sargent and Mrs Tuckfield is that Dr Rosenbloom’s solution will not necessarily suffice and that some provision must be made. Dr Rosenbloom deferred to them.
182. It does seem to me that Ms Rodway and Mr Latimer-Sayer make a strong point when they say that Mrs Sargent’s allowance of 8 weeks equates to 4 weeks waking night for two carers and that since assistance at night for repositioning and toileting will require two people, this is not an over-

estimate. That has persuaded me that I should adopt 8 weeks for this head of claim.

(ii) team leader hours

183. The current team leader is employed for 30 hours per week and I do not see the need for that level of time diminishing in the near future. Obviously, there is a potential overlap between this time and the time given to case management, but until the new regime after the move to better accommodation has truly bedded down and Mrs Adams has come to terms with it (as to which see paragraphs 443 – 446 below), I think it would be unrealistic to suppose that the need for team leader time is going to diminish. I would propose allowing 30 hours per week until James is 19 and then I will simply choose a half-way house between the position taken by Mrs Sargent and Mrs Tuckfield and say that 25 hours per week would be appropriate thereafter.

(iii) team leader enhanced rate

184. Mr Block and Miss Greaney make the fair point that the enhancement has recently been increased from £2 to £4 per hour, that there is no evidence of any difficulty in recruiting suitable people on this basis and that there is complete satisfaction with the current team leaders. I agree that those considerations (coming as they do from what is currently happening “on the ground”) are sufficient to displace the suggestion that there is a need effectively to double the enhanced rate for the future until 19. I do not doubt that the need to deal with Mrs Adams’ issues will continue to present its difficulties, but I do not see, on the present evidence, that more than £4 per hour is required as an enhancement.

185. However, that enhancement rate cannot remain static and I agree with Mrs Sargent that it will need to be increased in order to keep good quality staff and that a £5 differential is appropriate for the longer term. That figure should become effective when James is 19.

(iv) “on costs”

186. The “on costs” of the carers constituted by food and expenses, recruitment and advertising, training and payroll are all agreed in principle, but there are differing figures advanced by Mrs Sargent and Mrs Tuckfield.

187. In relation to food and expenses the range is between £2,600 and £3,640. I will take £3,250 as an appropriate figure. For recruitment and advertising, I thought Mrs Sargent had a strong point when she said that advertising and recruitment in the Lincoln area can be more difficult and expensive than in other parts of the country and, accordingly, I would accept her figures of £1,500 per annum until James is 19 and £2000 per annum thereafter.

188. Payroll at £1,000 seems to be the figure that Mrs Sargent mentioned in her evidence, though I note the figure of £1,200 in Mr Latimer-Sayer’s table. £1,000 is a mid-point in the range of £750 to £1,200 and I will take the figure

as that for this purpose. In relation to training, again I will take the mid-point of the bracket and say that the figure should be £1,650.

(v) future childcare

189. This is a claim for the additional costs of bringing up children in the event that, in due course, James has a family. Mrs Sargent has calculated the sum by reference to 20 additional hours of care each week over a 10-year period between the ages of 25 and 35 when such children as he may have would be with him on his own or he would accompany them on their activities. An annual figure is arrived at and then discounted by one-third for “contingencies” (which are not specified) and an appropriate multiplier applied to the multiplicand thus generated. The resulting figure is just over £67,000. No real issue is taken by the Defendant with the arithmetical approach and calculation (although Mrs Tuckfield feels that there would be no need for additional childcare expenditure because of the availability of the two full-time carers for James in any event), but it is said that the claim is too speculative. I am invited to take the same view of James’ prospects to becoming a parent as Laing J did in the case of *Totham v Kings College Hospital NHS Foundation Trust* [2015] EWHC 97 (QB) and say that the prospects are fanciful.
190. It is not, I think, helpful to look at decisions in other cases on an issue such as this: it all depends upon the particular facts. In this case it is not really disputed that James would be capable of becoming the father of a child though the process would not be without its complications. In this case, he would probably have sufficient cognitive ability to understand the choice he had made by committing himself to fatherhood. Furthermore, it is common ground that the opportunities for someone like James to meet a potential partner have become very much greater over the last 10 – 15 years and will doubtless continue to grow over the next 10 – 15 years or so. There is already evidence that James is attracted to (and indeed is attractive to) the opposite sex. Equally, the overall attitude of society to disability has changed markedly over the years and that which would have been regarded at one time as quite out of the question is no longer so regarded.
191. I acknowledge all these positive factors and it seems to me important that a court should not too readily say “it will never happen”. In this case, I do not think I would say that the prospect of James becoming a father is merely speculative or fanciful but, on the other hand, I would have to conclude on the evidence as it stands (which includes the evidence of Mrs Sargent that only one of the many male cerebral palsy patients with whom she has had dealings over the last 30 years has become a father) that the prospects are small and indeed sufficiently small to require a very significant further discount to be made to any calculation as to the potential additional costs. It seems to me that such a discount would reduce the figure to something that would bear no real relationship to that actual cost if the event itself materialised. An award of such a sum would, in my view, be wholly artificial. There is, perhaps, an argument that some part of the damages for the lost amenities of life should include an element for the reduced prospect of ordinary family life, but this is a difficult area and that kind of approach would also require some thought and

I doubt that any sum included within the award (if not contained within it already) would match the additional costs required in a case such as this.

192. Whilst, naturally, I hope that things turn out positively for James if a family is what he wishes to achieve in the future, I do not consider that I can award him any sum by way of damages in respect of the head of claim sought.

Physiotherapy

193. A fair amount of this claim has been agreed, but there are a few remaining issues.
194. The first disputed area concerns the period up to age 19. The issues are whether, as is contended on James' behalf, between the ages of 12 and 19 (i) he requires 36 individual hour-long sessions of "maintenance physiotherapy" annually, (ii) 10 sessions of initial training for the care team are required in one year (in other words, a "one off" piece of expenditure) and (iii) 6 sessions per year thereafter of ongoing training for the care team are required.
195. In relation to (i) Mrs Susan Filson, the physiotherapist called as an expert on behalf of James, broke down the 36 sessions she suggested were required annually for "maintenance physiotherapy" up to the age of 19 in this way:

"I think that on a one-to-one at school, the physiotherapist could probably see him now every two weeks, which would come to about 26 sessions, rather than the weekly that she is doing just through school time. Because he is growing, to keep it regular, say, 26 sessions for the one-to-one sessions. And then I would say that every term the physiotherapist needs a session with the school teacher and the TAs and perhaps the PE teacher to advise and see if there have been any changes and just to see positioning and things at school. That's another three sessions. Then each time he has his orthotics checks, which may be once or twice a year, the physiotherapist needs to be there with the orthotist, so that's another session. Then the seating, because he is growing, every six months they will be looking at his seating and that tends to take a double session. I worked a session out at an hour and to do a proper seating, it can be up to two hours, so I have allowed two sessions per seating, so it comes to four, but it's actually not four sessions, it's a double session. Then maybe one session, maybe to go to the sailing club to advise on posture for that or maybe, if he gets into the football or the riding, so one one year, one another, which actually adds up to about 36."

196. Mrs Wendy Murphy, the expert physiotherapist called by the Defendant, suggested that 24 sessions per annum (which would include carer training) for this period is a reasonable provision, the carer training sessions being arranged at convenient times to enable day and night-time staff to be trained. The case manager would have to organise the rota so that over a period of time, all members of the care team will have been present during James' physiotherapy sessions. In other words, she was suggesting a total of 24 sessions per year.

197. Mrs Filson said that that arrangement was impractical given that a total of 14 carers would form part of the team. I agree. It seems to me that, to the extent that training is required, separate training sessions for the carers is necessary whatever the level of maintenance therapy is provided for James. Mrs Filson explained the practical difficulties of training the carers at the same time as providing proper physiotherapy for James and that a double session is often the best way forward. Given that keeping the carer team up to scratch and up to speed with the techniques and any new equipment obtained, allowing for 6 sessions a year for continuing training is not unreasonable. Equally, I cannot see anything unreasonable about the “one off” set of 10 sessions, particularly in the year when the new accommodation and the new facilities become available.
198. As to the annual provision for James, I accept that physiotherapy is going to be important to him over the next few years in order to maintain the improvements already made about which Mrs Sarah Hilton-Bailey told me and which I accept. However, at the age of 19 it is agreed that the sessions required annually until the age of 21 would be 16 (including carer training) and from 21 until 45 20 sessions (including carer training). It would be odd if immediately upon his 19th birthday James immediately received about half the physiotherapy that he had been receiving annually for the preceding 6 or 7 years. I rather suspect, particularly in the last year or so of that period, that the physiotherapy may reduce gradually. If that is so, it seems to me that adequate financial provision for physiotherapy over the period up until the age of 19 will be made if the number of “maintenance physiotherapy” sessions is assumed to be at a flat rate of 30 per annum over the whole period.
199. The next area of dispute is in the post-45 period. On James’ behalf it is said that he is likely to develop musculoskeletal problems from about 45 onwards and, accordingly, it is appropriate to allow some additional physiotherapy thereafter. Mrs Filson considered that with his abnormal posturing as he gets older James will get more pain and problems and she allowed an additional 6 sessions per annum from age 45. She explained that these were six sessions would occur within a short space of time to deal with some problem that arose; it was not a long-term addition to the normal physiotherapy routine, but provision made for the need for additional physiotherapy if and when the need arose. Ms Rodway and Mr Latimer-Sayer contend that this is not unreasonable.
200. Mrs Murphy agreed the James would get more aches and pains as he ages but thought it unlikely that James would incur musculoskeletal injuries as such. She felt that the 20 sessions of physiotherapy and could not see what the 6 additional sessions were for.
201. I consider that there is a justifiable “half-way house” between these views. It seems to me reasonable to provide for the eventuality that James’ abnormal posturing will give rise from time to time for some additional therapy, but I would have thought an annual provision of 6 sessions is unnecessary. That should be spread over 2 years and, accordingly, I would allow for 3 additional sessions per year from the age of 45.

202. I will return to the multi-disciplinary team (MDT) meetings as a discrete issue later (see paragraphs 474 - 480).

Augmentative and alternative communication (AAC)

203. Much of this claim has been agreed, but there are some remaining issues. The claim arises principally in relation to the use of the eye gaze equipment that is essential for James to be able to communicate orally and in writing. Whilst there are some issues relating to the future provision of that equipment (see paragraphs 370 - 409 below), the present (fairly narrow) issues arise out of the need to provide the support of an appropriately qualified speech and language therapist to help James maintain and improve his communication skills using this equipment and to train staff at school when James is at school and his carers and support staff when at home in the use of the relevant equipment. There is no dispute about the need, merely about the cost and time involved in its provision.
204. The AAC speech and language therapist experts were Mrs Gillian Hazel on behalf of James and Ms Gillian Rumble on behalf of the Defendant. Both were well-qualified and well-informed and I found their assistance helpful. Mrs Hazel, with Ms Rumble present, demonstrated how the eye-gaze system works. It was described by one of the experts as acting like the mouse on a traditional computer, but the eyes of the operator govern the position of the cursor on the screen. As I understand it, there is an inbuilt camera in the PC that can “observe” where the eyes of the operator are looking so that the cursor can be moved around on the screen. The PC can be “trained” to recognise the way in which the individual operator wishes it to respond and, for example, a pattern of blinking can enable the operator to “click” in the way with which all PC operators are familiar. It is obvious that this is a sophisticated process which, like all computer technology, will doubtless improve (probably beyond current recognition) with the passage of time. However, it does, for example, require regular up-dating with vocabulary as James’ own vocabulary increases. (In order to use this technology to its best effect for learning purposes it is necessary to “differentiate” the school curriculum, in other words, as I understand it, to filter out parts of the school syllabus to make them more easily accessible. This has been carried out successfully so far under the supervision of Ms Marion Stanton and her charges for the past have been agreed and there is no dispute about her future involvement other, perhaps, than in respect of the MDT meetings. This is dealt with later.)

Hourly rate

205. Mrs Hazel and Ms Rumble were agreed that it is difficult to find suitably qualified and experienced AAC speech and language therapists, particularly in the Lincolnshire area. Mrs Hazel suggested the hourly rate (which reflects therapy time as well as travel time and travel expenses) should be £187.50 per session and Mrs Rumble suggested £165 per session on the same basis. A reasonable compromise would be £175 and that is the figure I allow.

Allowance between 13-16

206. The next issue between them is whether, as Mrs Hazel says, there should be an allowance for 125 sessions per year between the ages of 13 and 16 or 80 sessions, as Ms Rumble says. Mrs Hazel's contention is that since James is now at a mainstream school where his form tutor and teachers will change on an annual basis he will need a continuing high level of AAC input and that it would be wrong to reduce this by one-third from what is agreed he currently needs, given that his vocabulary and level of activities will be expanding at a fast rate during this period and bearing in mind the onset of important examinations.
207. Ms Rumble's view is that whilst intensive input is required in the first year of mainstream school (and the provision of 125 hours for the first year was agreed on that basis), there is no reasonable need for more than 80 hours of input per annum after the first year. His carers and support staff will, it is argued, be able to adopt a greater role in terms of programming his eye gaze system when vocabulary changes need and there will, accordingly, be a reduction in the support needed after the first year of intensive support. Furthermore, the current speech and language therapist provided by the NHS (Philippa Blackburn who has AAC experience) will be providing additional support such that 80 hours is all that is reasonably required.
208. Both arguments have a degree of force. I am inclined to prefer Mrs Hazel's essential approach because the next few years will be immensely important in James' education and it has to be borne in mind that the next 2 years or so are likely to be quite disruptive because of changes in accommodation and the introduction of new carers into his support team. It seems to me important that nothing slips by the wayside so far as AAC is concerned. I would have thought that 120 hours per year would be sufficient.

Allowance from 16-19

209. This is agreed at 72 hours per year if James remains in mainstream education rather than going to a Further Education college. Mr Block and Miss Greaney submit that the chance that James will return to a special school environment (which does exist) should result in providing that one year in this period at 46 hours per annum be allowed given the existence of AAC specialists within such an institution.
210. I reject that approach. The chance of James returning to that environment, on the basis of how his mainstream placement is currently progressing, is so remote that it can be ignored.

Rolling programme of training

211. Given the size of the care team for James (from and to which members will constantly be leaving and joining) once it is fully in place, Mrs Hazel says that an additional day's training of AAC input should be allowed per year (to be utilised on an *ad hoc* basis) to enable staff training.
212. The argument to the contrary is that the annual allowance for training is sufficient to cover the training needs of new staff members and that new carers

will be working alongside other carers who will be very familiar with the eye gaze system who will know how to programme it with new vocabulary and the new carers will also learn from being present during the AAC therapy sessions provided by AAC speech and language therapist.

213. I consider that some provision ought to be made, but I think that the one day's training provision should be spread over 2 years.

Assessments at communication aids centre

214. Mrs Hazel and Ms Rumble agree that every 3 years there will be a need to review the AAC devices and related equipment available to James. Mrs Hazel recommends that this is carried out at a multidisciplinary centre (such as one of the ACE Centres – 'ACE' standing for Aiding Communication in Education). She says that the staff at such centres are highly skilled and specialists within AAC.
215. Ms Rumble says that James will have highly skilled input from his private AAC speech and language therapist as well as on-going input from those with assistive technology expertise and in the light of that there is no reasonable need for him to attend the ACE Centre. She allows for 12 hours of AAC speech and language therapist input (£165 x 12 = £1,980) every 3 years to address the assessment of new AAC devices and related equipment and that is a reasonable provision.
216. The cost of doing this Mrs Hazel's way is £2,500.
217. It will probably turn out, in the fullness of time, to be a mixture of the two approaches. No injustice will be done if I take the figure to £2,250 every 3 years.
218. I will deal with the remaining differences between the parties in relation to the actual AAC requirements later (see paragraphs 370 - 409).

Speech and Language therapy (SLT)

219. The amount of the provision of SLT has been agreed, but there is a minor issue about the travelling costs of the therapist. The hourly rate has been agreed at £90 and both experts agree that provision needs to be made for travelling costs.
220. As with a number of aspects of the specialist expertise required for James, suitably experienced SL therapists are few on the ground in the area where he lives. The travelling had originally been assumed to be £30 per visit which was then increased in the written opening to £55 per visit. It then transpired that the new SL therapist recently instructed to help James charges £110 per visit for her travelling time and expense. The claim is, therefore, advanced on the basis of £90 per hour for the SLT itself (as agreed) and £110 per visit.
221. The Defendant says that the claim in the opening for £55 of travel time/expense per visit was reasonable and was accepted as such on the basis

that it treats one visit as consisting of two therapy sessions. In the circumstances, it is said that a reasonable hourly rate (including travel time and expense) is £145 per hour.

222. I have some sympathy with the Defendant's position here, but I do have to be mindful of the geographic constraints. Again, painting with a fairly broad brush, I will allow £160 per hour inclusive of travel time and expense.
223. There are claims for a periodic swallowing assessment every 3 years, provision for periodic review/attention by a dental hygienist and for orthodontic treatment. Whilst I can understand the first of these matters in principle, I can see no basis in the evidence for either of the other two: many people in any event see a dental hygienist from time to time and there is nothing about James to suggest that, because of his cerebral palsy, he will require orthodontic treatment. As to the first, I do not think that a formal review in the sense suggested is likely to be necessary: there will be a sufficiently observant care regime in place such that any issues with swallowing will be identified at an early stage. Any case manager will have this kind of issue in mind. I do not propose to make any allowance for these matters.
224. A number of other issues concerning future provision for James may arguably depend upon the way in which his accommodation is to be provided in the future and I will return to those (plus any remaining issues) after dealing with the accommodation claim. I can, however, deal with one small matter (chiropody) now.

Chiropody

225. There is a claim for chiropody costs at £216 per annum. Mrs Tuckfield agreed this in her first report and agreed it in her joint statement with Mrs Julia Ho, the expert occupational therapist instructed on James' behalf. The position now taken by the Defendant, supported by Mrs Tuckfield, is that his carers could cut James' toe-nails, the changed viewpoint being based upon a reference in the support worker records to the effect that his carers cut his nails at present. It is thus contended that there is no reasonable need for on-going chiropody services.
226. As I have said before (see paragraph 173), there is nothing wrong with an expert changing his or her view in the light of new evidence, but I find it surprising that, having agreed the provision on two occasions previously, a reference to the existing (arguably unsatisfactory) arrangement should cause a *volte face*.
227. Mrs Adams says that ordinarily she (not the carers) does this now (including finger nails) and Mrs Beesley says that she would be unhappy about the carers doing it and she is seeking a chiropodist in the local area. Without going into details, it is obvious that James' involuntary movements make cutting his nails a hazardous affair without some expertise and I can see nothing wrong with this aspect of the claim. It is important to James' welfare.

Accommodation

228. As I have indicated previously, there is agreement between the parties that the present accommodation that James and Mrs Adams (with the limited care regime to which I have referred) occupy is unsuitable (as indeed were the previous properties) and that it was reasonable to purchase the property which will form the basis of his long-term (indeed life-time) accommodation. That property (a bungalow) is known as ‘Yorke Hurst’ and is situated in the village of Skellingthorpe about three miles to the west of the centre of Lincoln. It was purchased for £295,000 with the assistance of an interim payment. The bungalow is situated in a reasonably large area of land, is adjacent to trees and woodland and is not far from where Mr Chafer senior and Mr Chafer junior live. As will appear, the land is such that it could accommodate a “new build” bungalow suitable for James’ needs or is sufficient to accommodate the necessary enlargement of the present bungalow to meet his needs.

Rebuild or adaptation?

229. The first issue to address is whether the additional cost of demolishing the existing bungalow and building a new property is reasonably to be laid at the Defendant’s door or whether the damages should merely reflect the costs of adapting the existing building. I was told by Mr Block that the “ball-park” additional cost of demolition followed by a new build is about £50,000. I am asked on behalf of James to find that the reasonable way forward is to demolish the existing buildings and start again because it will enable the construction of a purpose built, energy and cost effective property, with, it is argued, the further advantages of being able to plan the timing and cost of the building more accurately and for James to benefit from considerable savings in VAT that would arise on a new build compared with an adaptation of an existing building.

230. The Defendant argues that the additional expenditure should not be something for which it is responsible. It is not suggested that the demolition and new build option is an unreasonable way forward (indeed Mr Reynolds candidly acknowledged that, if he was doing this for himself, he “probably would want to knock it down and start again”), merely that the additional cost should, in effect, be paid for out of some other feature of James’ damages rather than being part of the compensation awarded by the court because his reasonable requirements can be met in a cheaper way.

231. The existing bungalow is a 1920s, twice extended, property. It was described in the surveyor’s report based on an inspection carried out in August 2013 as “originally a very small bungalow and whilst the extensions have allowed it to increase in size to a three bedroomed bungalow, the accommodation that it now provides is somewhat disjointed.” A good deal of damp was found in the original building and a number of matters were said to require early attention including the installation of a chemical damp proof course to all external and internal walls forming the original building and the re-roofing of the entire property. Some asbestos was found to exist in the outbuildings and was the subject of a separate report some while later. Most of that is characterised as being “low risk”, but obviously if demolition was contemplated of the

outbuildings there would need to be specialist help in ensuring that no danger from the asbestos was created.

232. Leaving aside for present purposes the asbestos issue, one only has to state the conclusions of the survey to see why anyone with any sensible eye to producing something that is tailor-made for someone with James' disabilities (and looking to the long term) would unhesitatingly conclude that demolition and building from scratch would be the obvious course. Indeed, by utilising all the modern methods of construction the long term costs of maintaining and heating such a property would almost certainly be reduced and/or maintained at a proportionate level. Anyone with the means to do this would, without doubt, approach things in this way even if they were only acquiring the property for, say, a few years with a view to selling it on. It would be a good investment to build in this way. Whatever the true nature of the life expectancy prediction in James' case, he is likely to be living in this property for a very long time. A £50,000 increase in spending now could achieve a very considerable saving in annual costs in the years to come and, of course, would provide him with an "ideal" home in the sense that it could be designed from scratch specifically with his needs in mind. For my part, I would say that this is a proposition that makes the claim for the additional immediate cost of demolition and building from scratch entirely reasonable and a legitimate sum to claim from the Defendant. Adopting the immediately cheaper option of simply extending the existing property can hardly be said to constitute reasonable mitigation of the loss that is sought to be recompensed by the provision of appropriate accommodation for James.
233. If that reasoning were not sufficient, then, in the circumstances of this case, I would conclude that demolition and a new build are justified for another reason. Mr Reynolds very fairly conceded that it would be impossible to extend the existing bungalow appropriately if there was a perceived need to give James proper access to three bedrooms within the property (by which is meant being able to propel his powered wheelchair into such rooms and turn around within those rooms in order to exit). In his (Mr Reynolds') suggested scheme for the extension of the present property this could not be achieved and it was acknowledged that no scheme utilising the existing rooms could be produced which would enable this manoeuvrability. Those bedrooms would almost certainly be rooms that would ordinarily be used by carers and, whilst she remained in the property, Mrs Adams, to which James would not usually require access. However, an inability to access those rooms and the adjoining family bathroom would deny him the opportunity to go freely and safely throughout the whole of the property. Whilst he could access his mother's bedroom to see her if she was confined to bed because she was ill, he would have to reverse out of the room. In my judgment, those enforced features of the living regime would be wrong in this case for the reasons to which I will refer in the next paragraph.
234. I would not want this case to be treated as a precedent for saying that in every case a disabled claimant should necessarily be entitled as of right to accommodation that permits access to and manoeuvrability within every part of the property. It is, of course, possible to envisage some disabled claimants

for whom this would not be a factor of any significance, if at all. However, James has full awareness of his surroundings and of his own limitations, has the ability to manoeuvre his powered wheelchair correctly, knows his own mind and, subject to the constraints of having a Deputy making important decisions for him in the future with his input, will be the owner of the accommodation in which he lives. An inability to be able to go everywhere in his own home safely would be to undermine the principle that damages are designed to place a claimant, so far as is possible, in the position he would have been in if uninjured.

235. As I have already indicated, Mr Reynolds did produce a suggested plan of how the existing property might be extended to meet James' reasonable needs. It first appeared as part of his report dated February 2014 when he thought that James was confined to a manual wheelchair (see paragraph 240 below). Nevertheless, he has continued to suggest that it would (with some modification) be suitable for James' requirements. However, when his suggested modifications to the existing bungalow are examined in detail, there are some considerable disadvantages with the layout that would have to be adopted such that it would, in my view, make adaptation an inappropriate option.
236. The present hallway leading from the present front door (which would be retained in this scenario) is narrow – some 985 mm in width, in other words, less than 1 metre – and the further hallway leading off that hallway in the direction of the current lounge (both of which would be retained in this scenario) is 1110 mm in width – so just over 1 metre. Mr Stephen Cumbers, the accommodation expert called on behalf of James, and Mr Reynolds are agreed that the minimum turning circle required is 1.7-1.8 metres. This would be needed in any hallway to enable James to turn within it rather than having to go solely in one direction, either forwards or in reverse. Because the wing where James' bedroom and therapy room would be located under Mr Reynolds' scheme is on the opposite side of the property from the side where the living room/conservatory would be located, James would have to go along these narrow hallways each time he wanted to get to and from the main living room and conservatory. That he would inevitably be required to go in one direction or the other does not seem at all satisfactory or safe.
237. The other specific area of difficulty with Mr Reynolds' suggested layout was the proposed dining room and kitchen layout. In its final manifestation (having been modified from its first representation) the kitchen and the dining room are on opposite sides of the present lobby area (which itself is quite narrow) and each is effectively an open plan room leading on to that lobby area. Mr Cumbers expressed his views about this in a way I thought was persuasive and I set out the gist of his answer to a question from Ms Rodway about his attitude to the proposed layout:

“I'm not comfortable with that layout at all ... because you have got a dining room and this is a lifetime home again for him ... where James can only get to one end of the table. He has his back (if he is positioned in his wheelchair up to that table) to whatever is happening in the kitchen. He can't get to the other end of the

dining room, he can't get around and circumnavigate that dining room at all. He is just stuck at that end ... with his back to the kitchen. He is also having to manoeuvre in a place, where ... the kitchen/dining room is in fact a through-room, everybody has to go through it. So ... where James is wanting to sit ... everybody is milling around going from one end of the bungalow to the other. And the kitchen area itself, if I were to place within that a turning circle of ... 1,700 millimetres/1,800 millimetres ... you can probably see with the scale of that room that it would pretty well occupy the space between the worktops and he would certainly be obstructing anybody else in that kitchen area So he needs to have somewhere where he can be positioned and I have suggested in my report that there ought to be a cul-de-sac arrangement of kitchen but the kitchen space needs to be adequately large so that there could be a separating breakfast bar beyond which the dining room and the dining space [takes] place, where James can be brought up to a breakfast bar and positioned in his wheelchair and therefore be part of the kitchen activities without necessarily obstructing and becoming an obstruction within the business end of the kitchen.”

238. He accepted in cross-examination that the people who might be “trafficking through” the “through-room” would generally be James’ mother or the carers and, of course, that is something to be borne in mind. However, as I see it, this is James’ lifetime property and one needs to take a longer term view. Even now he might have friends round to join him for a meal, but as time goes on that is even more likely – and, of course, desirable. It is quite plain that, like other members of his close family, he is an engaging and sociable person. Obviously, everything has to be kept within proportionate bounds, but it would be mean-spirited to provide him with accommodation that would undermine the opportunity to engage in this kind of activity. I do not think that the arrangement reflected in Mr Reynolds’ scheme, if it can reasonably be avoided, should be set in place now in a way that could impede the normal and desirable way in which uninjured people organise their lives.
239. As I have said, I found Mr Cumbers’ view on the proposed scheme persuasive. Mr Block criticises Mr Cumbers for criticising Mr Reynolds attempts to depict a suitable extension for Yorke House without himself having tried to draw up his own plan for an extension for the existing property. He says that Mr Cumbers accepted that it ought to be possible to provide something that met all reasonable requirements by extending the existing property of 98 square metres into something of 300 square metres plus (if that was what was required) within the land available. Putting that concession into context, what Mr Cumbers said was that it would involve putting the extension out in “two or three directions”, utilising what he described as the “irregular rectangular shape” of the external walls of the existing property that would be preserved. It is plain that he thought that such a course was not sensible, but nonetheless agreed that it was feasible.

240. Ms Rodway criticised Mr Reynolds for, as she put it, a lack of thoroughness and objectivity and not approaching matters as “objectively as a responsible expert should” pointing to the fact that he had not read the survey on Yorke Hurst until the day he gave evidence and that his original opinion was based upon the erroneous assumption that James was confined to a manual wheelchair and could not control and manoeuvre a powered chair.
241. I did not find this process of accusation and counter-accusation very helpful. Both Mr Cumbers and Mr Reynolds have a great deal of experience in this area that can be brought to the court for its assistance. Doubtless each could be criticised for some aspects of their approach and indeed each has been criticised by the opposing legal team. I have borne in mind the criticisms. However, for my part in this particular context, I see the putting forward by Mr Reynolds of his suggested scheme as his best attempt at demonstrating to the court how the existing property could be made part of the new accommodation for James. He has many years experience of assisting the court (whether instructed by the claimant’s side, the defendant’s side or jointly) in these matters and I am assuming that he has complied with the obligations of an expert witness. That means that what I see in his proposed scheme is either the best option, or at least one of the best options, available if the approach of retaining the bare bones of the existing property is adopted. It is, therefore, a scheme which it is legitimate to scrutinise to see how, in reality, it would work. For the reasons I have given, it has some major drawbacks, which, in my judgment, demonstrate yet further that demolition and a new build is the only sensible option in this particular case. That, as I have said, actually accords with Mr Reynolds’ personal view had he been going about this for himself. He also acknowledged that his scheme “works but it’s not ideal” and that, given a blank sheet of paper, he would not design the accommodation in this way.
242. One final point is that the dining room/kitchen arrangement under his proposed scheme would not accommodate satisfactorily the more regular use by James of the Neater Eater that I consider is likely to occur once he has moved provided, of course, the accommodation permits it.
243. Against the totality of this background, I am firmly of the view that demolition and a new build is the only sensible option in this case and that the immediate additional cost of doing so is reasonable and proportionate.

The actual requirements of the new property

244. The overall floor area required on Mr Reynolds’ view of James’ reasonable requirements is just over 237 m² given the need to provide accommodation for a second night carer. Mr Cumbers’ view is that a minimum of 327 m² is required on the same basis. They are broadly agreed on a number of areas and the simplest approach is for me to focus first on where Mr Block and Miss Greaney aver that Mr Cumbers’ specific suggestions go beyond what is reasonably required and what is proportionate because those suggestions largely (though not exclusively) give rise to the additional 90 m² proposed by Mr Cumbers.

Separate family dining room

245. Mr Cumbers proposes that there should be a separate family dining room of 15 m². It is contended on behalf of the Defendant that there is no reasonable need for a separate dining room because Mr Reynolds' proposed scheme makes adequate provision for the kitchen/diner. For reasons I have given (see paragraphs 237-238 above) I do not consider that Mr Reynolds' proposed scheme is adequate. That does not necessarily mean that Mr Cumbers' suggestion is itself reasonable, but I do not have any other reasonable option by which to judge it save to note that in the joint statement Mr Reynolds' comment on this proposal was that it was "included in the kitchen/diner". It does not seem to me that there is any specific objection raised to the amount of space (which, of course, is designed to accommodate the manoeuvrability of the powered wheelchair), merely to the need for such provision.
246. It does seem to me that, given everything that will be happening within his home, particularly if he has people in to see him from time to time, the provision of a separate family dining room would be entirely reasonable. I would accept that this is reasonably required. (This is a convenient point to deal with one other minor issue concerning the dining facilities. Although not an occupational therapist, Ms Coombes had suggested that a variable height dining table should be provided for James and I do not think that in principle it is contested: indeed it is consistent with my conclusion in paragraph 385. However, there is a choice between a table suitable for a single person (at £900 + VAT), an electronically operated table (at £3000 + VAT + delivery at £100) and a manual group table (at £1300 + VAT + delivery at £100). I do not see the justification for the electronically operated table with all the carers around to adjust the height, but I do think there is merit in the group table so that James can dine with other. I will allow £1660 every 10 years for this.)

Additional guest bedroom

247. Mr Cumbers provides for an additional guest bedroom for James of 16 m². It is predicated on the basis that most of James' friends/companions are likely to be wheelchair-bound or with disabilities – perhaps people he has met at school or elsewhere – who, in the ordinary course of events would visit him and sleep over. Provision, he argues, should be made for such eventualities.
248. The Defendant contends that there is no reasonable need for this facility on the basis that James will have a large exercise/physiotherapy room that could be used as a bedroom on the occasions that he has a guest to stay who needs wheelchair accessible accommodation. Any non-wheelchair guests can, it is said, use one of the other bedrooms.
249. Whilst I can see the attraction of such provision if money was no object, I am not persuaded that it would constitute a reasonable or proportionate expense. Whilst, of course, it is possible that James will have disabled friends/acquaintances, I do not think that a specifically designated bedroom is really called for to meet those occasional times when such a person might stay, particularly as I believe that through the use of other rooms (including the

exercise/physiotherapy room) such a guest could be accommodated satisfactorily for the odd night or two.

Independent living space for James

250. Mr Cumbers provides for some independent living space for James of 25 m². In his report he justified this by saying that James should be provided with a separate living area where he can be with his carers on a one-to-one basis and also have space to entertain friends and companions – for example, to enjoy music and activity without impinging upon the family’s ordinary living areas or having to revert to his own bedroom. He suggested that it should comprise a sitting area and a modest kitchen area with breakfast bar or small dining table. He said that ordinarily this would need to comprise approximately 40 m² of space but that he was anticipating that the therapy room for which provision would be made would, in effect, become James’ longer term dayroom and, accordingly, he deducted 15 m² to leave 25 m² to be found.
251. The Defendant contends that there is no reasonable need for this since James will have a large bedroom, a large exercise/physiotherapy room and the use of the family sitting room and conservatory.
252. Whilst the need for an area such as this would, it seems to me, diminish if Mrs Adams was not living permanently in the property, even in that situation I can see the justification for having some area like this in James’ own part of the property so that he can leave what would otherwise essentially be his bedroom to get on with other things. However, I am not persuaded of the need for the modest kitchen area with breakfast bar referred to nor am I persuaded that this room should, taken in isolation, be as large as 25 m². Since I see a potential inter-relation between space reserved for this use and the study/hobbies/communication room to which I will be referring below, I will reserve my decision until I have considered that issue.

Study/hobbies/communication room

253. Mr Cumbers provides for a study/hobbies/communication room of 8 m² which he suggests should be set up with James’ computer equipment and other peripherals where he could be accompanied by a family member.
254. The Defendant’s argument is that Mr Reynolds has allowed a larger exercise/physiotherapy room (23 m²) compared with the 18 m² provided for by Mr Cumbers who then provides for a separate hobbies/communication room and that the provision of one larger room will meet James’ reasonable needs and will provide greater flexibility of use.
255. I am persuaded by Mr Cumbers’ contention that the exercise/physiotherapy room should be reserved solely for those purposes. He said that the room would contain all the necessary equipment for home-based therapy and exercise, much of which is large and bulky. It needs to be a room where James can be hoisted to and from it and has wheelchair manoeuvrability space around it and that is why he advocates its retention for those uses and no other. As I have said, I agree.

256. However, the need for some space within the property for hobbies/communication does not appear to be in dispute (but if it is, I accept the need in principle) and, as indicated above, in principle I see the reasonable need for some independent living space for James over and above what is to be found elsewhere in the property.
257. Mr Cumbers has suggested that a total of 33 m² is necessary for this. I do not think the case for such a large area has been made out, but if, as I consider is feasible, these two areas of need can be met in one room, the only question is what area I should conclude to be reasonable. It plainly has to be large enough to house the computer equipment and so on and also a television and any other music equipment. If I double the 8 m² provided for by Mr Cumbers for the study/hobbies/communication room, giving 16 m² in all (a little over the size of the family dining room), then I believe reasonable provision will have been made.

Separate WC

258. Mr Cumbers provides for a separate WC of 3 m² (which would need to be near the front entrance lobby) so that James' carers and therapists can access a toilet other than in his specially adapted bathroom area or the family bathroom. Although he suggests that it should be large enough for James to use, it would be a multi-purpose WC available to all who are at the property and would be like a cloakroom in many houses.
259. The Defendant argues that there is no reasonable need for such provision.
260. This provision seems to me to be entirely reasonable. I would add to the list of those who might use the facility any disabled guest to the property. Without such a facility, the only WC available for a disabled person would be the facilities that James has in his part of the property. That would not be satisfactory.

Conclusion on these specific matters

261. The net effect of these conclusions is that I reduce by 25 m² the provision suggested by Mr Cumbers leaving 302 m² of provision.

More general conclusion on accommodation issues

262. The final question is whether there is any further deduction to be made from that figure because his floor area allocation is too great to be reasonable in any respect. Ms Rodway and Mr Latimer-Sayer invite me to recall that Mr Cumbers emphasised that he has provided minimum sizes for the rooms he has recommended. Mr Block and Miss Greaney invite me to say that 230 m² overall is sufficient.
263. I do not see this as an exercise in painting with a broad brush. It would be wrong simply to reduce what is claimed because it "seems too high". It needs to be emphasised that circulation space for manoeuvrability purposes is essential given the nature of James' disabilities and bearing in mind his ability

to control a powered wheelchair. There will be furniture in the property that will inevitably reduce circulation area.

264. Having looked at Mr Reynolds' views of the alleged over-provision of space (beyond the specific matters dealt with above), the main differences appear to be the conservatory (where Mr Cumbers says 16 m² and he says 6 m² if a conservatory is to be provided at all) and the two bedrooms other than James' bedroom (where Mr Cumbers says 16 and 14 m² respectively and he says 9 and 8 m² respectively). Their overall circulation space is expressed to be an additional 15% on top of the overall floor area.
265. If James is to have proper access (in terms of manoeuvrability) to the two bedrooms referred to (and, in my view, he should be entitled to that) and proper access to the conservatory (which I regard as reasonably required in principle) such that he can share it with his mother/carers/guests, all those rooms need to be of the size suggested by Mr Cumbers.
266. I am assuming that within the 302 m² thus provided that there is sufficient space for the separate shower room facilities that are accepted to be required if, as is likely, James has carers of both sexes. Consequently, each carer's bedroom should have a separate shower room (rather than a shared facility).
267. I trust that those conclusions will enable the necessary calculations to be made.

Additional issues arising out of the accommodation claim

268. There, as I understand it, are the following incidental issues arising out of the accommodation claim:
 - i) Whether there is a reasonable need for Torso height kitchen, utility units and wardrobes and cupboards.
 - ii) Whether there is a reasonable need for carer's kitchen units.
 - iii) Whether there is a reasonable need for a cord operated curtain track.
 - iv) Whether there is a reasonable need for an intruder alarm.
 - v) What is the appropriate level of contingency provision?
269. (i) Torso height kitchen, utility units and wardrobes and cupboards – Mr Cumbers recommended that all kitchen units should be arranged at torso level so that James could view and participate in what was taking place in the kitchen with equivalent provision in other areas throughout the property (in other words, no high-level compartments and no low-level drawer compartments). Mr Reynolds agreed that a worktop area that was lower which James could access for assisting with "pastry making or whatever" may be useful but could be accommodated in a standard kitchen. That concession in respect of the kitchen area suggests that an area should be provided so that James can take part in such cooking and/or preparation activities as he can. I agree that it is reasonable to provide such an area, but given that much of the

food preparation will, in practice, be carried out by his carers, I do not think that all units should be at such a level if so to provide would make it difficult for the carers to carry out these tasks comfortably. On the evidence I heard I am not able to judge to what extent that may be so if all kitchen units are arranged at torso level. If Mr Cumbers and Mr Reynolds can agree a cost for making provision of the kind I have identified, then the figure should be included as an element of the accommodation claim. If they cannot do so, I will endeavour to reach a conclusion on the basis of further written submissions.

270. The concession in principle was, in my view, rightly made because the logic of the proposition is to place James in the same position, as nearly as possible, as if he was not disabled. As I have indicated elsewhere, however, it is only reasonable to go so far in achieving this objective. It seems to me unreasonable to specify absolutely that there should be “no high-level compartments and no low-level drawer compartments” anywhere in the property. Some should be designed so that they are within James’ reach, but some storage space may have to be provided to which James would not ordinarily have access. Again, I will invite Mr Cumbers and Mr Reynolds to consider this issue further in the light of this broad conclusion and endeavour to agree some figure to be included in the accommodation claim. If this proves impossible, again I will try to reach a conclusion on further written submissions.
271. (ii) carer’s kitchen units – this is agreed.
272. (iii) cord operated curtain track – this has not been actively opposed by the Defendant and, accordingly, will be allowed.
273. (iv) intruder alarm – It is not disputed by the Defendant that this is reasonable, but the argument is that it is an ordinary item that would have been required in any event.
274. I agree that it might have been a feature of James’ home irrespective of his disabilities, but not necessarily so: insurers may stipulate that one is provided, but it depends on the neighbourhood.
275. In the absence of evidence that it would have been required by insurers in the neighbourhood where James will live, it seems to me appropriate to conclude that the alarm is required in consequence of James’ disabilities.
276. I will deal with the contingency sum below (see paragraphs 300-301).

Credit for rent received by Mrs Adams and for properties James would have purchased in any event?

277. The Defendant argues that Mrs Adams, who has received £440 per month by way of rental income on 1 Graveley Close since January 2012 (see paragraph 24 above), should give credit for 50% of that sum on the basis that it reflects housing costs that James would have incurred in any event until the age of 25 years. This amounts to £2,640 per annum.

278. This is a very unattractive proposition, but the approach must be applied if that is what the law requires. The argument is hotly disputed on James' behalf. The contention of Ms Rodway and Mr Latimer-Sayer is that the family would have stayed in their original home but for James' disabilities and it is reasonable for Mrs. Adams to keep 1 Graveley Close because it is clear that James will be able to live independently, albeit with a considerable support package, at some stage in the future at which point she may return to live there. As things stand, she does not benefit from the rental income because it is passed directly to her brother as a way of paying him back for his own generosity (see paragraph 24 above). Ms Rodway and Mr Latimer-Sayer argue that whatever care package is put in place, Mrs. Adams will undoubtedly continue to play an important role in James' life (beyond that of "just" being his mother) for which she will not be remunerated and any perceived benefit to her of living rent free in James' property should be seen as an incidental benefit for which credit should not be required to be given. This was the approach adopted by Swift J in *Whiten* at [459] – [470] having analysed the previous authorities including *M (a child) v Leeds Health Authority* [2002] PIQR Q46 and *Iqbal v Whipps Cross University NHS Trust* [2007] LS Medical 97. I respectfully agree with that approach and adopt it in this case.
279. In my judgment, no credit needs to be given in the manner contended for by the Defendant.
280. There is an issue regarding the value of the property James would have purchased in any event. The need to give credit for 50% equity in a property is accepted on James' behalf, but it is said that this should be for a property costing £68,450 to age 35 and thereafter for a property costing £142,470. The Defendant's case is that James would have purchased a property with a partner from age 25 year in the sum of around £125,000. Credit should be given for 50% of that sum – in other words, in the sum of £63,000.
281. It is difficult to do other than to paint with a broad brush here. Given the area where it is likely that James would have lived in his non-disabled state, I think a fair compromise of the figures would lead to the conclusion that from 25 to 35 he would have owned a property worth £75,000 and that from 35 onwards a property worth £150,000. The relevant credit will be for 50% of those sums.

Adaptations to father's and grandfather's homes

282. There is a claim for adaptations to the houses of James' grandfather and father to allow better access for him. This is advanced on the basis of £5,500 per property making a total of £11,000. The Defendant suggests that portable ramps of £500 could be installed making £1,000 in total.
283. The Defendant's suggestion seems reasonable and I am unable to see the justification for the more expensive approach.

Swimming pool at home?

284. The issue of whether it would be reasonable to allow for a swimming pool in principle in James' new accommodation became more narrowly focused during the trial. In the earlier stages of the preparations for this case the emphasis of the reports on James' behalf was upon hydrotherapy because of the perceived benefits of warm water exercise. However, with the passage of time it became clear that James was more physically able than a person who routinely requires hydrotherapy and it became common ground that there is no reasonable need for hydrotherapy. Notwithstanding the acceptance of that position, a consensus emerged amongst the experts on both sides that swimming provides James (who obtains a great deal of enjoyment from it) with physical and psychological benefits which are different from other activities that can be carried on other than in water and that he should be able to undertake swimming if he wishes. Mrs Beesley told me that "the care team are very keen to take James swimming because it's something he really enjoys" and described it as an activity that he loves. Dr Rosenbloom told me that James indicated to him "with his actions, rather than words, how much he enjoys swimming."
285. The psychological benefits were identified by Mr Johnson in this way:
- "From a psychological point of view, one of the benefits of swimming is that it allows James to move freely. He is spending a lot of time strapped in, as it were, and isn't able to exercise as well as if he was in a free state."
286. He also said this:
- "I support James swimming. The provision of the facility is not really within my expertise. It has got to be somewhere that he can access easily and readily without problems of fatigue, without problems of long travelling time and, of course, with adequate access."
287. Although Dr Rosenbloom chose his words very carefully, the sense I obtained from what he said was that, as an activity for James, it was one he supported. Dr Ferrie had expressed his support for it in their joint statement. Mrs Filson supported it too and gave reasons for that support.
288. Dr Rosenbloom and Dr Ferrie agreed that for James to undertake water-based activity he required an accessible pool with a suitable hoist or graded wheelchair access, suitable changing facilities and warm water.
289. The question at the trial became whether the one public swimming pool within tolerably easy reach of where James would be living, namely, Horncastle swimming pool, would provide a suitable swimming facility for James. If it did, there would be no need for a purpose-built pool at his home. The Horncastle pool is about 40 minutes' drive away from James' home which, Mr Block and Miss Greaney submit, would be a reasonable distance to travel for a swim at weekends or potentially after school. Whilst that is quite a distance for regular access to the pool, I am inclined to think that it would not have led

to the conclusion that it was an unreasonable proposal that he should make use of it, certainly in the longer term after he had left school.

290. What emerged, however, is that the pool is kept at a standard 29°C which it is common ground is too cold for James who needs 32°C. At a late stage in the evidence Mrs Murphy suggested that this problem could be resolved by James wearing a wet suit (called a ‘trisuit’), made of flexible material, that could be custom-made for him. It would, it was suggested, be much easier to put on James than a lycra bodysuit that he had tried previously and which he did not like. It did, however, emerge that Mrs Murphy had no experience of someone such as James using such a suit and had merely spoken to the salesman from the company that made it. Even assuming such a suit could be made, it is very difficult to see how James could readily be put in such a suit in the changing rooms at the pool (or indeed anywhere) given his strong involuntary arm movements.
291. The next issue was the provision of an appropriate seat to attach to the pool hoist, it being acknowledged that the chair currently in place would not be suitable or safe for James. Mrs Murphy suggested that a suitable seat could be purchased for James (either by him or by the pool itself) to attach to the pool’s hoist. Mrs Filson said that those responsible for public pools are usually very reluctant to allow people to bring in their own equipment since they would have no control over the situation and there would be public liability and insurance issues. She said that in her experience local authorities are not generally receptive to such proposals.
292. Mr Block and Miss Greaney were left to express the hope that Mrs Murphy’s view that a way through the problem could be found would prove correct.
293. The problem in this case may largely be a function of the geographic location of where James will live, but the evidence does demonstrate clearly that the only way in which the need (not just the desirability) for him to go swimming regularly can only met by some home-based provision. Mr Block and Miss Greaney contend that the evidence in support of a home pool provision in this case “falls short of the situations where the Courts have previously been persuaded that a home pool is reasonably required.” I was reminded of the following cases: (i) *Cassel v Riverside Health Authority* [1992] PIQR Q168 (where a claim for a hydrotherapy pool by a claimant with cerebral palsy was refused on the basis that it was not “an expense made necessary by the increased cost of caring for the plaintiff” and the evidence of the claimant’s mother was held insufficient to persuade the court of the need for a hydrotherapy pool); (ii) *Lewis v Royal Shrewsbury Hospital NHS Trust* (see paragraph 124 above) where HHJ Macduff QC asked whether there were “real and tangible therapeutic benefits” for a claimant with quadriplegic athetoid cerebral palsy of having a pool at home and concluded on the basis of the medical and physiotherapy evidence that there were real physical benefits that went beyond “providing activity, interest and pleasure”; and (iii) *Whiten* (above) where Swift J refused the claim for “aquatic physiotherapy” sessions with a physiotherapist in a specialist hydrotherapy pool. Her conclusion can be seen from the following paragraphs of her judgment:

“262. ... I have no doubt that the claimant enjoys his aquatic physiotherapy sessions, just as he enjoys his visits to the swimming pool with his family and/or carers. I readily accept that exercising in water is generally beneficial for him. However, I am not satisfied that the claimant has established a clinical need which cannot adequately be met by physiotherapy exercises carried out in an ordinary swimming pool with suitably trained carers and, occasionally, his treating physiotherapist. Consequently, I make no award for the costs of future aquatic physiotherapy.

263. Whilst it might be convenient for the claimant to have a pool at his new home, there is no evidence of a real need for that facility. The claimant will have trained carers and a suitably adapted vehicle to take him for sessions in a swimming pool at a local private leisure club whenever he wishes to go. The availability of suitable pool facilities will be one factor to be considered when the family come to decide where their new home should be sited.”

294. I do not, with respect, see those cases as providing any rigid test about what needs to be demonstrated in this context in any particular case. The guiding principle is whether a claim advanced reflects a claimant’s “reasonable requirements” or “reasonable needs” arising from his or her negligently caused disability (see paragraph 162 above). I respectfully agree with Judge Macduff that just providing pleasure would not ordinarily be sufficient and some real and tangible benefits would need to be demonstrated. Mr Block and Miss Greaney draw attention to the focus of the argument in *Whiten* which they suggest was whether any “clinical need” for the hydrotherapy pool was demonstrated. However, what Swift J said was that “a clinical need which cannot adequately be met by physiotherapy exercises carried out in an ordinary swimming pool with suitably trained carers and, occasionally, his treating physiotherapist” had not been established. The claimant in that case could go with his “trained carers [in] a suitably adapted vehicle to [to] a swimming pool at a local private leisure club whenever he wishes to go.” For the reasons I have given that option will not be available to James.
295. It does not seem to me that other cases provide the answer to the question in this case. Every case is dependent on its own facts and I would repeat what I said in connection with the issue of access to and manoeuvrability to all parts of James’ new home (see paragraph 234 above), namely, that the decision in this case should not be seen as a green light for claiming a home-based pool in every other case. James does have complex needs that do require to be met in ways that may not arise in other cases and merely because an example cannot be found in a previous case does not mean that the provision made in this case is wrong. Very many cases are, of course, resolved without the court being required to adjudicate and it is, therefore, unknown precisely how frequently the issue of a home-based pool is raised and either conceded or recognised to some extent in the overall settlement.

296. In my judgment, the case for a home-based pool is made out here on the basis of the real and tangible psychological and physical benefits that swimming will give to James, but which cannot be obtained in a convenient local public facility. It can only be provided by a home-based pool. The next question is how should it reasonably be met?
297. It is accepted that once I have determined the size of the pool reasonably required, Mr Cumbers and Mr Reynolds should be able to reach agreement on the likely costs of building such a pool.
298. Ms Rodway and Mr Latimer-Sayer submit that ideally the pool should be large enough for James in which to swim and to be in the pool with others. A pool measuring 7 x 4 m was recommended by Mr Cumbers to achieve this. Mr Reynolds drew attention to the idea of a pool within an extension therapy room partly enclosed by a conservatory called the 17fx Aquasport (at a capital cost of £95,000). It is 5.33 m length and 2.33 m width, but there is a seating area at one end which narrows the effective swimming area. Mr Reynolds is of the view that it could accommodate three people for activities. As I understand it, it can be made to offer a slow-moving jet stream of water against which someone can swim, although it is questionable as to whether James could cope with that.
299. Whilst I can understand that “ideally” a pool of the size mentioned by Mr Cumbers would be desirable, I do not think I can approach this issue on that basis – I need to alight upon some dimensions for a pool that are reasonable and which can be provided at a proportionate cost bearing in mind, as I do, that whilst there may be occasions when there is more than one person in the pool engaged in activities, more often than not it will be James on his own (doubtless attended by his carers) who will be using it (a) to give him enjoyment and (b) to enable him to receive the above-mentioned beneficial features of the exercise that regular swimming would provide. Overall, I think that a pool of roughly the dimensions of 5 x 3 m would be sufficient and the costings should be calculated on that basis.

Contingency sum

300. It is obviously sensible to provide a contingency sum to cater for unexpected expenditure in the substantial building project that will be involved in the provision of the new accommodation for James. 10% is contended for on his behalf; 5% on behalf of the Defendant.
301. It is, in my view, better to err on the side of caution. To that extent I propose to follow the example of Sir Rodger Bell in *Iqbal v Whipps Cross University Hospital NHS Trust* (see paragraph 162 above) who allowed a contingency sum of 10%.

Occupational therapy equipment

302. A number of items were in dispute between Mrs Ho and Mrs Tuckfield. I itemise them as follows:

303. (i) Replacement of wheelchair seating – The dispute is as to the frequency with which James’ wheelchair seating is replaced, Mrs Ho suggesting every 2 years (because James is a heavy wheelchair user and regular replacement is essential), Mrs Tuckfield suggesting every 2 to 3 years between the ages 12 and 18 years thereafter as frequently as the wheelchair is replaced, namely, every 5 years (which is agreed).
304. I consider that it is reasonable to replace the seating every 2 years until James is 18 and that he should have the seating replaced once during the 5-year period between every 5-year replacement of the wheelchair itself, namely, every 2½ years.
305. (ii) Spare wheelchair seating – It is said on James’ behalf that because he cannot use his wheelchair without appropriate seating, which has to be moulded especially for him and that it takes a while for his bespoke seating to be made, a spare seating system is reasonably required so that he always has appropriate seating either when his manual or power wheelchair seating fails or becomes wet. The Defendant’s case is that there is no reasonable need for such seating. He will have a spare power chair and, it is argued, the cover can be replaced and there is a wheelchair cape to wear in wet weather.
306. I think, on balance, that this is not necessary and make no allowance for it. A little ingenuity and foresight and the problem said to give rise to the need should not arise.
307. (iii) Wheelchair pump – It is said on James’ behalf that it is reasonable for him to have a suitable wheelchair tyre pump so he can pump up his tyres when necessary. Mrs Tuckfield’s says that the tyres could be pumped in a garage and that there is no reasonable need for a pump.
308. A pump apparently costs £50. It is said that it will need to be replaced every 5 years. Plainly, in my view, it is sensible and reasonable to have a pump available at all times. The alternative, if Mrs Tuckfield is right, is to get his wheelchair to the local garage. That makes no sense to me. Will it need replacing every 5 years? I doubt it. I will allow a replacement every 10 years.
309. (iv) Waterproof capes – It is said on James’ behalf that these (which cost £116 per year) are an additional item because they go over the top of an outdoor coat or jacket and protect the wheelchair. The Defendant’s case is that this is not an additional cost by reason of disability because James would have needed waterproof outer clothing in any event.
310. I cannot accept that these capes (the need for which I can understand) need to be replaced every year. I will allow the figure of £100 (reduced to take account of the need for waterproof outer clothing in any event) every 5 years.
311. (v) Replacement of wheelchair trays – I am invited to “take a view”. Every 4 years is the answer.
312. (vi) Replacement of Spectra XTR – Mrs Ho says 4 years; Mrs Tuckfield says 5. There is no science about this: 4½ years is my decision.

313. (vii) Maintenance of Spectra XTR wheelchair – It is argued that it is reasonable for James to continue to have his wheelchairs serviced and maintained by Contour at the annual cost of £1,665. Mrs Tuckfield obtained an alternative costing from Sunrise Medical for £150 per annum (although the true basis of what would be done for this figure was unclear), but she accepted that it was reasonable for James to have one point of contact and to have his wheelchairs maintained by the same company which supplied them. That was a sensible concession and it seems to me obviously desirable that the wheelchairs are maintained to the highest possible standard. I will allow the annual cost claimed.
314. (viii) Slings – It is contended that it is reasonable for James to have slings for his overhead track hoist and his portable hoist so they are always there to be used as and when necessary. It would, it is said, be inconvenient and time consuming for the slings to be transferred over. Mrs Tuckfield was of the view that the slings are interchangeable with the ceiling hoist slings, that they should accompany James wherever he goes and that it was reasonable to use the slings on the ceiling and mobile hoist. His carers can, it is said, move the slings and there is no reasonable need for a second set of identical slings.
315. I consider that James ought to have separate slings. I do not understand why they would need to be replaced every year. Replacement every 3 years seems reasonable.
316. (xi) Shower chair – It is contended that James would benefit from having a shower chair so he can have a shower, the cost of a suitable chair being £4,315. It is said that most boys of James' age will prefer a shower to a bath and that using a handheld shower in his adapted bath (Mrs Tuckfield's option) will not be the same thing.
317. I do not think that the preference for a shower (which I accept is likely) will necessarily simply remain whilst James is young and, accordingly, look on this as a legitimate long-term provision. I have little evidence, but replacement of the chair every 5 years seems excessive. I will allow replacement every 7 years.
318. (x) Electric tooth brush – This is claimed, but I cannot see that there is any justification, based upon James' disability, for claiming something that for many people is the standard means of cleaning their teeth.
319. (xi) Washing machine/tumble drier – It is contended that with two sleep-in carers constantly living in his home it is reasonable to make an additional allowance based upon a more frequent replacement of his washing machine than otherwise.
320. I do not see the real foundation for this. Washing machines require replacing from time to time. Purchasing a good one at the outset will probably mean that it will last longer, though that is not always the case. However, I cannot see the reason, based upon the consequences of James' disability, for more frequent replacement.

321. (xii) Portable table – It is suggested that this is a reasonable item. Mrs Tuckfield maintains that there is no reasonable need for such an item.
322. I do not think the case has been made out for something which, in any event, is a very modest cost.
323. (xiii) Advance seating system (and replacements) – Mrs Ho described this as “a chair on wheels” (an office type of chair with full support) which James would use when using his computer, or when he is at the table using his Neater Eater. She called a “doing chair”, not a sitting chair, and commented that James uses such a chair now (which was purchased privately) and is transferred into it and finds it comfortable. It is seen as an alternative to being in his wheelchair all the time. Mrs Tuckfield accepted that it was important for James to move position, but said that in her experience “certainly by teenage years ... children choose not to go into these functional seating systems ... [they] would rather stay in their wheelchairs.”
324. Since this provision is sought only until the age of 18, I think that it is reasonable for its replacement to be provided for, mostly because James is currently using it to his advantage and there is no indication that he is likely to cease to use it for the time being.
325. (xiv) Theraposture bed – The only issue is the cost, Mrs Ho says £4,095 and Mrs Tuckfield says £3,963.
326. A reasonable figure is £4,000.
327. (xv) Mattress protectors – The issue of whether provision for two such protectors annually in the sum of £50 each should be made depends on the nature of the bed purchased. Some beds come with the protector attached. Others do not.
328. This is a small item and I am not persuaded that it is necessary to make separate provision for it.
329. (xvi) Pressure relieving mattress – Mrs Ho suggested a portable mattress for when James is a holidaying or otherwise away from home because beds in alternative accommodation cannot be guaranteed. She recommends a “roly-poly” mattress that can be put in the luggage compartment on a plane. She said that it was “a small issue, but ... a very important issue.” If the mattress is wrong on holiday, then essentially the holiday is ruined.
330. I think there is force in that and, accordingly, regard this as a reasonable item.
331. (xvii) SP Point Swing and large trampoline – These items cost £8,480 and £5,532 respectively. They would be “one off” purchases for use during James’ remaining teenage years. The opportunity for James to engage in the kind of activities undertaken on a swing and a trampoline is not contested in principle though Mrs Tuckfield felt that they could be provided at far less expense. The Defendant contends that the provision of a swing at a cost of

£8,480 which is designed for multiple users in a playground environment is disproportionate as is a trampoline costing over of £5,500.

332. Some balance does have to be applied here. I would regard a sum of £5,000 as an appropriate provision by way of direct compensation for the need to provide facilities of this nature. If those helping James feel that the sums claimed should be spent, the balance would have to be found from his general damages.
333. (xviii) Sip and Puff Boat and a Wayfarer dingy – I will deal with these together. The sip and puff model boat costs £600 and would enable James to learn how to use sip and puff controls with a view to him controlling his own adapted dinghy in due course. Currently he goes to Rutland Water but the availability of an adapted dinghy is not guaranteed or there may be insufficient instructors available to accompany him. The contention is that by having his own adapted dinghy (which would cost £6,495) he would be able to use it more frequently and thus to spend more time on the water. It could be kept closer than Rutland Water (which is about an hour away by road) and he would be able to use it with trained carers.
334. The Defendant contends that there is no reasonable need for a sip and puff model boat and that the boats available for use at Rutland Water (which is a reasonable place for him to travel) are not operated by sip and puff controls.
335. Whilst I understand that James would like to undertake this pastime and that it would be more convenient to have his own dinghy, it is difficult to characterise the provision of such a dinghy as constituting a reasonable need that should be met by way of compensation. The ability to go sailing can be met in a different way and I agree with the argument that when he has a full team of carers in place, it should be easier to arrange sessions at Rutland Water. Accordingly, I cannot award anything under this head of claim.
336. (xix) Replacement of spare power chair – Mrs Ho says every 6 years, Mrs Tuckfield says every 7 years.
337. I will simply compromise this dispute at 6½ years.
338. (xx) Maintenance contract for spare power chair – This does not appear to be in dispute, but if it is it seems to me that the current cost is the best indicator of the reasonable costs, which I understand to be in the sum of £1,665 per annum.
339. (xxi) Seating for spare power chair – There is some evidence that the cost of this seating may be somewhat more than the £2,710 agreed between Mrs Ho and Mrs Tuckfield when they discussed matters.
340. I will, accordingly, allow a little more than the agreed sum, namely, £3,000.
341. (xxii) All-terrain power wheelchair – This kind of wheelchair, as its name suggests, is capable of coping with terrains that are rougher and more difficult than ordinary terrains. It would enable James, for example, to access the

woods near to his new home, go off the trails and enable him to go onto a beach. If he acquired a dog, it would enable him to take the dog for a walk. Mrs Tuckfield said that if this was the sort of activity that James would wish to be involved in she “could not argue” against it, her suggestion, however, being that this would be a solitary activity though she recognised that his carers would be likely to go with him. It is an expensive item - £16,500 to purchase and about £1875 per annum to maintain.

342. Mrs Ho suggested that this was “essential for James.” He is, she said, very good with his day-to-day powered wheelchair, but he wants to be doing more. The all-terrain wheelchair would enable him to do so. An all-terrain wheelchair that is set up for his seating need and his head control, would, she said, enable him to do what many of her clients are doing all the time.
343. Given the part of the country where James lives, and given the proximity of his forthcoming home to woods and countryside, I see this not only as a desirable acquisition, but as an entirely reasonable way of giving to James the opportunity to do what many uninjured in his locality, and elsewhere in the country, also do without having to think about preparing themselves to do so.
344. I agree with the proposition that such a wheelchair may be more frequently used in the earlier years of James’ life, though the pleasures of being able to “take a walk” in the woods or to take a “stroll along a beach” will still be there to be obtained in later years. In my view, this is a lifetime facility to which James is entitled.
345. Against that background, I think it reasonable to provide for the renewal of the all-terrain wheelchair every 6 years until James is 50 and then every 7 years thereafter.
346. (xxiii) Additional occupational therapy for the new home - Given that Yorke Hurst will be demolished and a new property built from scratch, it is submitted on James’ behalf that 20 hours of additional occupational therapy input should be provided on a “one-off” basis. There are, it is said, many items of equipment to position and consider which would involve working with the architects and the surveyors and engaging in site visits. Mrs Ho recommends 20 sessions and Mrs Tuckfield recommends 10 sessions for this purpose.
347. I cannot choose between these views and will simply “split the difference” on this issue and allow 15 hours which will presumably be spread between the year when the house is being built and the initial stages after the works are complete or nearing completion. At all events, it is a “one-off” provision.

Future travel and transport

348. There is no issue about the need to purchase a VW Caravelle at a cost of £42,000. There are ancillary issues concerning the periodic replacement, running costs and other matters arising from that vehicle. There is an issue about whether the purchase of an adapted motorhome is reasonable.

349. There is also a preliminary issue concerning the appropriate approach to the calculation of future travel and transport. This was not developed in the oral argument or indeed in the oral evidence and I feel less equipped to deal with it than I might otherwise have been had the issue been argued in this way. Whilst it is a while since I have had to consider the matter, my perception is that the way the Defendant contends that the issue should be approached is the established and conventional approach and that the approach advanced on James' behalf is somewhat novel. My preference, therefore, is to adhere to the established approach.
350. That involves periodic replacement of the VW Caravelle, with appropriate credit to be given for vehicles that would have been owned in any event, and provision to be made for increased associated costs (in other words, increased depreciation and increased standing costs associated with driving a larger, more expensive vehicle). I believe that all I need to do is to indicate my conclusions about the frequency of the periodic replacement of the VW Caravelle and the likely cost of a vehicle for James had he not been disabled (and when that would have been acquired) and the parties should thereafter be able to do the necessary calculations.
- (i) replacement of VW Caravelle and associated issues
351. The Defendant's contention is that since this vehicle will have a warranty, be properly serviced and maintained and probably not travel more than 10,000 miles per annum, 8-yearly replacement is reasonable. It is said that the Motability Scheme has a standard 5 years for wheelchair accessible vehicles which can be extended to 7 years.
352. Mrs Ho suggests a replacement period of 4 years and emphasis is placed on the importance for James of having a reliable vehicle because he would be unable to rely upon public transport in the event of a breakdown. It is suggested that it is noteworthy that the Motability Scheme provides for replacement new standard vehicles every 3 years and every 5 years for wheelchair accessible vehicles.
353. To some extent the appropriate replacement period will depend upon the likely annual mileage to which James' vehicle is exposed as the Defendant's contention suggests. That is rather difficult to assess. I suspect that there may be less mileage with advancing years but rather more in the period until, say, he is in his mid-40s to 50. However, I think it more appropriate to alight upon a lifetime replacement period and, so far as possible, a lifetime additional mileage per year arising from his disabilities.
354. Mrs Ho accepted that a 5-year replacement period was reasonable even though she would have preferred 4 years. A 5-year period is consistent with the decisions in *Lewis v Shrewsbury NHS Trust* LTL (see above) for a VW Caravelle, in *A v Powys Local Health Board* [2007] EWHC 2996 (QB) and in *Noble v Owens* [2008] EWHC 359 for a Chrysler Voyager, and in *Morgan v Phillips* LTL 29/9/08 for a Fiat Multipa. It is close to the 4½-year replacement period agreed for a VW Caravelle in the case of *Totham v St. George's NHS Trust* (see above). Accordingly, I choose a 5-year replacement period.

355. Should credit be given for the costs of a car that James would have acquired in any event? In accordance with the approach in *Whiten* (see above) at [476-477], I think that some credit should be given. In *Whiten* the claimant was also male, but appears to have been a Londoner, and Swift J felt that he would not have acquired a vehicle until he was 25 because it would be expensive to run in the city environment. It is suggested on James' behalf that he should give credit for a car costing up to £13,000 new as from the age of 18. I am, of course, reluctant to take a different course from that which, arguably, is generous to the Defendant when it has been offered on behalf of a claimant, but I do not think that, whatever prosperous future might have awaited James without his disabilities in the longer term, he would have been able to afford a new car at £13,000 at the age of 18. He is more likely to have acquired something of a more modest type if he had acquired a vehicle at all at that age. I think the best way of reconciling the competing interests here is for the calculations to be carried out on the basis that he would have acquired a new vehicle at £13,000 at the age of 23. So far as the longer term is concerned, it is suggested on his behalf that credit should be given for a car costing £13,000 to £18,000 new from the age of 35 onwards. That does accord more clearly with my view of his future but for his disabilities. I will say that credit for a new car in the sum of £18,000 should be given after the age of 35.
356. It is argued that James is likely to incur additional mileage for various reasons including attending medical and therapy appointments, orthotic appointments, picking up prescriptions, trialling and picking up equipment and so on. It is suggested that an additional 5,000 miles per annum is reasonable. The Defendant accepts that it would be reasonable to allow an additional 5,000 miles per annum to age 18 years but suggests that it is unlikely that there will be significantly increased mileage as an adult.
357. Knowing what I do about James' enthusiasm for doing as much as he can, I consider it likely that he will be demanding of his carers to take him out of his home as much as possible in the future and not just in his teenage years. Against that background, I think it would be appropriate still to provide for extra mileage after the age of 18 arising from his disability. Given that he will be living in a somewhat more rural setting than the claimant in *Whiten*, I propose to take 3,000 miles per annum after the age of 18 as the additional mileage figure.
358. There will be a need for additional insurance cover for carers to drive his adapted vehicle. Mrs Ho's estimate is £2,000 per annum. Mrs Tuckfield suggested a range of between £500 and £2,000 and took a mid-point of £1,250. Mrs Ho said her experience was that the costing was nearer £2,000 and in some cases up to £3,000.
359. I think this evidence is persuasive and I will allow £2,000.
360. A claim of £84 pa is advanced for new carers to have lessons to prepare them for driving a larger vehicle than they are used to. I consider this unnecessary. Other, more informal arrangements can be made.

361. A claim is for washing and valeting James' car is made. I suspect that if he was a busy person (which my view as to his likely future would suggest), he might well have incurred that expenditure in any event. I make no allowance for this.
362. Given my finding that James is unlikely to have children in the future, I have been asked to determine whether but for his disabilities he probably would have shared his transport expenses with a wife or partner with the result, as I understand the argument, that he should be credited for mileage that he would have travelled in any event on a shared basis (or shared costs basis) with his wife or partner.
363. I am inclined to think that Miss Greaney's argument is correct, namely, that I am being invited to speculate on how many journeys would have been shared between James and his wife or partner when I do not have the evidence reliably to calculate any deduction on this basis. A whole variety of unknown factors (such as where his wife or partner worked and whether she would have had her own vehicle) contribute to a scenario of uncertainty in this regard. I do not think I can make any allowance for this.

(ii) Adapted Motorhome

364. A one-off expenditure of just over £96,000 is claimed (with annual refurbishment costs of £1,000) to purchase a Kon Tiki motorhome to enable James to go on caravanning and camping holidays, a particular feature of his mother's family tradition. It is accepted that it is not possible to rent such a vehicle and it would need to be customised for James. It is said to be the only way for James to be able to attend certain events such as a music festival or to visit or stay with friends or family who do not have adapted facilities or space for him in their homes. There is also the issue of long journeys when finding suitable toilet facilities is difficult. Mrs Beesley gave evidence of many places that advertise the existence of disabled facilities which would be unsuitable or incapable of accommodating James' wheelchair. Equally, whilst the evidence suggested that the number of accessible toilets generally is increasing she gave evidence that they were still "few and far between" in Lincolnshire. It is acknowledged that a motorhome could be used for holidays in Europe although there would be costly ferry tickets, toll charges, fuel expenses, breakdown recovery insurance and hotel stop-over costs on any such venture.
365. The Defendant accepts that Mrs Adams' parents have always enjoyed caravanning and camping holidays, but it observes that, sadly, her mother has passed away recently and it is suggested that it is unlikely that James will continue to go on holiday with his grandfather for much longer. He may or may not go on holiday with his mother as an adult, it is said. It is argued that it is reasonable to make provision for long and short haul holidays and for Calvert Trust visits to the age of 18 years. Thereafter, it is said that "provision can be made for weekend breaks in suitably equipped accommodation." Attention is drawn to the purchase cost and it is argued that it would be disproportionate to make such costly provision for something that is not proven to provide a benefit that will enhance James' quality of life in a manner that cannot be achieved in other ways.

366. This claim is made as a separate item from the increased holiday costs to which I will refer below. Since the two issues are, at least in part, related I will deal with that claim before coming to a view of the two claims together.

Increased holiday costs

367. The increased holiday costs have helpfully been agreed at £11,000 per holiday for European holidays and £14,000 per holiday for long-haul holidays. The main issue is how frequently James is likely to go on long-haul trips in the future although, as I have indicated, there may be an impact on the provision made for the frequency of the European holidays at the additional figure indicated if I allowed the claim for the motorhome because some of those holidays are likely to be enjoyed by using the motorhome.
368. It is said on James' behalf that provision for long-haul holidays ought to be made on a bi-annual basis – every 2 years – and that the same should apply to European holidays, the two types of holiday alternating. The Defendant's argument is that the likely pattern of long-haul holidays but for James' disabilities would have been once every 5 years on the basis that he would have had an income commensurate with vocational qualifications and that, accordingly, his decision to undertake such trips would have been reduced accordingly.
369. I do not necessarily share the premise of the Defendant's argument, but experience shows that families, in particular, will generally undertake long-haul holidays less frequently than short-haul holidays, largely on the grounds of expense and being able to fit such a holiday into the schedules of everyone within the family. I think it is not unreasonable to conclude that throughout his life but for his disability James would have taken a long-haul holiday on average every 3 years, either with his family when he was still living with them or on his own (perhaps with any family he may have had). In the meantime he would have taken an annual holiday either in Europe or the UK. Will he do the same given his disabilities? Whether he will travel long-haul as much is open to question, but Mrs Sargent's evidence concerning the way in which those travellers with serious disabilities such as those possessed by James are accommodated nowadays is sufficiently compelling for me to conclude that this pattern will probably be replicated in his case. There has already been one successful long-haul trip to Florida. To that extent, I do not think it is unreasonable to calculate at least part of the future additional cost of holidays upon this basis.
370. If James has the advantage of the motorhome, then I consider that he will not necessarily take a European holiday every year because he will have the ability to go anywhere in the UK in reasonable comfort with all the facilities at hand that he needs. If he does not have the motorhome, I believe he would look for the relative "luxury" of going somewhere every year where some sunshine could be guaranteed.
371. There are strong arguments in favour of the motorhome in James' case, not arising solely from the caravanning tradition within the family. It will give him some independence that would only arise otherwise if there were disabled

facilities around the country that would cater adequately for his needs. The evidence suggests otherwise. The clear downside is the capital cost involved. However, as I have said, I think there will be less of an incentive to take regular foreign holidays in Europe if he has the motorhome and, to that extent, some of the immediate expenditure will be “saved” over his lifetime. Equally, some of the near European holidays might well be taken utilising the motorhome with, I would imagine, some saving of cost.

372. I will, therefore, allow as a head of claim the acquisition of the motorhome (with the annual refurbishment costs claimed), but on condition that future additional holiday costs are calculated on the basis that over any 3-year period there will be one long-haul holiday, one European holiday (on a full additional cost basis) and one UK holiday utilising the motorhome. I will invite the parties to endeavour to agree the additional cost that is attributable to such a holiday, in default of which I will decide the matter on the basis of written submissions.
373. The annual cost of activity holidays at the Calvert Trust to age 18 years has been agreed at £3,000 per annum (see Appendix). The remaining issue is whether an allowance should be made for weekend/city breaks at the cost of £3,000 per annum (to allow for 2 short breaks per annum) from the age 18 years. Largely because of the significant capital cost of the motorhome, I propose to make a broad-brush deduction of what would otherwise be a reasonable claim for this kind of break to one of £1,000 per annum.

Future information technology

374. There remain a number of issues concerning the future provision of aspects of information and other technology. I will deal with each separately below.
375. (i) back-up eye-gaze system – It is agreed that James requires a principal eye-gaze system (at the initial cost of £12,699) which will need replacement every 3 years (see Appendix, paragraph 10(1)). There is an issue as to how the need for a back-up system if his principal system malfunctions should be provided. Dr Beale’s recommendation is for a second integrated I-15 My Tobii system, given that it is accepted that the My Tobii I-15 is the best system for James to use – in other words, an entirely separate system should be purchased every 3 years at the same cost as the principal system. Mr Clayton has suggested a PCEye Go – a slim eye gaze unit that can attach to any laptop, computer tablet and desktop. It is argued that this is a very flexible option and would provide a reasonable temporary back-up system. It costs about £3,000.
376. I accept the importance of the eye-gaze system for James and I can well understand the frustration should it malfunction. However, I do not think it is reasonable or proportionate to have an entirely identical system, possibly lying idle for 3 years, just to cater for that eventuality. Many people have to put up with similar frustrations. It seems to me that what Mr Clayton suggests would be a reasonable temporary “make do” system if, contrary to his expectation, the warranty (perhaps of an extended nature) relating to the principal system does not provide for a temporary replacement whilst it is repaired.

377. (ii) touch screen tablet – There is no dispute that James requires one. Dr Beale says it will cost £2,000 because of the need for a system with “hot swappable batteries”, whereas Mr Clayton says that this is not necessary and the requirement could be met for £1,000.
378. I cannot really resolve that difference and propose simply to split the difference on this. I allow £1,500.
379. (iii) digital camera – The difference between Mr Clayton’s position and that of Dr Beale is that he has allowed the cost of the basic customisation of a digital camera for James’ use whereas Dr Beale has allowed for a more specialised pan and tilt function. Dr Beale allowed £500 for the camera and £1,000 for customisation, but recognised the need to deduct £100-200 for a standard camera. It is suggested that it is reasonable for James to have control over the same functions (such as pan and tilt and zoom) that he would have been able to control had he been able to hold and operate a camera himself.
380. The Defendant’s case is that there is no evidence that James has a particular interest in photography. It is, it is said, more likely that but for his injuries he would have owned a standard digital camera and that the basic customisation costs meet reasonable provision and are proportionate.
381. Dr Beale’s approach costs £1,350 with a 3-year replacement period; Mr Clayton’s involves an initial cost of £500 with a 5-year replacement period.
382. Whilst it may be true that James has not yet demonstrated a particular interest in photography, he is only 12 and may not yet have been offered the opportunity to use a camera that is designed for his use. With his general interest in things that he does and sees, and with the opportunity for travel, I am sure he will wish to record scenes and events from time to time. I am inclined to think that Dr Beale’s solution is rather more expensive than reasonably necessary and a fair compromise of the competing solutions is to allow a £500 initial cost with a 4-year replacement period.
383. (iv) Wireless music system – I can deal with this very shortly.
384. Wireless computer based music systems are increasingly common and I am sure James would have had one (or something similar) irrespective of his disability.
385. (v) Height adjustable table – The experts present a range of cost between £750 and £1,000 plus VAT and a range of replacement periods of 7-10 years.
386. I will allow £1,000 (inclusive of VAT) and an 8-year replacement period.
387. (vi) customisation of printer, scanner and copier – Based upon Dr Beale’s view it is submitted on James’ behalf that it is reasonable to allow £250 (which takes into account £200 for standard costs) every 3 years for the customisation of printer, scanner and copier to be operated with the eye-gaze system. Mr Clayton said that while the grids need to be set up, the printers do not need to be customised.

388. I think it reasonable to make some provision for this given the importance in James' life of the eye-gaze system. I would have thought £200 every 3 years would be reasonable.
389. (vii) Customisation of special needs software – It is not disputed that this is reasonably necessary and that it will be necessary every 3 years. Just as customisation is crucial for successful use of eye-gaze equipment itself, the associated software also needs to be customised although Mr Clayton suggested that not much of this software would need to be customised for James. He suggested a 3-yearly figure of £3,500. Dr Beale suggested £6,500 based upon direct personal experience.
390. Again, I doubt that I will do either party an injustice if I take £5,000 as the 3-yearly cost.
391. (viii) Visits for installation, assessment and training – Again, the need for this on a 3-yearly basis is not in issue. Dr Beale says £4,500; Mr Clayton says £3,500.
392. I will say £4,000.
393. It is not disputed that James will need certain environmental controls which he can operate using the eye-gaze system (see paragraph 10 of the Appendix) and I do not apprehend that it is seriously in dispute that James has the cognitive capacity to appreciate when he wants to alter his own internal environment as all who are not so disabled may do and that he has an appreciation (which will doubtless increase) of safety considerations. However, some items remain in dispute.
394. (ix) External door openers - The issue here is whether all external doors should be motorised and be capable of being operated by James. Each door so motorised would cost £2,500 and there would be a need to replace each one every 10 years. So much is agreed. Whilst the final design of the new home remains to be concluded, it is likely that there will be 4-5 external doors, 5 being the more likely figure. Mr Block and Miss Greaney submit that, having regard (i) to the safety issues that this would present, (ii) to the normal use of such doors and the barrier created by such doors given the number of support staff and therapists that will visit the property and (iii) the proposition that James will be supported at all times by two carers, there is a balance to be struck between respecting James' autonomy and the practical implications of motorising all external doors. Mr Clayton had suggested that motorising 2 doors would be sufficient. Ms Rodway and Mr Latimer-Sayer submit that all such doors should be motorised.
395. There is some uncertainty at present about the precise layout of the house, but I do see the desirability of James having control over the main doors within the property. In my view, if funds are provided for the motorisation of 4 doors, adequate and proportionate provision will have been made. That will doubtless be born in mind in the design of the property.

396. (x) CCTV – The contention here is that James will have a large number of strangers coming into his house and for safety reasons CCTV is suggested as a means of “keeping an eye on his carers and checking the facts e.g. that a particular night was a waking care night.” It also offers, it is argued, a measure of protection against would-be burglars in the future as he will be vulnerable. The countervailing argument so far as the carers are concerned is that James will have two carers in attendance at all times which is a distinguishing feature from the usual situation of one carer being present.
397. I have to say that I do not consider that this is a necessary or reasonable provision. Whilst James will, of course, be vulnerable to some extent, I would have thought carers would find CCTV intrusive and although the occasional recruitment of an unsatisfactory carer can never be avoided completely, there will be a sufficient number of professionals coming and going on a regular basis (together with the close attention that Mrs Adams and her family and the case manager/team leader will keep on what is going on) for any problems to emerge quite quickly.
398. (xi) Door intercom system – This is a relatively inexpensive item (£330 every 10 years) and the suggestion is that when he is older, it is reasonable for James to be able to see who is at the door and let them in. Whilst there will be two carers in attendance at all times in the property (which, in my view, negates the need for an electric gate and garage door: see below), this is such a modest item that I am prepared to allow it.
399. (xii) Electric gate and garage door – The combined cost of these items is £7,000 every 10 years. The argument in favour is that James will have the cognitive capacity to operate these and there is no reason why he should not be able to control these himself rather than being reliant upon his carers.
400. I see the argument, but there is need for proportionality here and there does seem to me to be some advantage in only the carers being able to open the gates to the property from the safety and security point of view. They will doubtless consult James in the event of any doubts.
401. I do not propose to allow either of these items.
402. (xiii) Pager system and video surveillance – This costs £1,200 replaceable every 10 years. The pager/surveillance system is recommended by Dr Beale so that James, when he is left on his own, can call for help and the carers can speak to him and see him on a video surveillance screen before responding to his call for assistance. The Defendant contends that there is no reasonable need for such a system given the comprehensive package of care that will be provided.
403. It does seem to me that the provision of this system is reasonable and desirable. James will find it oppressive if there is a carer in, for example, his day-room every minute of the day keeping an eye on him. He and the carers will need some space and this system will help to ensure that, if James gets into trouble whilst on his own, someone can be called quickly. It is, in the

scale of things, not too expensive and therefore constitutes a proportionate response to an identifiable need.

404. (xiv) Installation, programming and training – It is agreed that provision must be made for this every 10 years. Dr Beale suggests £5,000, Mr Clayton suggests £4,000. The appropriate figure depends upon the amount of equipment I have determined that it is reasonable to provide.
405. Since I have disallowed one or two quite significant items of equipment, I think that £4,000 is the appropriate figure.
406. (xv) Consultancy with architect – This provision is designed to enable liaison between the architect for the new accommodation and AT supplier. It is said to arise every 10 years, though I do not quite understand why that should be so. I should have thought that this is essentially “one-off” expenditure with perhaps a need to revisit issues occasionally. Mr Clayton suggests £500 based on one day of liaison; Dr Beale suggests 3 days costing £1,500.
407. I will allow £1,000 on a “one-off” basis for the new accommodation and then £500 once for every 10-year period thereafter.
408. (xvi) Development of AT hardware – The figure claimed here is £2,500 every 10 years. The rationale is said to be the need for the environmental controls (which are usually operated by way of infrared or voice commands) to be customised for use with James’ eye-gaze equipment. Mr Clayton was of the view that no such provision is required because James is an eye-gaze user. The hardware, he says, will still be set up using an infrared system. Dr Beale says that this provision is needed to adapt James's AT system so that it can control the rest of the environmental system, which is normally controlled by physical buttons or physical remote control.
409. The position here is not as clear as I might have wished, though I accept that the importance of the eye-gaze system to James as being the essential means by which he can control things around him. I will have to paint yet again with a fairly broad brush and will allow £1,500 for this item every 10 years.

Other miscellaneous expenses

410. Two specific items have been agreed (section 12 of the Appendix), but there are some remaining issues:
411. (i) Additional clothing costs – The issue is whether the annual allowance should be £500 or £200 or some intermediate level. On behalf of James it is contended that he will require more frequent changes of clothing because of drooling, occasional accidents and messy eating although Mrs Ho largely estimated the £500 allowance on the basis that he will get hot in the wheelchair and his clothes will require more frequent washing resulting in more frequent replacement. In addition, it is said that James scuffs his shoes and these need to be replaced more frequently. Mrs Tuckfield’s estimate is

based on the fact that James would have required frequent replacement of clothing as a child in any event.

412. There are undoubtedly features of James' presentation that will lead to greater wear and tear on clothing and a continuing need for their replacement beyond the norm. I would have thought that £400 per annum would suffice for this purpose.
413. (ii) Additional bed linen and towels for James – It is said that James requires a lot of extra towels for bathing. Mrs Adams spoke of this and estimated the additional expenditure on towels at £148 pa. Also continues to have occasional accidents, requiring his bedding to be changed leading to more frequent replacement of his bedding. It is suggested that £200 per annum should be set aside for this. The Defendant submits that James is now ordinarily continent and the occasional accident at night should not give rise to a claim for additional bed linen and towels.
414. For my part, I consider that the modest additional expenditure on these items each year will be covered adequately by the £400 per annum I allowed under (i) above.
415. (iii) Bed linen and towels for carers – The argument is that since it is now agreed that James requires two sleep-in carers at night their bedding and towels will need changing and washing every few days leading to more frequent replacement. Mrs Tuckfield suggested that the carers' bedding and towels which is used frequently can be replaced every 6 years. This is disputed on James' behalf, the suggestion being that there will be a need for 4 sets of bedding and towels which are cleaned on a regular basis if two sleep-in carers are required.
416. I consider that any claim is modest here and will allow £150 per annum.
417. (iv) Sundries – This claim relates to items like kitchen rolls, toilet paper for carers, disinfectant, wipes, antibacterial sprays and so on which are required in greater quantities because of James' disabilities. It is not disputed in principle – Mrs Ho suggests £20 per week (£1,040 per annum) and Mrs Tuckfield suggests £10 per week.
418. I will allow £750 per annum.
419. (v) Increased toys/games/equipment - Mrs Ho suggests an increased allowance for toys/games/equipment because James damages games, toys and books as a result of his athetoid movements. Furthermore, disabled toys and games are generally more expensive because they need to be adapted. The Defendant argues that there is provision in the claim for garden play equipment, computer software, physiotherapy balls and other equipment. It is unlikely in these circumstances that additional costs will be incurred. There is, it is argued, no reasonable need for an additional allowance. Mrs Ho accepted that the claim should only run “until such time as he has all the computer equipment”.

420. I do not think the fact that other equipment designed for enjoyment has been included in the claim undermines this claim in principle, but the allowance really does need to be modest. I will allow £150 per annum until the age of 16 by which time all the computer equipment should be well and truly in place.
421. (vi) Gardening/decorating/DIY – This is agreed in principle in the sum of £1,500 per annum. There has been a suggestion by the Defendant that this was provided for in the accommodation claim. Ms Rodway and Mr Latimer-Sayer say that it is not and have given reasons in writing why that is not so. In the absence of any response on behalf of the Defendant I will take that as the position. An issue has arisen as to when it should be seen as commencing. Mrs Ho had advanced the claim from when James became 25 and she confirmed this in her evidence. The logic of starting it then was not questioned by either James’ legal team or by the Defendant’s team and the issue went somewhat by default.
422. I can see the logic of saying that it should start immediately on James taking up occupation in his completed new property and, accordingly, allow that sum per annum from, for convenience, 2 years hence – say upon James attaining the age of 14½ years.
423. (vii) Increased telephone costs – This is agreed in principle subject to proof of the figure claimed, namely, £120 per annum. That figure was based upon some unchallenged evidence of Mrs Adams. My understanding was that this was to be left to me to make an assessment.
424. I do not doubt Mrs Adams’ evidence, but I am sure that as the new care regime settles down and everyday life becomes more routine, there will be less need for additional landline calls. I accept they may, however, be more frequent because of James’ disabilities. £75 per annum should comfortably cover this.
425. (viii) Additional cleaning costs – Approximately £1,500 per annum is claimed for the additional costs of cleaning the larger property that James will live in. The Defendant argues that there is no reasonable need for this provision. It is said that (as is the case now) he will have two carers and there is evidence that the existing carers undertake some cleaning and other domestic tasks. Mrs Adams did indeed describe how they tidied up after James and sometimes did some ironing. The contention is advanced that in future “[the] requirement to undertake cleaning can be written into the carer’s contracts.”
426. Although Mrs Tuckfield seemed to think that was established practice, I am bound to say that it seems odd to me that people engaged to be carers should also be expected to be domestic cleaners. Of course, to some extent they will be responsible for general tidying up from time to time (including ironing and so on), but their primary responsibility will be to care for James with his complex care needs. I think Mrs Tuckfield accepted that they would not be responsible for any “deep clean” of the property.

427. I think that this head of claim is legitimate, but it is, perhaps, open to question whether as much as £30 per week will be spent on this. I will make an allowance of £1,000 per annum.
428. (ix) Activities – Since, unfortunately, James is unlikely to obtain paid employment, he will need to fill his time with activities. Mrs Ho has suggested an allowance of £25 per week for the additional cost of these activities. The Defendant contends that there is no reasonable need for this allowance because James would have had leisure pursuits in any event that would doubtless have cost something to pursue. It is emphasised also that provision has been made for play equipment in the garden, soft play equipment and a football wheelchair to age 30.
429. I think the Defendant’s argument is sound and I accept it.
430. (x) Additional Car Parking – A little over £60 per annum is sought for the additional car parking costs said to arise out of James’ disability - e.g. attending medical and therapy appointments, orthotic appointments, buying equipment and so on. Further additional car parking charges have been incurred when carers have accompanied him and his father to the cinema.
431. This kind of claim is difficult to quantify, but I regard it as *de minimis* in any event in the scale of a claim of this kind. I do not propose to make any allowance.

Future management of the award, MDT meetings and Mrs Adams’ position

432. I have put these various matters together because there is a loose inter-relation between some of them.

Deputyship costs

433. A major issue has arisen in this case about the Deputyship costs. The issues I have to consider relate to the future costs (and those specific issues are identified in the schedule set out in paragraph 447 below), but the Defendant has raised concerns about the past costs which, it is said, should inform my assessment of the future costs. As it is, the past costs have been agreed, but the Defendant seeks to make a number of criticisms about the manner in which they were charged, evidenced, it is said, by the manner in which they were subsequently assessed by the court. I am not really satisfied that what has happened in the past is relevant to my assessment of these costs in the future save, perhaps, in respect of the effect that Mrs Adams’ continued involvement in James’ life and his care in the future may have on those costs. To that extent I do not propose to deal with this aspect of the Defendant’s case in any detail. I regard it as unfortunate that the issues should have been raised in the manner they have.
434. As previously indicated, James’ Deputy is Mrs Denise Stephens who, of course, acts also as his litigation solicitor. Mrs Stephens is a well-known and experienced solicitor in the clinical negligence and serious personal injury sphere. She is now a partner with Shoosmiths, having formerly been with

another well-known firm in Hampshire, Moore Blatch. She transferred from Moore Blatch to Shoosmiths in 2011. She was handling James' case whilst at Moore Blatch and took the case with her on her move to Shoosmiths. She has been doing Court of Protection work for about 10 years and is currently a Deputy in 8 cases, with one other potential case pending. Whilst there are, of course, obvious differences in the two roles there is no objection in principle to a claimant's litigation solicitor acting also as his or her Deputy: it can result in a saving of costs and the relationship with the family will often have built up over a period which can prove a benefit. I do not understand that to be in issue. She said that she does about 90% litigation and 10% Deputyship work.

435. The particular focus of the criticisms made by the Defendant in relation to the past Deputyship costs was for the period from 31 May 2011 to 31 May 2013. The bill for the Deputyship costs submitted for assessment by the Supreme Court Costs Office was in the sum of £44,923 and it was reduced on the eventual assessment to £27,978, a reduction of approximately 38%. In fact it should be noted that the amount by which costs attributable to the Deputy's work were reduced by about 11%, the usual reduction, according to Mrs Christine Bunting, the expert called on behalf of James, being between 5-15%. That reduced figure has been the agreed figure for the Deputyship costs during that period – or at least has been included within the figure of £1.3 million for past costs. As for the period since 31 May 2013 I propose to assume that the parties will accept whatever costs are assessed by the Cost Officer or the Costs Master of the Court of Protection.
436. No suggestion is made that Shoosmiths billed for work that was not carried out. Equally, although Mr Hugh Jones, the expert called by the Defendant, had at one stage raised the spectre that some of the work charged was outside the scope of Mrs Stephens' authority, that she had wrongly charged work as the litigation solicitor to Deputy work or had duplicated case management work, none of these suggestions was pursued in cross-examination of her and he could advance nothing in support of these suggestions when he gave evidence. However, the assertion is made on the Defendant's behalf that "Mrs Stephens has to date failed to properly manage the estate within the agreed confines of cost-effectiveness and proportionality" and that she showed a "lack of understanding of her duty as a Deputy". It is suggested that billing for all work done as a Deputy and leaving it to the Costs Master to reduce the bill to an appropriate level was wrong.
437. The basis of that suggestion is that the bill submitted to the Costs Master was prepared by simply translating into the bill the work done by each fee-earner at the hourly rate specified in the current Guideline Hourly Rates irrespective of whether the work done by that fee-earner was work that demanded the attention of that level of fee-earner. Stripping this suggestion down to its bare essentials means that there was a fair amount of work charged out at Grade A rates when the nature of the work probably only justified Grade D rates. The Grade A fee-earners were Mrs Stephens herself and another colleague at Shoosmiths. As I have indicated, although there was a large reduction in the bill submitted (unusually large, as Mrs Stephens herself acknowledged on the

basis of her personal experience), the percentage reduction attributable to the Deputyship time spent being within the average bracket.

438. The origin of the suggestion I have identified in paragraph 436 above was, I think, Mr Jones who described the bill for the relevant in his report or witness statement period as “grossly excessive” although it emerged that he had not at that stage read the 21 Deputyship files that covered the relevant period. Whilst his view was, to some extent, vindicated by the ultimate view of the Costs Officer, I think it regrettable that such an opinion was advanced without having looked at the files in what, on any view, is a difficult case.
439. Turning briefly to the assessment of the bill, there is a procedure whereby, following a review by the Costs Officer of his or her first assessment of a bill, an oral hearing can be requested. I understand that it does not happen that frequently, but it is open to a Deputy to request such a hearing if it is felt that the reviewed assessment is still not satisfactory. Mrs Stephens said that she did not avail herself of that opportunity. Had she done so, it is, of course, possible that some of the significant reductions might have been modified if, as a result, the real difficulties in this case had been put forward to the Costs Officer or the Costs Master. (I think I should observe that the description of the background to the bill of costs submitted, which is given on the first page of the bill, will not necessarily have conveyed to the Costs Officer the difficulties experienced by Mrs Stephens with Mrs Adams during the relevant period, to which I will refer below, and some of the complexities of the situation.) At all events, whether that would have been the result of an oral hearing is unknown, but it is partly for that general reason that I reject the submission made by Mr Block and Miss Greaney that the annual costs thus assessed “are highly relevant to the future costs.” They suggest that, split evenly, these are about £14,000 per annum, inclusive of disbursements and VAT, and that since there was during the relevant period at least one relocation to a rental property, the purchase of Yorke Hurst, the change from primary to secondary education, the existence of an outstanding SENDT appeal, the organisation of case manager, therapists, carers, aids and equipment, vehicle and so on, this should be seen as the appropriate figure by which to judge the cost of the reduced Deputyship activity in the following years.
440. What has emerged is that the reasons for the large bill were derived from a combination of factors. First, it is quite plain from Mrs Beesley’s evidence that Mrs Adams has found decision-making extremely difficult. That is, I emphasise, no criticism of her: the difficulties that she has had to confront over the 12 years since James was born have been set out above (see paragraphs 21 - 32). It is simply a fact. I do not propose to recite all the matters mentioned by Mrs Beesley, but it has been very difficult to get Mrs Adams to commit to a number of matters and that has extended the time spent by Mrs Beesley, as case manager, on her tasks. Inevitably, that same general problem has, to some extent, affected the time spent by Mrs Stephens in her role as Deputy. She has spoken of the need from time to time to spend two or three hours with Mrs Adams (having travelled many miles from her office to Lincoln and back). She too gave examples of issues that were time-

consuming in that role: for example, Mrs Adams delayed filling in a form for Disability Living Allowance so that James could have a vehicle under the Motability scheme, something Mrs Stephens had to unravel. Getting Mrs Adams to focus on the need to challenge the Statement of Educational Needs for James was also time-consuming. These are just two examples. The second broad explanation for the large bill derive from the change of firm for Mrs Stephens and the need to set in place in her new firm a deputyship structure that was more streamlined than before and that during the relevant period there was a need to employ a Grade A solicitor for quite a lot of the work that would ordinarily have been carried out by someone of lower grade, that need arising from maternity leave.

441. If there was to be any criticism of the bill generally, it might be that someone within Shoosmiths should have taken the time to identify those situations where a Grade A fee-earner's time (albeit incurred in fact) ought to have been charged out at a lower grade fee-earner's rate. However, the evidence was that this practice, though obviously desirable if possible and indeed carried out in some cases, is not the current universal practice. That being so, I cannot see how Mrs Stephens or her firm can be criticised for submitting the bill in the form that it was submitted and leaving the assessment to the Costs Officer.
442. What is much more important is how the future costs are to be assessed and it is to that issue that I will turn after expressing my conclusions on the impact that Mrs Adams will have on the future arrangements for James.

Mrs Adams in the future

443. I have already indicated my view that Mrs Adams will continue to play an important role in James life. At least until he is 18, and almost certainly for several (probably many) years thereafter, she will continue to live in the new accommodation that is to be provided for him subject, of course, to any change in her personal circumstances. Even if she moves out at some stage and even if (which I very much hope for her sake that she does) she obtains some employment in order to put her obvious skills to good use, she will continue worrying about and being concerned for James as any parent does for any child even when the child is an adult, but more particularly so having regard to his disabilities and vulnerabilities. She will undoubtedly remain very close to James even if she moves out of the property.
444. With the passage of time, I am sure her anxieties will subside and, on the balance of probabilities, her psychological difficulties will improve once the new accommodation and care regime have bedded down. However, I am sure that any case manager and Deputy will have to consider her views in the longer term because it would be unrealistic to assume that she and James will not communicate and discuss issues concerning his life and welfare. It is recognised on all sides that James has cognitive skills and that, within the limits of the systems available to him, will be able to communicate his views and those views will have to be taken into account. My conclusion, therefore, is that built into the assessment of the future Deputyship costs must be adequate provision for including Mrs Adams in the discussions, making some allowance for the fact that she may wish to discuss matters for longer than in

other cases. Equally, of course, though one hopes it will not happen, there may come a time when she and James disagree about important matters. At that stage the role of the Deputy may increase significantly, both in discussing matters with James and with Mrs Adams. It is not, of course, beyond the realms of possibility that James' natural father may become more involved in the future.

445. I would add this observation in relation to Mrs Adams. I do not consider it realistic to suppose that the moment this case is finally over and the precise amount of the damages is settled Mrs Adams' mental state will start improving immediately. Over the passage of time, I am sure it will do so, but the immediate aftermath of the final resolution of this case will involve decisions about the property, additional carers and how James' education and welfare are to be dealt with in the next few, potentially difficult, teenage years. That will undoubtedly give rise to anxieties that will, at least to some extent, simply replace those associated with the litigation itself. This will, I am sure, present its challenges to all concerned.
446. That, therefore, is my general conclusion in relation to Mrs Adams and the impact that her position will have on the future costs of the Deputyship. I must now look at the specific items that remain in dispute.

The remaining issues

447. The remaining issues are reflected in the following table prepared by Mr Latimer-Sayer and agreed by Miss Greaney. I should explain that Year 1 is to reflect the first year after the final conclusion of these proceedings (and the other years find their place accordingly) and 'CoP', of course, stands for Court of Protection.

ISSUE	CLAIMANT (£)	DEFENDANT (£)
1. Year 1 CoP and Deputyship costs	45,399	12,293 Mr Jones allows an additional £2,000
2. Year 2 CoP and Deputyship costs	31,776	9,734
3. Annual Co P and Deputyship costs from Year 3 to age 18	26,688	7,175
4. Annual CoP and Deputyship costs from age 18	31,776	7,175 Mr Jones allows an additional £1,000 - £1,500
5. Allowance for contingencies ²	30,000.00	22,500 to 30,000 ³

² Mrs Bunting assessed the total Deputyship cost of dealing with an unexpected crisis at £7,202 on each occasion and allowing for 5 or 6 unknown events and discounting for accelerated receipt, the sum of £30,000 is claimed.

ISSUE	CLAIMANT (£)	DEFENDANT (£)
6. Additional applications to CoP within C's lifetime	4,044 ⁴ x 2 applications	n/a – included in the sum for contingencies
7. Additional work due to change of accommodation	17,911 to 21,727 ⁵	n/a – included in the sum for contingencies
8. Annual tax return	480 to 960	282
9. Advice re building contracts	600 to 900	n/a – included in the sum for contingencies
10. Work regarding a will on behalf of C	Non-statutory will – 8,684 to 9,099 Statutory will – 16,275 to 21,970	Non-statutory will – 8,684 to 9,099 Statutory will – 11,354 to 14,644
11. Work regarding cohabitation	Without court approval – 4,300 to 6,800 With court approval – 6,037 to 8,537	n/a – included in the sum for contingencies
12. Prenuptial agreement	Without court approval – 5,500 to 8,000 With court approval – 7,309 to 9,809	n/a – included in the sum for contingencies
13. Pension auto-enrolment	3,265 to 4,537	n/a – included in the sum for contingencies

448. The figures that need to be explained in particular are those in sections 1-4 of the table. Each is based upon the opinion of Mrs Bunting for James and Mr Jones for the Defendant. Mrs Bunting is a Chartered Legal Executive and Director of Deputyship services at Hyphen Law in Swindon. She has many years' experience in working as a Deputy and is frequently appointed to act as a professional Deputy by the Court of Protection. Mr Jones was for many years a partner with Pannone LLP specialising in Court of Protection and Deputyship matters. He is the founder of Hugh Jones Solicitors in Manchester which is described as "a firm of independent Court of Protection solicitors". It was founded in 2013. He and Mrs Bunting have similar years of experience in the field. The figures in each column are those put forward in their reports and confirmed during their joint discussion. During the hearing Mr Jones made the additions to his figures indicated in sections 1 and 4. I need not spell out the full extent of how these figures are arrived at, but the most significant

³ Mr Jones suggested £22,500 if the life expectancy was to age 50 or £30,000 if to age 70.

⁴ This figure is agreed as a figure in respect of each application but Mr Jones is of the opinion that any such applications are already included in the sum allowed for contingencies.

⁵ This claim has been discounted by 50% for contingencies and by a discount factor of 0.7254 (13 years) for accelerated receipt.

component in each is the estimated number of hours of professional time suggested and the relevant grade of fee-earner. All figures are exclusive of VAT which would have to be added. All Mr Jones' figures include the cost of one annual visit. These figures can be tabulated as follows:

MRS BUNTING	MR JONES
<p>1. Grade A - 40 hours @ £217</p> <p>Grade B - 23 hours @ £192</p> <p>Grade C - 50 hours @ £161</p> <p>Grade D - 75 hours @ £118</p> <p>TOTAL - £30,000 + VAT</p> <p>Professional fees for Deputy to visit James – 2 visits of 2 hours and travelling time of 6 hours and 52 minutes - £3,848.14 + VAT</p> <p>+</p> <p>Other disbursements⁶</p>	<p>1. Grade A - 18 hours @ £217</p> <p>Blended Grade C/D⁷</p> <p>- 36 hours @ £139.50</p> <p>TOTAL - £9,000</p> <p>+</p> <p>£2,000</p> <p>GRAND TOTAL:</p> <p>£11,000</p>
<p>2. Grade A - 24 hours @ £217</p> <p>Grade B - 15 hours @ £192</p> <p>Grade C - 45 hours @ £161</p> <p>Grade D - 62 hours @ £118</p> <p>TOTAL - £22,000 + VAT</p> <p>Professional fees for Deputy to visit James – 1 visits of 2 hours and travelling time of 6 hours and 52 minutes - £1,924.07 + VAT</p> <p>+</p> <p>Other disbursements</p>	<p>2. Grade A - 12 hours @ £217</p> <p>Blended Grade C/D</p> <p>- 30 hours @ £139.50</p> <p>TOTAL - £7,000</p>
<p>3. Grade A - 20 hours @ £217</p> <p>Grade B - 14 hours @ £192</p> <p>Grade C - 30 hours @ £161</p>	<p>3. Grade A - 6 hours @ £217</p> <p>Blended Grade C/D</p> <p>- 26 hours @ £139.50</p>

⁶ These include the Office of Public Guardian supervision fee of £320, Security bond provision (of £600), the SCCO Detailed Assessment fee of £220 and the Cost Draftsman's fees of 6% of the professional fees claimed plus VAT on the draftsman's fees.

⁷ A concept introduced by Master Peter Haworth.

Grade D - 52 hours @ £118 TOTAL - £18,000 + VAT Professional fees for Deputy to visit James – 1 visits of 2 hours and travelling time of 6 hours and 52 minutes - £1,924.07 + VAT + Other disbursements	TOTAL - £5,000
4. Grade A - 24 hours @ £217 Grade B - 15 hours @ £192 Grade C - 45 hours @ £161 Grade D - 57 hours @ £118 TOTAL - £22,000 + VAT Professional fees for Deputy to visit James – 1 visits of 2 hours and travelling time of 6 hours and 52 minutes - £1,924.07 + VAT + Other disbursements	4. Grade A - 6 hours @ £217 Blended Grade C/D - 26 hours @ £139.50 TOTAL - £5,000 + £1,000 - £1,500 GRAND TOTAL: £6,000-6,500

449. I will deal with each of these sections separately though some of the observations I make in relation to Year 1 are applicable to other future years too.

Section 1 – Year 1

450. Both experts are agreed that this will be an intensive year, but there is a significant disparity between their assessments even allowing for the increased provision made by Mr Jones during the trial. It will be appreciated that Mrs Bunting conducted a detailed analysis of what she perceived to be the requirements during that year and indeed expressed concerns, having heard some of the evidence in the case, that she had under-valued these costs to some extent. Mr Jones' approach was, as he accepted in cross-examination, much more impressionistic.

451. To some extent, it will always be necessary to have an impressionistic approach to an issue of this nature because of all the imponderables about what the Deputy will or may need to do in the future. Mrs Bunting said, and I

accept, that there are no typical cases – “they vary hugely”, she said. In that context Mr Jones’ long-standing experience in this area is, of course, potentially valuable, though no more so than that of Mrs Bunting who, as I have indicated, also has considerable experience in the area. However, whilst there is much to be said for some standardisation of approach in these matters, unless a fixed fee structure is put in place for Deputyship costs this is one area where the “one cap fits all” approach is not going to provide the solution: each case will be fact-specific. In so far as it is ever appropriate to speak of a ‘typical cerebral palsy’ case involving a child, those cases without major management issues will involve a child who does not have any significantly retained intellect, perhaps very limited mobility, and the Deputy is able to deal directly with the his or her parents, both of whom are themselves capable of dealing with the issues involved. Often there are two parents to share the burden of decision-making. This case is plainly very different from such a case for very many reasons.

452. Furthermore, the likely management costs involved cannot, certainly in this case, be determined exclusively by the kind of “factory figures” that the economies of scale that some firms can bring to the process yield, though such figures may be helpful in keeping figures advanced by others in perspective.
453. This is also a reason for not being over-influenced by what has been agreed or awarded in other cases. Mr Block and Miss Greaney reminded me of what had been agreed in *Farrugia (a protected party by his mother and litigation friend, Lorraine Farrugia) v Burtenshaw and ors* [2014] EWHC 1036 (QB) and in *Whiten* (see above). In respect of the latter case they say that the on-going annual cost agreed was less than one-third of the on-going annual cost sought in this case and that the sums awarded for the statutory will and replacement of a Deputy are well below the figures sought on behalf of James. There was no claim in *Whiten*, they say, for the “numerous additional costs sought in this case.” I will, of course, have regard to this in a very broad way, but I repeat that what may have been agreed or decided in one case can have little bearing on what may be awarded in another case. I would observe that in *Whiten*, the claimant had extremely limited mobility and the assessment was that when he reached adulthood the maximum level of cognitive functioning he would achieve would be equivalent to a child of 4-5 years [13] and Swift J accepted evidence that “the claimant’s reasoning and functioning level is likely to remain well below the level of a 4-5 year old, so that, while he may apparently be able to perform a task at that age level, he will not have the underlying skills of reasoning and understanding possessed by an undamaged child functioning at that age level.” In that case both parents of the claimant were university graduates.
454. Just as I do not find much assistance by reference to other cases, I would not expect to see what I decide in this case to be cited in support of or against a claim for Deputyship costs in another case. At all events, on any view, James’ situation is very different from that of the claimant in *Whiten*.
455. For reasons already foreshadowed I have not the slightest doubt that the first year after the final resolution of this case will be one of intense activity. The accommodation aspects will predominate, but there will be care team issues as

well. That intense activity will continue into at least the second year, although not quite at the same level. It seems to me to be important not to underestimate the level of Deputyship activity during these periods. Given that Mrs Stephens has played a very significant role in the family's affairs over the last few years, I do not think it at all unreasonable that she should continue to do so at a high level of involvement, certainly in the next few years. Some continuity is important and her involvement seems to me to be important in James' best interests bearing in mind also that his best interests will be served by enabling Mrs Adams to come to terms with and accept what is happening.

456. I am prepared to accept that £30,000 is a reasonable estimate for the professional costs during that first year and that the overall hours attributed to the work by Mrs Bunting are a fair estimate. Given that Mrs Stephens will be involved at a high level I would have combined the hours of the Grade A and Grade B fee-earners and apply the Grade A rate to those hours (which totals £13,671) and then apply the blended rate of £139.50 for the Grade C and Grade D fee-earners to the combined hours advanced by Mrs Bunting for them. The grand total on this basis is about £31,000 which I would round down to £30,000 (to take account of the fact that some of the Grade A work ought to be charged at Grade B rates) to which VAT of £6000 must be added. I would allow for two visits during the year at £2000 per visit (inclusive of travelling expenses and VAT) and I will allow a round-figure sum for other disbursements of £3500 (also inclusive of VAT where relevant), thus yielding £43,500 in total for the first year.

Section 2 – Year 2

457. I am prepared to allow £22,000 for professional costs during the second year after the final resolution of this case (based upon Mrs Bunting's estimate of the hours likely to be involved), again by rounding down slightly the effect of the same kind of calculation and for the same reasons as mentioned under section 1. To that must be added VAT of £4,400. I will allow for one visit during the year at £2,000 (inclusive of travelling expenses and VAT) and a round-figure sum for other disbursements of £2,500 (inclusive of VAT where relevant), thus yielding £30,900 in total for the second year.

Section 3 – Year 3 to age 18

458. I would anticipate that by the end of the first two years after the conclusion of this case the new accommodation should be complete and the care regime properly in place, with a good deal of daily input from the case manager and team leader. I do not think that the role of the principal Deputy will ever cease in this case, but I believe that by this stage Mrs Stephens' regular role will have diminished from what it will have been in the first two years. I consider it entirely reasonable to continue to allow one annual visit by the Deputy to see James – it is important that James meets his Deputy in person at least once a year. With the developing means of personal communication via the Internet they may well be able, where necessary, to communicate electronically (perhaps by Skype or something similar) at times, but whatever means of communication is adopted it will, of necessity, be time-consuming: James will take some time to communicate his views and patience and understanding will

be required from the Deputy. This is not a case where there are many opportunities for shortcuts. Nonetheless, in the years ahead a fair measure of the Deputyship work will be capable of being carried out by those at a lesser charge out rate than Mrs Stephens' charge out rate.

459. Those latter observations are, of course, applicable to the longer term as well as for the period after the first two years post-trial up until the age of 18. Focusing on this period, Mrs Bunting has suggested the hours set out in section 3. In the expectation that all issues in this case will have been resolved by the time that James is, say, 12½ years of age (in June 2015), he will be 14½ by the time he is properly installed in his new accommodation with the full care regime. There will, therefore, be 3½ years until he is 18. It does seem to me that, as ever, the Deputyship requirements will vary from year to year, but generally the level of activity will be at a more administrative level in this period than at the level of important decision-making. In my view, Mrs Bunting's suggestions need some modification for that reason. For my part, I would have said that 20 hours of Grade A fee-earner's time would be sufficient and a total of 70 hours of Grades C and D fee-earners' time (at the blended rate) would be adequate. The total, slightly rounded down, would be £14,000, to which VAT of £2,800 must be added. I would continue to provide for one annual visit by Mrs Stephens in the sum of £2,000 (inclusive of travelling expenses and VAT). I would allow for general disbursements at £2,000 (inclusive of VAT where relevant). This yields £20,800 per annum for this period.

Section 4 – from 18 for life

460. Mrs Bunting is suggesting something over £31,500 in total per annum for this period and the amount attributable to Deputyship time is £22,000 plus VAT (with one annual visit also provided for). The overall figure, which includes VAT and disbursements, is, she confirmed, at a level of management costs being charged for Deputyship work for clients who have a serious level of brain damage. Mr Block suggested to her that the figure is considerably out of line with figures granted in other cases, being at least double, he suggested. (If he was referring to *Whiten*, I have identified the differences between that case and this above: see paragraph 453). Mrs Bunting said that she could not comment on other cases, but said that, in her experience, the management costs are frequently undervalued with a consequent impact on other heads of damage.
461. I am, of course, dealing with a specific case, not with the general position. The work of a Deputy is very important, but these figures, on an impressionistic basis, do seem very high. I would merely observe that the use of the GHR for the charge out rates, whilst plainly established practice for many years, does represent a use for the GHR for which, at least in their origin, they were not designed. They were put in place to assist the courts in deciding on the recoverable costs in summary assessments made in the context of contested civil litigation (see Report to the Master of the Rolls of the Costs Committee of the Civil Justice Council, May 2014). I understand from Mrs Bunting that some kind of review is currently underway and that cost-budgeting is being

actively considered. Doubtless this is part of the general impetus that exists to reduce costs associated with litigation and allied matters.

462. I consider that I should bear this in mind when looking broadly at the Deputyship costs for the future in this case. It is, however, important to recall that this will potentially be a challenging case for the Deputy because of the combination of James' disabilities, the overall family dynamics and the geography of where James lives. As it seems to me, the best structure in the circumstances is to provide for an annual figure that is relatively conservatively assessed, but to provide a somewhat more generous contingency figure than might otherwise be the case to cater for the occasional "spike" in Deputyship time that might happen from time to time. The basis upon which the £30,000 contingency figure is advanced on James' behalf is set out in footnote 1 above. Mrs Bunting identified the following as possible moments of "crisis" when additional Deputy time might be required: illness of close family members, bereavement, changes in the family dynamics such as Mrs Adams' cohabitation or remarriage and the introduction of or change in a vocational activity. The possibility of James engaging in a relationship is another. I will return to these matters having dealt with the basic annual cost.
463. Having considered that the appropriate figure for Deputyship time in the immediate pre-18 period was £14,000 per annum (see paragraph 459 above), it seems to me that the slight increase that both experts consider necessary in adulthood would be catered for by allowing £16,000 per annum. To this must be added VAT of £3,200 and again provision should be made for one annual visit by Mrs Stephens in the sum of £2,000 (inclusive of travelling expenses and VAT). Again I would allow for general disbursements at £2,000 (inclusive of VAT where relevant). This yields an annual figure of £23,200.
464. Painting with a broad brush, it seems to me that it would be appropriate to make provision for a contingency figure of £40,000, rather than the £30,000 suggested on behalf of James. That contingency figure, however, is to be held against unknown contingencies of the kind identified above.
465. I must now deal with certain matters which have been identified as potential known contingencies. I will deal with each by reference to each of the other sections in the table set out in paragraph 447 above.

Section 6

466. The assessed amount of each potential application is agreed, but Mr Jones felt that this should be included within the general contingency figure. It could, in my view, be included in such a figure, but it has not been included in my approach to that figure. Accordingly, since only two applications are sought to be provided for, I will allow the sum of £8,000 on this account.

Section 7

467. Since I do not see any real prospect of James moving accommodation once he has moved into the new property, I cannot see the need to make the provision sought under section 7.

Section 8

468. An annual tax return will be required. James would have been obliged to submit an annual tax return each year had he not been disabled, but it would not necessarily have been as complicated as that which will have to be returned in the light of the financial position obtaining because of his disability and, accordingly, in principle I can see that an allowance should be made. I would have thought that an allowance of £500 per annum would suffice for the costs of this. For the avoidance of doubt, that includes VAT.

Section 9

469. James will have the benefit of architects' advice in relation to the new property into which he will move. I cannot see the need for this provision.

Section 10

470. It seems to be accepted that, despite his cognitive capacity, James will almost certainly not have the capacity to make a will. Provision should therefore be made for the making of a statutory will. I think it reasonable to accept Mrs Bunting's view that provision for two such wills in James' lifetime. Mrs Bunting and Mr Jones agreed in the joint statement that the cost of one statutory will fell within the range of £11,354 to £14,644, the mid-point of which is £13,000. Accordingly, I allow for two such wills at that figure.

Sections 11 and 12

471. Consistent with my view on the issue of whether James will be likely to form a relationship such that he will cohabit or marry (see paragraph 191), I do not consider that an allowance should be made for these two items. If I am wrong in my view for the future, this would have to be seen as an unexpected contingency embraced within the £40,000 I have provided for in paragraph 464 above.

Section 13

472. Mrs Bunting has drawn attention to the forthcoming statutory obligation of an employer to make pension provision for employees and to the potential impact of this upon a Deputy who is employing members of a care team. The care team for James is already large in number and will be larger in due course. It is uncertain precisely how these statutory changes will impact, but Mrs Bunting suggests that it would be appropriate to make some provision for the Deputy to be able to obtain advice about it and to maintain such scheme as may be required. I agree that it would not be right to treat the whole potential cost of this as being embraced within a contingency sum, but since the true cost is uncertain I will have to take a conservative approach and adopt modest figures. If there is any shortfall, it will have to be swept up under the contingency sum.

473. As I understand the way the claim is advanced, it is suggested that there could be Deputyship costs of £1,500-2,000 plus VAT for the setup of the scheme

and then £1,000-1,500 per annum management costs (plus associated VAT and expenses) thereafter. Given the uncertainty, I do not consider I can award the sums on that basis. However, I think it right to provide for £1,000 (inclusive of VAT) in the initial year in which the new statutory obligations arise and £750 per annum (inclusive of VAT) for each year thereafter to cater for the continuing obligations that arise. The parties will have to agree the year in which the initial obligation will arise and to calculate the award accordingly.

Multi-disciplinary team meetings (MDT)

474. The issues here are whether 1 or 2 hours should be allowed for the agreed need for MDT meetings, how frequently they should take place, whether these meetings should just occur until James is 18 or for life and how they should be costed.
475. In the first place, I would have thought it sensible to provide for meetings that last two hours in the initial stages. There are complexities involved which, of course, may resolve with the passage of time, but it is important to have time to iron out any differences of view in the early stages or to ensure that everyone is working towards an accepted common objective. I accept that the physiotherapist, who is an integral part of the whole process, should attend the whole meeting and should be entitled to charge accordingly. Mr Johnson considered that there should be monthly meetings in the first year after the final resolution of the trial. Mr Baldwin, who was not called to give evidence, thought that 4 such meetings should be sufficient.
476. Whilst it might be said that Mr Johnson's view is unchallenged by evidence, it is challenged on behalf of the Defendant. I can see the sense of having several meetings early on and I would allow for one every two months for the first six months of Year 1 and then twice more in that year. After that until the age of 18 I would have thought that 4 meetings per year would suffice.
477. Thereafter, until the age of 25, I would have thought 3 meetings per year would be sufficient and that thereafter a case for 2 such meetings a year could arguably be made, but the claim has been limited to one such meeting per year and I should, therefore, accept that approach. I do think it important that these meetings continue throughout James' life and I do not think that they should be rushed. Indeed, since they are likely to take part in his home as time goes on, it is possible that he will be consulted by the professionals present. Given his communication difficulties, this will prolong the meeting. For that reason I am of the view that 2 hours should always be set aside albeit for reasons that are different from those that dictate a 2-hour meeting in the initial years. Taking a different view would mean that James' lifetime disabilities are being given less attention than they should be.
478. The remaining issue is how these meetings should be costed for future purposes. As advanced on James' behalf, they would cost over £3,000 on each occasion. The claim is advanced on the basis that each of the following would charge for their time to attend: the neuropsychologist, the physiotherapist, the occupational therapist, the AAC specialist, the speech and language therapy

specialist, the case manager, Ms Marion Stanton, the team leader and three support workers.

479. I do not see any basis for the case manager, the team leader and the three support workers to be paid outside their normal working time to attend such meetings. The meetings can presumably be arranged around their working patterns. Furthermore, the AAC specialists agreed that the attendance of the specialist AAC adviser at such meetings is incorporated within the figure allowed for that expert. I think it is important that Ms Stanton attends these meetings over the years until James has finished his full-time education (which I imagine will be at the age of 18 years or thereabouts), but I think it would be difficult to justify her paid attendance thereafter.
480. I trust these observations will enable an appropriate annual figure to be agreed.

Conclusion

481. I believe I have now dealt with all disputed matters so far as possible.
482. I will invite James' legal team to take financial advice on the implications and both parties to endeavour to agree a formula for the final resolution of the claim in the light of these conclusions. In default of agreement I will have to consider the issues further either on the basis of written submissions or by way of a further oral hearing.
483. I should like to express my appreciation to all Counsel and to their Instructing Solicitors for their assistance and to those responsible for the provision of the daily transcripts and the Livenote facility.

APPENDIX

LIST OF AGREEMENTS

1. GENERAL DAMAGES

Agreed at £290,000.

2. INTEREST ON GENERAL DAMAGES

Agreed at £12,151.

3. PAST EXPENSES AND LOSSES

Agreed at £1,300,000.

4. INTEREST ON PAST EXPENSES AND LOSSES

Agreed at £252,026.26.

5. FUTURE CARE AND CASE MANAGEMENT

It is common ground that future care and case management should be paid by way of an annual periodical payment and that this should be split into two care periods: (i) from 12 to age 19; and (ii) from age 19 for life. The agreements can be summarised in the following table.

FROM AGE 12 TO 19	FROM AGE 19
(1) Hourly rates are agreed at £10 per hour weekdays and £11 per hour weekends / holidays.	(1) Hourly rates are agreed at £10 per hour weekdays and £11 per hour weekends / holidays.
(2) Day care during term time is agreed at 7 hours per weekday x 2 carers.	(2) Day care is agreed at 14 hours per day x 2 carers (full double-up).
(3) Day care on the weekends during term time and throughout school holidays is agreed at 14 hours per day x 2 carers.	(3) Night care is agreed at 10 hours per night (paid for 6), provided by 2 sleep-in carers.
(4) Night care is agreed at 10 hours per night (paid for 6), provided by 2 sleep-in carers.	(4) It is agreed that there should be an allowance for waking night care (although the extent of the allowance is disputed).
(5) It is agreed that there should be an allowance for waking night care (although the extent of the allowance is disputed).	(5) It is agreed that there should be no deduction for "ordinary parental care" in any event.
(6) It is agreed that there should be no deduction for "ordinary parental care"	(6) Case management is agreed at £21,000 pa.

<p>in any event.</p> <p>(7) Case management is agreed at £21,000 pa.</p> <p>(8) It is agreed that there will be 14 fulltime employed carers for the purposes of calculating credit for carer thresholds in respect of ERNIC and carers' pension contributions.</p> <p>(9) The ERNIC threshold is agreed at £7,956 per carer.</p> <p>(10) The pension threshold is agreed at £5,772 per carer.</p> <p>(11) Annual insurance is agreed at £135 per annum.</p>	<p>(7) It is agreed that there will be 14 fulltime employed carers for the purposes of calculating credit for carer thresholds in respect of ERNIC and carers' pension contributions.</p> <p>(8) The ERNIC threshold is agreed at £7,956 per carer.</p> <p>(9) The pension threshold is agreed at £5,772 per carer.</p> <p>(10) Annual insurance is agreed at £135 per annum.</p> <p>(11) Annual training costs are agreed at £2,000 per annum.</p> <p>(12) Food and other expenses are agreed at £4,420 per annum.</p>
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6. FUTURE EDUCATION

Agreed at £150,000.

7. FUTURE MEDICAL TREATMENT AND THERAPIES

(1) Orthopaedic Surgery

Agreed at £11,922.

(2) Counselling and Psychological Treatment

Agreed at £85,000.

(3) Physiotherapy

The following items are agreed:

- (i) Annual maintenance physiotherapy from age 19 to 21 – 16 sessions, £1,920 per annum.
- (ii) Annual maintenance physiotherapy from age 21 to 45 – 20 sessions, £2,400 per annum.
- (iii) Additional physiotherapy after botox – 8 sessions, £960.
- (iv) Additional physiotherapy required after orthopaedic surgery – 15 sessions, £1,800.
- (v) Wide neuroplinth - £1,000, with one replacement.
- (vi) Annual maintenance of the neuroplinth - £70 per annum.
- (vii) Walking aid - £2,000, with two replacements.
- (viii) Lecky standing frame - £2,300, with one replacement.
- (ix) Duo tandem tricycle - £5,500, one-off provision.

- (x) Physiotherapy balls, wedges, I-joy mechanical horse, buoyancy aids etc - £1,000, one-off provision.

(4) AAC

The following items are agreed subject to court's finding as regards the appropriate rate per session and the James' likely educational path:

- (i) AAC input from age 12 to 13 – 125 sessions.
- (ii) AAC input required at mainstream school from age 16 to 19 – 72 sessions per annum.
- (iii) AAC input required at local college further education (Year 1) – 115 sessions per annum.
- (iv) AAC input at specialist residential college – agreed at 24 sessions per annum.
- (v) AAC input after end of education – 15 sessions per annum.
- (vi) AAC input after age 25 – 15 sessions per annum.
- (vii) Training agreed save for the rolling programme of training which remains disputed.

(5) Speech & Language Therapy

SLT is agreed at £90 per hour. The following are agreed subject to the court's finding as regards the appropriate rate per session including travel expenses:

- (i) Years 1 and 2 – 120 sessions of SLT per annum.
- (ii) Years 3 to 19 – 80 sessions of SLT per annum.
- (iii) From 19 to 25 – 30 sessions of SLT per annum (if at non-residential college).
- (iv) From age 25 – 30 sessions of SLT per annum.

(6) Occupational Therapy

The following are agreed:

- (i) OT from 12 to 19 - £2,820 per annum.
- (ii) OT from age 19 - £780 per annum.

(7) Seating Reviews

Agreed at £750 per annum.

8. FUTURE AIDS AND EQUIPMENT

- (1) The Chunc manual wheelchair (and then adult manual wheelchair) - £3,000, replacement every 5 years.
- (2) Annual maintenance of the manual wheelchair - £100 per annum.
- (3) Replacement tyres of the manual wheelchair - £100 per annum.
- (4) Wheelchair insurance for the manual wheelchair - £25 per annum.
- (5) Portable ramps - £135, replacement every 10 years.

- (6) Replacement batteries for the power wheelchair - £180 per annum.
- (7) Insurance for the power chair - £69.50 per annum
- (8) Recharging for the power wheelchair - £91.25 per annum
- (9) Portable hoist - £2,337, replacement every 10 years.
- (10) Annual maintenance for portable hoist - £200 per annum.
- (11) Lecky bath seat - £556 one-off.
- (12) Burnett body supports - £250, replacement every 3 years.
- (13) Presalit changing table - £2,700, replacement every 10 years.
- (14) Maintenance costs of changing table – £100 per annum.
- (15) Boris toilet seat - £1,828, replacement every 5 years.
- (16) Careflex chair – £1,500, replacement every 5 years.
- (17) Spare covers for Careflex chair - £250, replacement every 5 years.
- (18) P-Pod chair - £1,400, replacement every 5 years.
- (19) Maintenance of bed - £100 per annum.
- (20) Soft play equipment - £3,000, replacement every 10 years.
- (21) Batteries for spare power chair - £180 per annum.
- (22) Insurance for spare power chair - £69.50 per annum.
- (23) Football wheelchair - £9,500, replacement every 6 years until age 30.
- (24) Seating for football wheelchair - £3,400, replacement every 6 years until age 30.
- (25) Insurance for football wheelchair - £69.50 per annum.

9. FUTURE ORTHOTICS

Agreed at £72,153.

10. FUTURE INFORMATION TECHNOLOGY

The following items are agreed:

- (1) Main eye gaze system - £12,699, replacement every 3 years.
- (2) Mounting system for desktop use - £250, replacement every 3 years
- (3) Mounting system for floor standing use - £900, replacement every 3 years
- (4) Mounting system for wheelchair use - £1,850, replacement every 3 years
- (5) I-Pad with software, mounting and software - £750, replacement every 3 years
- (6) Laptop PC for carers - £750, replacement every 3 years
- (7) Additional back-up disk, switchbox, cabling etc - £500, replacement every 3 years
- (8) Text capture system - £2,370, replacement every 3 years

- (9) Adaptations of bed controls - £2,000, replacement every 3 years
- (10) Adaptations of toys and electrical devices - £450, replacement every 3 years
- (11) Mainstream software - £300, replacement every 3 years
- (12) Technical support - £500 per annum
- (13) Insurance of AT system - £250 per annum
- (14) Internal door openers - £1,500 each x 10, replacement every 10 years
- (15) Window openers - £675 each x 10, replacement every 10 years
- (16) Curtain openers - £700 each x 10, replacement every 10 years
- (17) Power socket controllers - £250 each x 11, replacement every 10 years
- (18) Lighting controls - £120 each x 10, replacement every 10 years
- (19) Annual maintenance of environmental controls - £1,250 per annum
- (20) Discount for IT equipment which would have been purchased in any event - £500, every 5 years.

11. FUTURE ADDITIONAL HOLIDAY COSTS

It is agreed that:

- (1) 4 carers will be required to accompany James on holiday now and as an adult.
- (2) Additional European holidays will cost £11,000 per holiday.
- (3) Additional long-haul holidays will cost £14,000 per holiday.

12. FUTURE MISCELLANEOUS

The following items are agreed:

- (1) Gardening, decorating and DIY - £1,500 per annum (but see paragraph ?? above).
- (2) Allowance for office equipment and stationery for carers - £100 per annum.
- (3) Extra costs of Blue Badge breakdown recovery compared to standard breakdown recovery - £60.75 per annum.
- (4) Sailing membership for £600 pa to age 25 covering the cost of 4 adult memberships to enable James' carers to take him sailing.
- (5) Cost of the removal of bats prior to the demolition of Yorke Hurst demolition - £4,200.