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Case No: HQ12X02351

IN THE HIGH COURT OF JUSTICE
QUEEN'S BENCH DIVISION

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 04/05/2016

Before :

MR JUSTICE IRWIN

- -

Between :

AB **(by his Litigation Friend CD)**	**Claimant**
- and -	
ROYAL DEVON & EXETER NHS FOUNDATION TRUST	**Defendant**

- -
- -

Christopher Wilson-Smith QC and Nathan Tavares (instructed by **Stewarts Law LLP**) for the **Claimant**
Robert Seabrook QC and Richard Mumford (instructed by **Beachcrofts LLP**) for the **Defendant**

Hearing dates: 2-9 February and 11 February 2016

- -

Approved Judgment

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.

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MR JUSTICE IRWIN

Mr Justice Irwin :

Introduction

1. The Claimant was born on 16 January 1966 and is thus now 50 years old. He had a troubled background, on his account being subject to bullying and emotional abuse at home. At eighteen months old he sustained a serious scald injury to his right shoulder, leading to an extensive period of hospitalisation and permanent shoulder weakness. He became involved in drug abuse from about the age of fifteen. He has an extensive criminal record, consisting for the most part of acquisitive offences associated with drug abuse or of offences of possession of drugs. He has received several custodial sentences.

2. The Claimant has had a difficult personal and work life. In his late teens he worked on fishing boats but following an accident in which he nearly drowned he left this occupation. He subsequently worked only for intermittent periods, in a hospital, in a factory or as a chef. He has obtained some NVQ qualifications in catering and in industrial cleaning whilst in prison. When he was eighteen years of age, his then girlfriend became pregnant and subsequently gave birth to his daughter, "CD", now his Litigation Friend. The Claimant's relationship with his girlfriend did not last, he says because of the opposition of her family. He had no contact with his daughter from the time when she was about six years of age, until they resumed contact in the last few years. CD gave evidence before me. She sought her father out via the internet in 2010/11 and slowly began to build a relationship with him. Following phone and internet contact, they met for the first time during 2014 and have exchanged visits since. CD has four children and lives in Cornwall. The Claimant has recently moved to be near her. I return to this aspect of the story in more detail later in this judgment.

3. In 2009, the Claimant was unemployed and living in a council flat in Exeter. He was under the care of the Community Mental Health Team, having a diagnosis of depression and drug abuse. He was suffering a good deal of pain in his right shoulder and was awaiting a shoulder arthroscopy for a surgical operation on the shoulder. He was on strong prescribed painkillers and his general practitioner was concerned about him abusing those prescribed drugs. He had been released from a period of imprisonment shortly beforehand and was being prescribed heroin substitutes.

4. On 20 June 2009, the Claimant, then aged 43, was admitted to the Royal Devon and Exeter Hospital, Exeter as an emergency surgical admission, suffering from epigastric pain. A condition called cholecystitis was suspected, but in fact the cause of the Claimant's symptoms was a developing spinal abscess. It is agreed that various signs, including loss of motor power in the legs, were missed or not acted upon in time. It was this failure which led to litigation. As the liability issue crystallised between the parties, there was a factual dispute as to whether it was likely that a MRI scan would or could have been performed in time to permit successful surgery. Against this background, liability was compromised on the basis that the Claimant would receive:

> "… 60 per cent of such damages as are assessed by the court … if not agreed. Such damages to be assessed on the basis that but for the Defendant's admitted breach of duty, the Claimant

would have been neurologically intact after treatment for his spinal abscess."

5. The compromise on liability was enshrined in a Court Order of 30 June 2014. At the time of the settlement and of that order, it had not been suggested to the Defendant that the Claimant lacked capacity to litigate, or to manage his financial affairs, or that he was or ought to be a protected party. However, it is clear that the Claimant's legal team became concerned as to whether he was capable of managing his own affairs. Reports were obtained from a Dr Denman, Consultant Psychiatrist, dated 14 April 2015 and Dr Luis van Graan, Consultant Neuropsychologist, dated 13 July 2015. Application was made to the Court on 9 September 2015 and on that date Master Roberts, being satisfied that the Claimant was a protected party, appointed the Litigation Friend. The Order and the supporting expert reports were then served on the Defendant. On 25 September 2015, Master Roberts retrospectively approved the steps taken to date in the litigation, including the liability settlement.

6. The issue of the Claimant's capacity is potentially significant in the assessment of damages. In fact, there is a good deal of convergence on the facts of the matter, as I shall set out later in this judgment. However, the Defendants make several key points to be considered. They say firstly that the loss of capacity, if and when demonstrated, cannot be attributed to the medical failure, and on that there is agreement. However, the Defendants go on to say that any lack of capacity which is demonstrated, past or future, derives from the Claimant's abuse of illegal drugs. Hence any consequential losses are irrecoverable due to the operation of the legal policy expressed in the Latin maxim *ex turpi causa non oritur actio*. I address this below.

7. The Claimant has received a series of interim payments as follows:

		Rate of interest	
Date	**IP**	**p.a.**	**Interest**
07/07/2014	£125,000.00	2%	£3,928.82
11/05/2015	£35,000.00	2%	£509.79
16/10/2015	£100,000.00	0.50%	£147.84
Subtotals	**£260,000.00**		**£4,586.45**
Total			**£264,586.45**

The Nature and Development of the Claimant's Physical Disability

8. The Claimant sustained an injury to the spinal cord which has left him paraplegic. There is a degree of disagreement between the consultant experts in spinal injuries as to the detail of his lesion. Mr Jamil for the Claimant found on sensory testing that the Claimant's sensory level was at Thoracic 8 ["T8"], although his epidural abscess was

confirmed on MRI scan to be at T4. Mr Jamil's view is that it is not uncommon for spinal cord injury victims to have preservation of, or recovery of, sensation for several segments below the actual site of spinal cord damage. Therefore Mr Jamil concludes that it is probable the Claimant's level of injury is at T4. Mr Thumbikat for the Defendants concludes the Claimant has sustained a lesion at T7: using the agreed ASIA classification he is to be described as a T7 ASIA B paraplegic. Mr Thumbikat found the Claimant to have normal sensory awareness at T7 on the left and T8 on the right. In his view, the proper approach is to conclude that, where no specific muscle exists for testing at a particular level (as is agreed to be the case here), if the sensation is normal then the motor level is also considered as normal. Therefore the Claimant is properly classified as a T7 paraplegic. Mr Jamil responds that Mr Thumbikat's approach only holds good if both pinprick and light touch responses were completely normal between T4 and T7. Until then Mr Jamil considers that the neurological level should correspond to the lesion revealed on imaging.

9. In giving his evidence, Mr Jamil emphasised that in his view this issue is not academic, since a lesion at T6 and above renders a paralysed person prone to the risk of other consequences as a result of "autonomic dysreflexia", a condition of sudden rise in blood pressure which can potentially cause brain haemorrhage. In reply, in the course of his evidence Mr Thumbikat emphasised his view that it was the neurological level which was important. Here the neurological level is at T7 and it would be right to expect the vertebral lesion to be at about the T4 or T5 level since anatomically this is appropriate. Mr Thumbikat also pointed out that the treating clinicians concluded that the overall neurological level was T7. On this issue I conclude in favour of Mr Thumbikat, bearing in mind his analytical approach to the question and the view of the treating clinicians. It therefore seems unlikely to me that the Claimant will be at risk of automatic dysreflexia.

10. It is agreed between the experts that the Claimant has a small but lifelong risk of suffering syringomyelia, that is to say a development of a syrinx or cavity in the spinal cord. If a syrinx were to develop, it could bring important and sometimes serious additional neurological compromise. In the circumstances the Claimant seeks provisional damages in the case in the light of that risk, a claim in essence not resisted by the Defendants.

11. The functional effects of his injury are very considerable. He has pinprick sensation down to the sensory level at T7, below which there is reduced perception of sharp sensation down to the anal verge. There is complete paralysis of the lower limbs and paralysis of voluntary anal contraction. The Claimant suffers from contractures of the calf muscles and shortening of the Achilles tendon on each side. He is doubly incontinent. His bladder is managed with a suprapubic catheter, which is changed every five weeks or so by a district nurse. The catheter is connected to a night bag. There have been problems with catheter blockages over time. Bowel management is carried out by a nurse using suppositories, following which the Claimant is normally hoisted over a toilet seat for bowel emptying. There have been a number of bowel "accidents".

12. The Claimant has severely impaired sexual function. With concentration and effort, and the help of Viagra, he can achieve a degree of reflex erection and ejaculation.

13. There is an important interaction between the Claimant's spinal lesion and his pre-existing injury to the right shoulder. As I have indicated, this injury derives from a scald, or burn injury, at the age of eighteen months. The Claimant has developed contracture formation within the skin, which has affected his right shoulder function since childhood. He has never been able to move the shoulder as fully or freely as normal. He was unable to elevate the right arm above his head when a teenager, and he began to get pain in his right shoulder during his early twenties. The pain was located in the region of the acromio-clavicular joint ["the AC joint"]. If the Claimant ever knocked his right shoulder he would experience pain and sometimes swelling. Progressively the shoulder became more troublesome, and for that reason, at the time of his injury, he was on the waiting list for an arthroscopic subacromial decompression of the right shoulder. He underwent such procedure at Odstock Hospital following his spinal lesion. Curiously, no records of the operation appear to have been found, but the orthopaedic surgical experts for each side agree there are scars consistent with the surgery on his right shoulder, and it is clear that it took place. The Claimant confirms the surgery, states that it took many months for him to recover his ability to use his shoulder but that thereafter the operation reduced his pain by about 50 per cent.

14. However, both before and after the surgical intervention, the compromised right shoulder has made transfers more problematic for this man suffering from relatively high paraplegia. He has had considerable pain in the right shoulder as a result of the heavier use involved in transfers. For a long period following his spinal injury he had access only to a manual wheelchair. He had temporary access to an electric wheelchair following the shoulder surgery. Even after the discharge from Odstock Hospital, self-propulsion of a manual wheelchair has brought pain. His arms are relatively short as compared to his trunk height, something which has been corrected by the use of lifting blocks in both hands. He has used a sliding board for transfers when not hoisted. He has attempted to limit the number of transfers in a day to avoid shoulder provocation.

15. His mobility was improved once he obtained an electric wheelchair of his own in February 2012 and on his account since then he has not used a manual wheelchair, except when going out in a car. He has attempted to continue exercise to strengthen his upper body, but this has caused him right shoulder pain and these efforts have fallen off somewhat. He has had only limited physiotherapy input into his management since his discharge from Odstock Hospital.

16. The orthopaedic surgical experts for both sides are agreed that the Claimant will come to further surgery on his right shoulder. Mr Handley for the Claimant considers that the Claimant will come to at least one further surgical intervention and perhaps three, namely a revision of the initial decompression, possibly a rotator cuff repair, and thirdly a surgical shoulder joint replacement. Mr Handley would not himself tend to perform the rotator cuff repair and under cross-examination agreed that the Claimant might have required a revision of the original surgery. However, he was clear in his view that but for his medical accident, the Claimant would not have required surgical replacement of the joint. Mr Constant for the Defendant considered the Claimant is likely to come to all three further episodes of surgery. He projected forward 20 years for the final operation. He, too, felt that the revision of the original surgery might have come about even in the absence of the spinal injury. On balance, therefore, I

find that the Claimant is faced with the prospect of at least one, and possibly two, additional surgical interventions to his shoulder, with the relevant recovery periods, as a consequence of his spinal cord lesion.

17. Another consequence of the Claimant's spinal injury is that he has had persisting problems with pressure sores. These may have related in part to his poor condition of life during much of the intervening period, and in part also to the fact that at one stage he gained a great deal of weight, reaching 17st in weight at a height of 5' 8". At the date of the trial he had lost this weight again. By February 2015, he was back to weighing 10st 4lbs.

18. One of the most important consequences of the injury for the Claimant is that he has suffered from frequent extremely painful spasms in his legs. The consultants in pain medicine are agreed that these spasms are rated "severe". They occur when straightening the legs, transferring to or from the wheelchair and when the wheelchair goes over uneven ground. They occur on multiple times each day, lasting for brief periods of time. They are a direct consequence of the spinal cord injury. The experts agree that the prognosis for the painful leg spasms is of a stable long-term condition, unlikely to improve or worsen of its own accord in the foreseeable future.

19. The experts agree that all appropriate medications have already been tried for treatment of the leg pain and the shoulder pain. The Claimant has been prescribed extensive drug treatment in attempt to deal with the pain and spasms. They are agreed that detoxification from opioids would be the ideal outcome, but that it is a "counsel of perfection". Dr Munglani for the Claimant believes that the total morphine dose should be reduced below 100gm per day for reasons of safety, a proposition with which Dr Dolin for the Defendant is in agreement: Dr Dolin would prefer that the opioids should be removed entirely. A drug called Baclofen has been prescribed through oral delivery, in an attempt to prevent the spasms, but this has had little or no effect. The expert pain consultants are agreed that intrathecal delivery by pump of Baclofen is not appropriate in this case for a number of reasons, of which the most important is the risk of infection, given the Claimant's history of pressure sores, many of which have been open lesions for sustained periods of time.

20. The Claimant also suffers from unrelated low back pain and has a degree of hip osteoarthritis. Neither of these are disabling, but they do form part of the complex picture and at least to some degree interrelate with the effects of the spinal injury.

21. Another element was added to the Claimant's complex situation in 2012 when he was diagnosed as suffering from Type II Diabetes. Despite some tentative suggestion of connection to his spinal lesion, I find it probable that this development did not arise from the index event. Both of AB's parents contracted this condition, in respect of which there is a strong familial tendency. However, it is a relevant factor in considering the care of the Claimant and his life expectancy.

22. I have summarised the main points of the physical impact of the Claimant's spinal lesion. This accident also brought psychological consequences for the Claimant. However, before considering those, it is appropriate to set the context. The interlocking factors of this Claimant's history, his pre-existing difficulties including drug abuse, and the psychological effect of his injury make the task of predicting his future particularly complex.

AB's Account

23. AB gave me the clear impression that he was attempting to be frank in his evidence. He acknowledged the chaos and criminality that had been part of his life. He was taken to the detail of his long criminal record and made no quibble about it. As he himself said, his criminal offending and his drug abuse went together.

24. It is clear that he was offending consistently from his teens. Apart from a period in early adult life when he was in a stable relationship with the lady who became his wife, he agrees he had no sustained period of employment or indeed stability. He has consistently used cannabis on a regular basis, injected amphetamines for a very long period, on his account until 6½ years ago. Since then he has also injected "legal highs". He has not always been accurate about some of the detail. In his written statement he claims to have been "clean of heroin since 2011" but in oral evidence acknowledged that he had had heroin since then. However he was clear that he has never injected heroin, as opposed to smoking the drug. He acknowledged also that he has in recent times smoked crack cocaine.

25. Taken together, this amounts to long-term, sustained drug abuse. It is also clear that matters became, if anything, worse during 2014 and into 2015, when AB was living in his flat in Exeter and, following the significant interim payments, had access to funds. It is clear on his own account that the Exeter flat became a chaotic environment, a place being used for widespread drug abuse by others. On AB's account he did not give money to others but if people were ill "he would try and help them out and get them something, and they knew this and that's what they used to do". He also made it clear that by the time this situation had developed, people were repeatedly burgling him. He said that happened four times, which was the reason he took to having weapons to protect himself.

26. This history provides a bleak backdrop for the prospect of drug-free life in the future. AB was adamant that he wished to remain clean, as he was firm had been the case since his rehabilitation. As all have acknowledged, this is a very short time. AB was clear that his motivation was the relationship with his daughter and grandchildren. I turn to her evidence shortly, but I should record I accept his intention is genuine; he has a real desire to make something of this relationship.

27. My impression of AB chimes very much with the overall thrust of the expert evidence. There is an impulsive side to his character, demonstrated once or twice in his reactions to the evidence and the proceedings. It is clear that he intends to go on smoking cannabis and when he set out his intention to remain clear of illegal drugs, he actually meant "other than cannabis". Even without the assistance of expert evidence, my conclusion would have been that AB is unlikely to avoid future drug abuse entirely.

The Claimant's Social Situation

28. The Claimant was discharged from Salisbury Spinal Unit in March 2010 and then spent six weeks in a nursing home. He then moved to a bungalow provided by his local authority. Following that, he moved to a local authority flat in Barley House, in Exeter. The block of flats was positioned at a reasonable distance from the centre of town at the top of a hill. The flat was on the ground floor with one bedroom, a wet

room, a living/kitchen area and the use of a lawn. The Claimant had little social support. His former brother-in-law, Mr David Pearson, has given the Claimant an admirable degree of support in different ways down the years. Mr Pearson lives in Dawlish, about 30 minutes drive away from the Exeter flat. As the Claimant rebuilt his relationship with his daughter, contact with her, with her partner and latterly her children became more significant to him, but they could be of limited practical use, even once they got to the stage of mutual visiting, given the distance to Cornwall.

29. It is agreed that the flat in Barley House was not suitable for the Claimant's needs. In addition, the condition of the flat rapidly, and seriously, degenerated.

30. This picture is reinforced by the helpful and frank evidence of Michael Chevalier, who acted as the Claimant's case manager from the late summer of 2014. Mr Chevalier was an impressive witness. He described how the Claimant, at that stage, had a social services package involving daily visits, assisting him to get up, be washed, dressed and spend time in his standing frame. Mr Chevalier also described how at that stage district nurses were attending to the pressure sores on his hip and heel, which were already of longstanding. Further, there was a carer coming in in the evenings to help the Claimant get ready for bed and a special support worker to help him with shopping and with administration. In his statement of January 2015, Mr Chevalier described the home in the following terms:

> "Roy has a very chaotic home situation and it remains so. He is surrounded by people who look on him as a means of support. He complains frequently of having things and money stolen from him. He is very poor at managing his finances and he makes poor and impulsive judgements about purchases. He bought a car last year and gave it to his daughter which has had to be scrapped, according to her, because it was unroadworthy and too expensive to repair. He is cavalier with correspondence, often throwing mail into the corner of the room unopened. As a result, he has run up debts with council tax, water and other accounts. He can be forgetful and will often double book appointments or forget to notify the care agency when he is going away. I have had a number of fruitless visits when he has failed to be there or to answer the door."

31. Mr Chevalier notes that conditions at this flat became so bad that local authority care workers were instructed only to go to the premises two at a time. Mr Chevalier emphasises that the Claimant was frightened of his own situation, and for a considerable period before he left Exeter was saying to Mr Chevalier, and to Mr Pearson, that he had to get out, and wished to go to Cornwall to be near his daughter.

32. In September 2015, the Claimant's care package from his local authority was withdrawn, apparently at the instigation of a locum social worker, with 48 hours notice and with no discussion with the Claimant or notification to Mr Chevalier, his case manager. Mr Chevalier took a number of steps. He obtained a reassessment by a full-time social worker which demonstrated clear and eligible needs. However, the previous provider of care declined to resume service and no other provider was found. The Claimant then had to rely on assistance provided by friends and funded by

himself. Mr Chevalier was party to this agreement and states that an aspect of the arrangement was to keep the premises clean and in some sort of order. This never happened, and the premises became even more unhygienic and chaotic. At around this period, the Claimant admitted to Mr Chevalier that he remained a regular drug user, consuming crack cocaine. He was arrested and prosecuted for an attempted supply of a small quantity of crack cocaine to an undercover police officer. His physical health was highly precarious and nurses were no longer prepared to attend his home to deal with pressure sores or blocked catheters.

33. By the autumn of 2015, Mr Chevalier was extremely anxious to arrange for the Claimant to move away from the flat in Exeter. For quite a time, the Claimant had wished to move to Cornwall but neither he nor his daughter had found any suitable premises. Mr Chevalier engaged a specialist firm to look for accommodation. In the meantime he set about attempting to find drug rehabilitation units for the Claimant that would be able to manage his physical needs. In October 2015, the Claimant moved to Broadway Lodge in Weston-super-Mare. The plan was for three months' rehabilitation, after a two week initial trial, to see if Broadway Lodge could manage the physical problems. However, this admission broke down. The Claimant injected a "legal high" on admission. He had a large and serious pressure sore on his left heel, with smaller lesions on the right heel and left hip. He sustained a urinary tract infection on 21 October and was sent to hospital, where sepsis was diagnosed. He came back to Broadway Lodge three days later, but on 29 October Broadway Lodge informed the Claimant that they felt unable to manage his complex medical needs. The Claimant became very angry and, despite advice to stay at Broadway Lodge, given both by the institution themselves and by Mr Chevalier, the Claimant left on the same day. He booked into a hotel in Bridgewater.

34. Mr Chevalier was then faced with the task of trying to maintain the Claimant in hotels in the Somerset area, rather than permit him to return to Exeter. A chaotic period followed as the Claimant moved through five separate hotels. Mr Chevalier was unable to get any statutory input for the Claimant, since he was not registered with a local GP. He had to be taken to the Accident and Emergency Department in Taunton for dressing of pressure sores. Every effort to get the Claimant admitted to rehabilitation units failed until Mr Chevalier contacted the Royal Buckinghamshire Hospital in Aylesbury, a private specialist provider. Despite the high cost, Mr Chevalier concluded that this was the only practical answer, providing the expertise and experience to deal with the pressure sores and other physical needs, and allowing the Claimant to resume an attempt at rehabilitation. At this stage, Mr Chevalier had concluded that an alternative case manager was necessary, particularly since he was remote from both Aylesbury and Cornwall. An alternative case manager, Ms Catrin King was appointed and an alternative drug rehabilitation placement was found at Gladstones Clinic in the Cotswolds. The Claimant moved there in December 2015.

35. Whilst the Claimant was resident at the Gladstones Clinic, a rented property was finally found in Illogan, in Cornwall. A tenancy agreement for a year was signed in relation to this house in January 2016. On discharge from the Gladstones Clinic in mid January 2016, the Claimant moved to Illogan. A further alternative case manager, based in Cornwall, was found but it proved impossible for her to build a relationship with the Claimant. Accordingly Ms King has resumed acting as the Claimant's case manager, despite the distance.

36. It is the Claimant's evidence, unchallenged at trial, that his admission to the Gladstones Clinic was successful, in that he has been "clean" in relation to hard drugs during and after that admission. The Claimant has now settled into the Illogan house with a live-in carer.

The Risk of Future Drug Abuse: The Claimant's Psychological State

37. The Claimant's misuse of drugs is important both in considering the psychological impact of his spinal lesion and when considering his historic and future capacity to manage his own affairs. As I set out below, the Claimant is firm in asserting that he is clean of hard drugs and intends to remain so. The evidence of his daughter is that if he does revert to misusing hard drugs she will not wish to carry on with any close relationship with the Claimant, and nor would she wish that he should have contact with her children. I accept this represents a strong incentive to the Claimant and I accept that he understands that.

38. I have considered carefully the evidence of the Claimant, his daughter, the psychiatrists and the neuropsychologists. It is devoutly to be hoped that the Claimant's good intentions, the incentive and opportunity offered by his family and his move to Cornwall will help him to succeed in staying clear of serious drug addiction in the future. There is a real chance that he will do so. The fact that he will be living in better surroundings and with live-in carers will be a help to his achieving that end. It is likely also to mitigate the frequency and degree of drug abuse even if he does relapse. However, I find on the evidence that it is probable he will revert and abuse hard drugs once more. In my judgment, too little time has passed since he achieved abstinence to conclude otherwise. I sincerely hope that time and the Claimant will prove me wrong.

39. The Claimant was examined during mid to late 2015 by neuropsychologists on behalf of both sides. In June 2015, he was seen by Dr. Louis van Graan instructed on his behalf. There is agreement between the neuropsychologists that during both examinations the Claimant was trying his very best to complete all tests. Dr van Graan thought that the Claimants pre-morbid ability would have been in the average range but verbal ability slightly lower than non verbal ability. He found there was a marked deterioration in aspects of verbal intelligence, and on a measure of verbal abstraction his performance was significantly impaired with deterioration from the average range to that in the "borderline-impaired range". Spatial reasoning and construction was average. His span of processing, ability to focus, sustain attention and exert mental control were tested. His information span was blunted and he evidenced difficulty in sustaining attention and maintaining mental control. Delayed recall of visuo-spatial information was blunted and verbal learning and recall was defective. He had problems with memory of everyday matters. Performance on measures of verbal learning was defective. Performance on a measure of verbal abstraction was abnormal and he demonstrated a score on a specific questionnaire which indicated the presence of marked cognitive impairment relating to executive function.

40. Dr van Graan found that the Claimant scored for severe depression. He concluded that the Claimant was able to weigh information and reason appropriately "but only in the context of a limited span of information". In his view the Claimant would have the capacity to litigate "in very simple cases". He concluded that a case as complex

as the current case was beyond the Claimant's ability. He does retain ability, or capacity, for everyday matters that relate to activities of daily living, but Dr van Graan concluded he did not have the cognitive ability to retain reason and abstract financial or legal complexities. Dr van Graan concluded that in terms of Section 2(1) of the Mental Capacity Act 2005 the Claimant was unable to make decisions for himself in the context of the current litigation and was unable to manage his financial affairs, in each case because of the consequences of drug abuse.

41. In October 2015, the Claimant was examined and tested by Dr J L Welch on behalf of the Defendants. Dr Welch saw the Claimant at his Exeter flat and in the course of his evidence told the court that, such was the condition of the flat, Dr Welch declined to sit down anywhere and conducted his whole examination and testing of the Claimant whilst standing up:

> "I stood casually and he worked on the kitchen bench, which we cleaned for the purpose."

42. Dr Welch emphasised that in approaching the tests the Claimant was doing his best and indeed was himself resentful of the idea that he might not have capacity to make decisions.

43. Dr Welch took a careful history from the Claimant, in the course of which he gave a graphic description of the pain in his legs. He had pain which he graded as:

> "…level 6 on the 10 point scale, which is intrusive and present for up to 70 per cent of the day. Pain wakes him at night. Occasionally he will have pain which is of the intensity of 8 or 9 and normally this is associated with spasms in both legs. He told me that he felt he could deal with the pain in his right shoulder if that was all he had to contend with, but the pre-existing pain in his right shoulder and the newly acquired pains in his legs make the overall level of pain intolerable and necessitates strong medication …"

44. Dr Welch accepted the description of pain and its psychological impact, noting that the Claimant had been depressed to the extent where he had contemplated suicide which "is not unusual in such cases". The Claimant also told Dr Welch about the cognitive problems he had sustained since suffering his injuries, which might be due in some measure to the medication he took to control pain, particularly Gabapentin. His memory was worse, he tended to forget appointments and forget things he had to do. "He tells me that new learning would be out of the question".

45. When Dr Welch performed comprehensive neuropsychological assessment he too found that the estimated pre-morbid abilities were in the normal range with an estimated full scale IQ of 92. Dr Welch concluded that the current intellectual functioning was indicated by a full scale IQ score of 83, with considerable variation amongst the components. Verbal comprehension was functioning at the 37th percentile, perceptual reasoning equivalent to functioning at the 30th percentile, the working memory score equivalent to functioning at the 13th percentile and processing speed equivalent to functioning at the 3rd percentile. Dr Welch concluded that the Claimant's ability in terms of reasoning, and in particular verbal reasoning, was

"more than adequate … to reason effectively and to weigh information". The problems with processing speed were due to distractability and difficulty in attending to the task in hand, some of which was related to mental fatigue and some:

> "…a product of his long-term heroin abuse which gives rise to lasting difficulties with attention and mental speed, even when active drug taking has ceased".

Memory abilities were tested and there were significant problems with recall:

> "Overall the assessment of memory would suggest impoverished verbal and non verbal immediate recall, good delayed recall of relatively small amounts of information and slow learning. These scores are not commensurate with the estimates of pre-morbid function."

46. Dr Welch's assessment of the Claimant was that his test scores suggested:

> "Moderate depression, moderate anxiety and mild stress symptoms. He indicated specifically that he did not experience any positive feelings at all, he found it difficult to work up initiative, he tended to over-react to situations and was worried about situations in which he might panic and make a fool of himself. Lack of enthusiasm and self-worth were also evident throughout the profile. This confirms the level of psychological disturbance that [AB] expressed in interview and underscores the importance of psychological therapy as part of his rehabilitation. I understand that the current rehabilitation programme is geared towards his drug taking habits but I expect that there are also psychological issues associated with his paralysis which need further exploration and therapy input."

47. Dr Welch explored matters relating to mental capacity with the Claimant. He noted that the Claimant understood the purpose of litigation, understood the roles of his solicitor and barrister and understood why a Litigation Friend had been appointed, even though he did not agree with the need for such an appointment. In relation to management of money, Dr Welch recorded the following:

> "With regard to management of money [AB] was able to describe his weekly and monthly outgoings and sources of income. He agreed that he was not particularly vigilant with regard to bill paying and thought that the role of a buddy/support worker would be important in this regard as he admitted that he needed prompting and reminding. He also gave some explanation as to what he might do with a large sum of money and this involved taking advice on investment, placing money in Trust for his grandchildren and daughter and specifically he has a notion of buying a bus and attending festivals. This is his idea of a commercial venture which he would help run and fund, making and serving food stuffs from a converted bus. When reminded of his limitations with regard

> to mobility he showed evidence of having given this some thought and realising that adaptation and input from able bodied collaborators would be necessary for the venture to succeed."

48. In his own conclusions on capacity, Dr Welch acknowledged that the history of drug taking in the Claimant's case:

> "…could have had a profound effect on understanding of litigation process and management of money. However whilst there is evidence of problems in relation to processing speed and to tension in particular … in my opinion his problems are not sufficiently severe to suggest that he fails to demonstrate capacity."

Dr Welch went on to suggest that his situation with relation to capacity may change over time. Dr Welch felt that the steps to be taken in relation to the Claimant meant that "he could be expected to resume total abstinence from harmful drugs" and in such case would retain capacity.

49. When the neuropsychological experts discussed the case they agreed that the Claimant suffers from "a mild to moderate neurocognitive disorder". Dr van Graan believed that this condition resulted from a history of head trauma and substance abuse disorder, whereas Dr Welch believed it to be related only to the substance abuse disorder. The experts agreed that the Claimant "suffers organic brain damage affecting cognitive function". The cognitive impairment included "specifically marked decrements in aspects of memory and attention/cognitive control". The neuropsychologists agreed that "the Claimant lacks capacity to manage financial affairs when he's dependent on drugs". They agreed the Claimant "is likely to have capacity to manage financial affairs when he is free from drug dependency". They agreed that he could retain capacity to manage his financial affairs were he to be successfully rehabilitated from substance misuse, and were he to be provided with assistance and supervision.

50. A degree of confusion emerged in the course of the oral evidence as to whether the neuropsychologists had in fact agreed on the impact of cannabis consumption by the Claimant. It was clear that Dr Welch was principally focussing on "the harder drugs" which he felt were more important in terms of the long term cognitive impairments. However, Dr Welch did agree that frequent abuse of cannabis could significantly acutely affect capacity, meaning that capacity would be affected whilst the Claimant was under the influence of the drug. Dr van Graan felt that cannabis abuse was important for its effects on capacity. He also reaffirmed that if the Claimant were provided with a high level of support, that would improve his prospects of abstinence but it would still not move the estimate to probability.

51. Dr Francesca Denman was the consultant psychiatrist called on behalf of the Claimant. She first saw AB in March 2015 and reported in April. Having reviewed the Claimant's history, including his misuse of drugs, she concluded that the Claimant suffers from a substance abuse disorder (classified as ICD-10 F19.20) and an underlying personality disorder "best classified as emotionally unstable personality disorder (ICD-10 F60.3)". She also felt that he was likely to be suffering from a mild

cognitive impairment (ICD-10 F06.8) and it was she who suggested he should undergo neuropsychological testing. She concluded that he was certainly depressed and lonely and had significant levels of pain derived from his spinal injury. Moreover the pain-relieving medication which he had been prescribed affected his cognitive function and his mood. In that report Dr Denman concluded that AB had the capacity to understand and retain information, but was likely to have impaired capacity in his ability to weigh decisions. His decision-making was "often impulsive and … disorganised". He had "no real sense of the likely span of his future needs, the size of his financial settlement and the need to husband resources". Dr Denman at that stage concluded that the Claimant was unable to make relevant decisions for himself in relation to the litigation within the terms of Section 2(1) of the Mental Capacity Act 2005. He did:

> "…not appreciate the nature of the agreements that had been negotiated on his behalf in that he has no realistic appreciation of the different elements of his financial settlement, for example, vastly overweighting the value of the settlement in relation to pain and suffering as opposed to provision for future care and support. Overall therefore I think that [AB] is not able to weigh the consequences of a range of potential decisions in relation to the litigation…"

His capacity was:

> "so marginal, even quite small changes in his circumstances could improve or deteriorate his decision-making capabilities. There is undoubtedly some fixed level of difficulty but it is not so severe as to mean that whatever else happened to [AB] his capacity would remain fatally impaired."

52. Essentially, putting the matter in a simplified way, Dr Denman felt that if the Claimant could become and remain totally abstinent, he would likely regain and/or retain capacity, at least for daily living.

53. Dr Denman's second report dates from October 2015 when she had available the neuropsychological report from Dr van Graan and a range of updated information. Dr Denman concluded that the neurocognitive testing was consistent with her view that the Claimant:

> "…lacks capacity to manage his financial affairs in all but the most rudimentary way and that he lacks capacity to litigate in complex matters. [His] cognitive deficits are likely to be due to multiple factors. To the extent that they are due to organic brain damage, [AB]'s deficits will remain static over time. To the extent that [AB]'s cognitive deficits are due to [emotional unstable personality disorder] they will fluctuate over short time periods with a tendency to reduce markedly at times of emotional stress. Finally that proportion of [AB]'s deficits that are due to drug intoxication and its aftermath may respond to abstinence."

54. Psychiatric evidence on behalf of the Defendant was given by Dr Jonathan Haynes. He reported on 17 November 2015. Dr Haynes conducted a very careful review of the evidence then available, which included the evidence from the case manager Mr Chevalier. By then the Claimant was on the brink of the first admission for drug rehabilitation and the plans for a move to Cornwall had advanced from earlier in the year. Dr Haynes reviewed the extensive medical records available to him. His opinion begins by stating that:

> "[AB] has a complex history of mental disorder, starting with childhood bullying and emotional abuse from parents, resulting in longstanding low self-esteem and impulsivity together with mood lability. Medical records indicate the presence of head injuries, though I did not establish information that indicated that these were of great severity. There has been long-standing drug use, since the age of 18 … which causes neuropsychological impairment through damage to the frontal lobes of the brain affecting executive function and increasing impulsivity."

55. Dr Haynes diagnosed the Claimant as meeting the criteria for poly-drug dependence (ICD-10 F14.2, F15.2, F11.2). Dr Haynes did not consider that the Claimant met the full diagnostic criteria for emotionally unstable personality disorder but did agree that he exhibited traits of the disorder. Dr Haynes considered the Claimant may suffer from the neuropsychological effects:

> "…of chronic amphetamine misuse on his frontal lobes, affecting executive function, and resulting in poor decision-making and impulsivity".

56. However, Dr Haynes went on to conclude that he considered the Claimant did have:

> "…capacity to litigate and capacity to manage his financial affairs with appropriate advice which he is able to seek".

Dr Haynes noted that this was a different conclusion from that of Dr Denman but that it was likely the period of abstinence from drugs had resulted in the change. He concluded that the prospects of AB remaining abstinent were not good and:

> "… for this reason I consider it likely that capacity to litigate and manage his finances will not be on the balance of probabilities sustained."

57. When the psychiatric experts met they agreed that, while the Claimant is regularly using [illegal] drugs, he lacks the capacity to litigate. Dr Denman had not examined the Claimant whilst free of drugs but did not see reason to oppose the opinion of Dr Haynes that the Claimant has capacity to litigate when abstinent. Again, the psychiatrists agreed that when the Claimant was regularly using drugs he lacked capacity to manage his finances.

58. In giving evidence, essentially the expert psychiatrists restated these positions. Dr Denman restated her view that the Claimant would benefit from cognitive behaviour

therapy to deal with the psychological impact of his pain. She emphasised the difficulty for someone like the Claimant in maintaining abstinence. For someone fulfilling the diagnostic definition of dependent poly substance abuser, abstinence was "extremely difficult and … probably not volitional". She emphasised her view that the difficulty with capacity was the Claimant's inability to weigh information and make a coherent decision rather than act impulsively. She was of the view that 2½ months abstinence was not long enough to predict future abstinence. He still fell to be diagnosed as a dependent poly substance abuser, although he could be described as being in remission. She agreed with Dr Haynes that he did currently have capacity for managing his affairs and conducting litigation, but I formed the view that Dr Denman's agreement on this point was tentative.

59. Dr Haynes, in his evidence, confirmed that he regarded dependence or substance misuse as an illness within the ICD-10 definition. He stated:

> "I consider that substance misuse has an intricate set of causative factors where there is a degree of choice of decision-making, but it is complicated by personality factors, by previous experiences and by chemical changes in the brain that might occur because of chronic substance misuse."

Dr Haynes accepted that the difference between himself and Dr Denman as to the Claimant's underlying personality disorder was not a matter of real substance: he accepted that the Claimant has traits of personality disorder but was cautious about a diagnosis of the disorder itself. As to capacity, Dr Haynes's view was:

> "There is a high probability that he will give in to his impulses and start using drugs again. When he starts to use drugs his capacity will deteriorate and become lost as his drug use escalates."

Conclusions on the Claimant's Psychological State and his Capacity

60. It is clear that the Claimant has longstanding psychological problems, predating his spinal injury. I accept that these derive from a number of factors: his personality, his difficult youth and his historic drug abuse being the most important. I accept from Dr Denman there is likely to be a component related to mild head injury. I accept that he has a personality disorder, rather than merely traits pointing in that direction. He is also properly to be categorised as suffering from polydrug dependency, currently in remission, predating the medical accident.

61. In that complex context, the Claimant has suffered serious psychological consequences from his injury. These have been significant, and must not be ignored or treated as trivial because of his pre-existing difficulties. I am confident that, although his life was already chaotic, problematic and unconventional, the disability and the pain have had a major impact. The best "before and after" picture came from the Claimant's friend, David Pearson. He was an impressive witness, who underplayed none of the Claimant's pre-existing problems, but emphasised how big has been the impact of his injuries.

62. An important ingredient here is the extent and duration of the pain felt by the Claimant, particularly from his leg spasms. It is unsurprising that he has suffered depression, and has on occasion had suicidal thoughts. These are matters to be reflected in his award for pain, suffering and loss of amenity. They are also a proper basis for future cognitive behavioural therapy.

63. I turn to the question of capacity, beginning with relevant provisions of the Mental Capacity Act 2005, which read:

> **"1 The principles**
>
> (1) The following principles apply for the purposes of this Act.
>
> (2) A person must be assumed to have capacity unless it is established that he lacks capacity.
>
> (3) A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success.
>
> …
>
> **2 People who lack capacity**
>
> (1) For the purposes of this Act, a person lacks capacity in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain.
>
> (2) It does not matter whether the impairment or disturbance is permanent or temporary.
>
> (3) A lack of capacity cannot be established merely by reference to—
>
> (a) a person's age or appearance, or
>
> (b) a condition of his, or an aspect of his behaviour, which might lead others to make unjustified assumptions about his capacity."

64. As the Supreme Court emphasised in *Dunhill v Burgin (Nos 1 and 2)* [2014] 1WLR 933:

> "… even before the Mental Capacity Act 2005 came into force, capacity to manage and administer all one's property and affairs was to be judged in relation to the activity in question and not globally." (see the Headnote)

65. The psychiatric experts are agreed, in simple terms, that the Claimant at the time of trial, and because he is abstinent of "hard" drugs, has the capacity to conduct litigation

and manage his financial affairs. I have recorded my view that, at least for Dr Denman, this conclusion is highly tentative, and really consists of her feeling unable to contest the observations of Dr Haynes who saw the Claimant more recently, following withdrawal from drug abuse.

66. I should record my clear view that, when the Order of Master Roberts of 9 September 2015 was made, the Claimant was under a disability. The evidence of Mr Chevalier underscores that. Indeed the evidence of serious drug abuse by the Claimant, at least until he began his rehabilitation, means that the better view is a lack of capacity must be taken to have continued until after that treatment (or attempted treatment) commenced.

67. It was in my view perfectly proper for those representing the Claimant to continue to operate within the confines of Master Roberts' Order. The law must accommodate practicalities. The psychiatric experts' note of discussion is dated 16 January 2016, and the trial began on Tuesday, 2 February. Until 16 January the psychiatric evidence was not finally clarified. In my view there was no obligation on the Claimant's legal team, in the unusual circumstances of this case, to make an immediate application to the Court to revoke the Order. It is also clear that throughout the trial, the Claimant has been fully consulted as to the conduct of the case and in that way has been largely treated as a client with capacity.

68. The problem of capacity for the future is difficult. Even assuming that the Claimant remains abstinent of "hard" drugs, how far will his capacity extend? I accept that he has capacity for the purpose of the trial. But the "material time" next to be contemplated will be the moment when a very large sum of money is paid over, with the intention that the money will so far as possible satisfy complex needs over a long period of time. Control over such an award is a more complicated matter even than giving instructions and evidence in the course of this hearing. Here I bear in mind the views of Dr van Graan as to the limits of the Claimant's capacity. I have come to the conclusion that, even if he does <u>not</u> revert to the use of crack cocaine, "legal highs", amphetamines or heroin, the Claimant will probably not achieve and sustain the capacity to make the relevant decisions about the organisation and disposition of his life, and about spending which will arise following the award in this case.

69. This is particularly so because of the compromise reached in this case. The level of award will be assessed without reference to that compromise, but for this purpose I cannot ignore the fact that management of the eventual award will involve particularly difficult choices, given that the Claimant will have at his disposal only 60 per cent of the full quantum of damages, and indeed rather less than that, given the interim payments already made. I am convinced they are beyond the Claimant's current capacity, and will be so even if he remains free of serious drug abuse.

70. It is common ground that, if the Claimant were to resume use of some or all of the other drugs mentioned, he would lose the degree of capacity he now has.

71. There is no suggestion that the Claimant's incapacity at the next "material time" to be contemplated derives from his spinal cord injury. It does not. It derives from a complex conjunction of factors: his personality disorder, his impulsive personality, a component relating to mild head injury and the effects of his historic drug abuse, however medically categorised. There is no basis on which to quantify the

contributions of those components. Whilst I have found it is probable the Claimant will revert to abuse of hard drugs, I cannot say when, or whether such relapse will be partial and remitting, or total and long lasting.

72. The complex implementation of the large award, in respect of which I find the Claimant will be under a disability, will take time. It is to be anticipated that it may take around a year to obtain and refit a property for the Claimant's long-term use, to institute a care regime which represents the best compromise between the Claimant's needs and the available funds, and to reach and implement similar decisions on the purchase of equipment and transport. Doing the best I can, I therefore conclude that, in respect of the period until these initial decisions and arrangements are made, the Claimant will be under a disability irrespective of current drug abuse. I estimate those arrangements will take about one year to complete, following the payment to the Claimant of the substantive award following on after this judgment.

73. After that time, it seems to me probable that, absent reversion to abuse of illegal drugs, and even assuming moderate (illegal) use of cannabis, the decisions facing the Claimant are likely to be less complex. They will address staff changes within an established regime, repair and replacement of equipment, current expenditure and similar issues. As I address below, this is clearly a case for maximum use of periodical payments, and so once the initial decisions are taken, such later decisions will predominantly involve expenditure of income not capital. Doing the best I can, I conclude that at that material time the Claimant will probably have capacity, if he does not revert to significant abuse of drugs. The probability is therefore, that any lack of capacity after one year following satisfaction of this award will derive from reversion to illegal drug abuse.

74. How do those conclusions sound in law?

Ex Turpi Causa, Non Oritur Actio

75. The application of the principle of illegality to recovery in tort claims is difficult. The principle (or legal policy) of illegality has been considered by the House of Lords or the Supreme Court four times in the last decade: see *Gray v Thames Trains Limited* [2009] 1 AC 1339; *Hounga v Allen* [2014] 1 WLR 2889; *Les Laboratoires Servier and another v Apotex Inc and others* [2015] AC 430 and *Bilta (UK) Limited (in liquidation) v Nazir* [2015] 2 WLR 1168 [2015] UK SC 23. In *Hounga*, Lord Hughes put the matter thus:

> "54. As Lord Wilson JSC's penetrating analysis clearly shows, a generalised statement of the conceptual basis for the doctrine under which illegality may bar a civil claim has always proved elusive."

76. In the course of his judgment in *Les Laboratoires Servier*, Lord Sumption observed:

> "13. … The doctrine necessarily operates harshly in some cases, for it is relevant only to bar claims which would otherwise have succeeded."

77. In the course of his speech in *Gray*, Lord Hoffmann identified narrower and wider forms of the rule:

> "29. … [The Appellant's] principal argument invokes a special rule of public policy. In its wider form, it is that you cannot recover compensation for loss which you have suffered in consequence of your own criminal act. In its narrow and more specific form, it is that you cannot recover for damage which flows from loss of liberty, a fine or other punishment lawfully imposed upon you in consequence of your own unlawful act. In such a case it is the law which, as a mater of penal policy, causes the damage and it would be inconsistent for the law to require you to be compensated for that damage."

78. In paragraph 32 of his speech, Lord Hoffmann emphasised the two forms of the rule stating that:

> "The wider and simpler version is that which is applied by Flaux J: you cannot recover for damage which is the consequence of your own criminal act."

This approach was approved by Lords Phillips, Scott and Rodger in *Gray*.

79. This case is not one where the Claimant seeks compensation for the direct or indirect consequences of a criminal penalty. The Claimant is not forced to rely upon any relevant illegality in order to prove his claim (cf *Tinsley v Milligan* [1994] 1 AC 340, *Clunis v Camden and Islington Health Authority* [1998], QB 978 and *Cross v Kirkby The Times 5 April 2000;* [2000] CA transcript number 321, CA). Rather, this case is concerned with the broader principle, recognised by Lord Hoffmann, which had been summarised by Sir Anthony Clarke MR in the Court of Appeal in *Gray* as follows:

> "20. … as applied to a case like this, where it is not suggested that the cause of action arises out of an illegal act, the question seems to us to be whether the relevant loss is inextricably linked with the Claimant's illegal act or, as Beldam LJ put it, so closely connected or inextricably bound up with his criminal or illegal conduct that the court could not permit him to recover without appearing to condone that conduct."

80. As Lord Hoffmann himself put it (paragraph 54) in *Gray*, the question is whether the:

> "Injury [or head of claim] was the consequence of the Plaintiff's unlawful act."

81. I deal with two preliminary points made by the Claimant. Firstly, the Claimant seeks to debar the Defendant from any application of the *ex turpi causi* principle on the ground that illegality must be pleaded and was not pleaded in the defence in this case. The Claimant asserts that: "all matters of illegality must be pleaded and particularised" relying on *Otkritie v Urumov* [2013] EWCA Civ 1196 at paragraphs 11/12.

82. I reject this argument. As the *Otkritie* decision makes clear in paragraph 11:

> "If the facts giving rise to the illegality are such that the illegality is "manifest" or obvious, the court must take the point of its own motion."

It seems to me that in this case, the issue was obvious as a question, although I must not be thought to mean that the answer to the question is obvious. In any event, the matter was raised in the counter-schedule at least by implication which put in issue any claim relating to the costs of deputyship.

83. The next preliminary issue raised by the Claimant is that it is said that he has no significant responsibility for his drug misuse and that the case therefore falls into the exceptional category identified in *R v Drew* [2003] 1 WLR 1213 and considered by Lord Phillips in his speech in *Gray* between paragraphs 9 and 15. I reject this argument also. I accept of course the evidence that the Claimant satisfies the diagnostic criteria for poly-drug misuse, substance abuse disorder and/or poly-drug dependence. I understand the psychiatrist's evidence that for such an individual, further drug abuse may not be "volitional". However, it seems to me there are two objections to the argument. Firstly, the Claimant cannot be taken to have lacked volition in relation to his drug abuse throughout his life. Insofar as the consequences of his past drug abuse are concerned, he cannot be taken to have no responsibility for such acts. Secondly, on his own case he has stopped abusing hard drugs and intends to avoid them in the future. However difficult it may be for him to live up to his intentions, it is a matter within his choice. He says he has made such a choice. Moreover, such a relapse would involve serious criminal offending (whether prosecuted or not) and the law cannot be seen to remove responsibility for such future offending in the way suggested.

84. In closing written submissions, the Defendant made three allied points which they say stand separate from their reliance on *ex turpi causa*. They say that the consequences of the Claimant's past or future drug use were not caused by the alleged negligence, but rather by reason of the Claimant's voluntary act, thus breaking the chain of causation; that recovery for such consequences would be unreasonable since they proceed from a failure by the Claimant to mitigate his loss and that such consequences were not foreseeable as resulting from the Defendant's failure and thus the Defendant should not be required to compensate for any such consequences. It seems to me these arguments are closely allied to the wider form of the *ex turpi causa* rule identified by Lord Hoffmann. Indeed, in paragraph 54 of *Gray* he said the following:

> "It might be better to avoid metaphors like "inextricably linked" or "integral part" and to treat the question as simply one of causation. Can one say that, although the damage would not have happened but for the tortious conduct of the defendant, it was caused by the criminal act of the claimant? (*Vellino v Chief Constable of the Greater Manchester Police* [2002] 1 WLR 218) Or is the position that although the damage would not have happened without the criminal act of the claimant, it was caused by the tortious act of the defendant? (*Revill v Newbery* [1996] QB 567)."

85. I take the view that these arguments, at least on the facts of this case, add little. Before the trial of the action, the period when the Claimant most obviously lacked capacity appears to me to have derived quite directly from his drug abuse, although the other contributory factors I have mentioned were undoubtedly present. Whether one takes the view that such historic lack of capacity arose from a break in the chain of causation or that such historic lack of capacity falls to be disallowed by the application of the wider principle of *ex turpi causa* is academic. Equally, the fact that a lack of capacity was not foreseeable by the tortfeasor at the time of the tort would normally be irrelevant: the tortfeasor must take his victim as he finds him. If the Claimant had lacked capacity for other reasons than drug abuse, that complication would have been equally unforeseeable but the Defendant would have had no proper argument for excluding the consequential costs.

86. I therefore exclude from the award any costs associated with a lack of capacity before the trial.

87. I have identified the period of a year from the award as presenting the Claimant with particularly difficult and complex decisions. Since I have concluded he will lack capacity during that difficult and complex phase of decision-making, even though he has currently stopped abusing hard drugs and even if he stays free of serious drug abuse, it follows that during this period his lack of capacity is not directly caused by or "inextricably bound up with" any illegal acts.

88. After the conclusion of that period, it seems to me that, if the Claimant lacks capacity for the more manageable decisions he will then face, it will be because he has reverted to abuse of illegal drugs with serious effects of his mind. I therefore decline to make any award in respect of the costs attendant on a lack of capacity after one calendar year from the satisfaction of the award in the case.

Scott Schedule

89. The parties have helpfully drafted a Scott Schedule capturing the various agreements and contentions. In addressing the detail of the various head of claim, I have attempted to carry over my conclusions into the Schedule, which I annex to this judgment. For some detailed issues the entry in the Schedule represents my judgment as to the contentions made. There remain outstanding some minor matters which will require completion before an overall figure can be finalised.

Life Expectancy

90. This is a complex topic, about which the experts have not reached agreement. It is agreed that the Claimant is faced by multiple factors which reduce his life expectancy: his spinal cord injury, his smoking, his diabetes and, if he reverts to abuse of hard drugs, that factor as well.

91. It is agreed that the factors are cumulative, but it is not appropriate merely to add together the reduction in life expectancy which would be derived from each factor, were it to exist in isolation. Fortunately the mathematics by which cumulative risks are to be calculated does appear to be agreed. The formula can be expressed as follows: if X is risk 1 at 25% reduction in life expectancy, and Y is risk 2 at 20% reduction in life expectancy, the cumulative reduction is reached by the formula X +

Y (1.0-X) = Z. With these hypothetical values, the calculation would be 0.25 + 0.20 (1.0-0.25) = 0.40. I derive that from the report of Dr Waller, and subsequent evidence from the other experts agreeing with the approach.

92. It is also agreed that the starting point must be the projected life expectancy of a 50 year old man in the United Kingdom in 2016. That projected figure takes into account future improvements in life expectancy. Figures for other parts of the developed world vary somewhat and some of the literature recites US or Australian "uninjured" starting points, and/or outdated starting points, which can be a trap for the unwary. The Defendant's expert Mr Thumbikat gives 82 years at death as the current life expectancy in the UK and 86 years as the projected life expectancy. I accept that estimate.

93. The Claimant will understand that the process is a matter of statistics. As has often been said, the only certainty about such calculations which now follow is that they will be wrong. The uncertainties are as to how far wrong, and in which direction.

94. Experts who gave their views on this issue were Dr Waller and Mr Thumbikat for the Defendants, Mr Jamil and Professor Almond for the Claimant. There was a discussion before the trial between Mr Jamil and Mr Thumbikat, who appeared to agree on a reduced life expectancy to age 72, but it emerged this was not a true agreement but a misunderstanding. I need not tease out the history of that. During the trial there were further discussions between Professor Almond and Dr Waller leading to a joint Note of 4 February 2016. Following the trial I permitted supplementary reports from Mr Thumbikat and Mr Jamil, and further written submissions which were completed on 24 February. I have taken all that material into account.

95. The first step is to assign a figure for the reduction in life expectancy referable to the spinal cord lesion and the paraplegia.

96. The Claimant is to be categorised as a mid-thoracic paraplegic, or paraplegic at Frankel Grade B (incomplete preserved sensation only). This rather crude categorisation is to be applied when considering the literature. The scientific papers produced are relatively few in number. I will refer to them by the lead author's surname and year of publication.

97. In his initial report of June 2015, Mr Thumbikat makes several key points. The data relating to life expectancy for those with non-traumatic spinal cord injury ["SCI"] is very sparse. Such patients tend to be older and to have more co-morbidities. However, given that the effects of such injury, the "manifestations", are similar, Mr Thumbikat accepts it is reasonable to proceed from the data derived from traumatic SCI.

98. Mr Thumbikat then relies on the Frankel 1998 paper to suggest a 31% reduction in life expectancy for those in the Claimant's category. This paper is based on UK figures. He looked also at the Australian study in Middleton 2012 which suggests a 12% reduction, and at Strauss 2006, an American study, which suggests a 20/21% reduction in further life expectancy. Mr Thumbikat then discounts the American and Australian studies and applies some additional reduction in the Claimant's case, giving his view that, taking into account spinal cord injury related factors alone, the

Claimant would have a life expectancy of 23 years, to age 72. The Claimant was 49 at the date of that report.

99. In my view that was a conservative exercise. Although the Frankel figures are the only British figures available, they are based on data ranging from 1943 to 1990. This is the oldest study in the literature relied on. One can of course set to one side the actual predicted life expectancies as outdated, as Mr Thumbikat did. However, the concern remains that the reduction in life expectancy may also be outdated. The authors themselves note that there had been a "considerable improvement in survival in the last 10 years". This study excluded those who died within the first year following their injury, whereas the other relevant studies excluded those who died in the first two years, meaning that the latter studies more confidently exclude those who die from the immediate consequences of their injuries, which may of course not be confined to SCI. This point was acknowledged by the authors of Strauss 2006, commenting on the Frankel paper.

100. Mr Jamil for the Claimant criticises the Frankel 1998 paper on methodological grounds, and on the basis that the principal authors are clinicians without "background in data collection or scientific method". He also criticises the paper on the ground that the "number of individuals … who fit the Claimant's age group and level of injury was only 32", meaning that the sample size was small. I am concerned by this. The only cohort of 32 I can find in the Frankel 1998 paper is those aged 46/60 at injury, whose injury was cervical, not thoracic (Table 2). The cohort for "para[plegic] ABC" aged 31-45 at date of injury (the Claimant being 43 at date of injury) was 346 for injury years 1943-1990, (Table 2) and 152 for injury years 1973-1990 (Table 3). This is not encouraging when considering Mr Jamil's methodological criticisms.

101. In Strauss 2000, the authors engaged in a huge study of long term mortality of American SCI victims, with an overall cohort of over 19,000 people. They looked at mortality after two years post-injury. The authors conceded that, since their cohort were injured between 1973 and an unspecified date close to the preparation of their paper in mid 1999, their mortality rates "may be overestimated for recently injured persons" because of possible improvement in long-term survival. I also note that their calculations are made by reference the 1992 US Life Table, which will have set a high benchmark for comparison with large numbers within their cohort. Thus a death in 1973 is compared with uninjured life expectancy of two decades later. Nevertheless, the additional years life expectancy from this study would suggest the Claimant would live until 72 (Table 6), before considering other factors than his SCI: 21.99 years, as opposed to 27.62 years, a percentage reduction of around 20%. On the face of it, this would seem to be a somewhat conservative figure, for the reasons I have mentioned.

102. In Strauss 2006, the authors look at improved survival for victims of SCI both in the immediate post injury period of two years and thereafter. Their conclusion is there has been a very major improvement in the early period and no statistical improvement thereafter. This is counter-intuitive, given what the authors characterise as the "improvement in long-term rehabilitative care". However, the study is large, and looked at a long period, from 1973 to 2004, with a database of nearly 39,000 people. The methodology appears to be sophisticated and the main conclusion for our purposes from this study is that the gap in survival between SCI victims who have survived two years from injury and comparable individuals from the general

population may have widened, and there is no evidence that the gap has narrowed. If this is correct, then it serves to bolster the relevance of older studies (such as Strauss 2000) provided the study is focussed on the population two years after injury.

103. A similar conclusion was reached by the authors of Middleton 2012. They conducted a large study of the survival of SCI victims in Australia between 1955 and 2006. The study was confined to patients of a single specialised SCI unit in Sydney. They reviewed the literature to compare with their own findings and observed "we did not observe any trends towards reduction" in mortality after the second post-injury year.

104. However, what is notable about the Australian study was that the reduction in life expectancy for the cohort to which the Claimant belongs was markedly less than in the other studies. In the classification adopted here, the Claimant falls within "T1-S5 ABC", in other words the broad range of paraplegics including those with a markedly higher lesion than his, and those with markedly lower injury. The Australian study found an 88% of normal life expectancy for this cohort: in other words, a 12% reduction. Although the cohort for this study was drawn from one large specialised unit, that fact would not seem readily to explain the discrepancy with the other studies, given that the mortality effects studied are confined to the period after two years from injury, when the great preponderance of patients will be living in the community.

105. The Australian study was attacked in a letter from Shavelle, Strauss and others 2013 on technical grounds, although the attack focussed on a cohort of more seriously injured tetraplegic patients. This led to a robust rebuttal by Middleton, Walsh and others 2013. I am not equipped by any evidence to resolve this dispute. Mr Jamil makes the point that the journal "*Spinal Cord*" did not retract the Middleton paper, following the Shavelle, Strauss letter, and I am prepared to give the Australian study some weight.

106. Mr Jamil also makes the points that the Australian population, like that in Britain, was more homogeneous than the American, and that the Australian health care system is more akin to the NHS in Britain.

107. The final paper is Shavelle 2015, which essentially makes two points: firstly that there has been no improvement in long term survival post two years from injury over the last 30 years, and secondly, as a consequence, there is said to be a relative worsening of the life expectancy in SCI victims compared with the general population. This study is based on the American population and it maybe reflects the specifics of their healthcare systems over the relevant period.

108. I bear in mind two points made by Mr Thumbikat. Firstly, he says that the problems attendant on non-traumatic SCI are often worse than those who suffer traumatic injury. He suggests no value for this effect. Whilst I can understand the point in principle, it is hard to see why it should make a significant difference in this case. There is no indication here that the spinal lesion was connected with any other health problem. As I have said, Mr Thumbikat does not quantify this suggested effect.

109. Secondly, Mr Thumbikat suggests that the Claimant has more problems and difficulties than most SCI patients within his category. I understand this point in general terms, but, again, Mr Thumbikat does not quantify the effect. Secondly, it

seems to me there is a real risk of double-counting here, if I were to apply a rather generalised reduction in life expectancy and then make further reductions for the known and predicted intercurrent problems.

110. Taking all those matters into consideration, including the Australian study as a countervailing factor to more negative matters, I conclude the proper reduction for SCI is a 20% reduction in life expectancy.

111. I turn to the other factors: diabetes, smoking and drugs. In relation to all of them the Claimant has argued that these factors will affect many in the uninjured population, and thus the effect will be lessened. As a refinement of that proposition, the Claimant's post trial Additional Note argues as follows:

> "We note that in the Strauss paper ("Trends in Life Expectancy After Spinal Cord Injury"; Arch Phys Med Rehabil Vol 87), which took its data from the NSCISC database – the same database which provided the data for Strauss' paper from 2000 (referred to in the table above) the authors state that : "*Another limitation is that the NSCISC database does not include information on many factors such as smoking history, associated injuries, or pre-existing major medical conditions that might be of prognostic importance in determining life expectancy. If there were trends in these potentially important prognostic factors, it would confound the assessment of overall trends in mortality over time*" (p.1084). "

112. One part of that argument I have already reflected in my conclusion. The marked downward trend in smoking in the western world is likely to be part of the general increasing life expectancy. That is one reason why the 1992 uninjured life expectancy in the Strauss study will tend to produce an unrealistically high reduction in mortality for those with SCI, in a cohort which goes back to 1973.

113. Beyond that point, I cannot accede to this argument from the Claimant. The injured and uninjured population will have contained smokers and diabetics, in all these studies. It is only if it were shown that there were more smokers or more diabetics in the injured cohort as opposed to the uninjured cohort, that there would be a risk of double counting in respect of smoking or diabetes. In the absence of such evidence, the SCI studies must be taken to have smokers and diabetics in each group in equal numbers, and thus correctly to have identified the effects of SCI, not these confounding factors. Matters would be different if we were relying on the studies for actual life expectancies, rather than quantifying reduction from the projected UK male life expectancy, but we are not.

114. The Defendant's expert Dr Waller relies on the paper by Leal and others 2009 for a prediction of reduction in life expectancy for Type II diabetic smokers, factoring these two risks together. The Leal paper predicts life expectancy for Type II diabetes by reference to historic blood pressure, a measure of long term diabetic control [Hb A1C) and total cholesterol. Mr Storey has systolic blood pressure below 120. His total cholesterol is unknown and there has been no measure of his long term diabetic control. Dr Waller assumes that it is mid range. Dr Waller takes the figure for a 55

year old at 18.2 years, giving a predicted age of death at 73.2 years, which he says is "a reduction of 34.4%" for these factors alone.

115. One problem with this approach is that the Claimant is 50, not 55. This ought to benefit the Claimant, although to a marginal degree. A more important problem is that the Leal paper is based on historic ages at death, whereas the projected life expectancy from which Dr Waller has calculated the percentage reduction (correctly) incorporates future improvement in life expectancy. Without more, this would be to compare apples with pears. The Leal paper looked at deaths from a database, which were subjected to computer simulation modelling. There is no evidence before me to assist whether the reduction from a projected 86 to a projected 72/73 is methodologically correct.

116. A further problem with the application of the Leal paper relates to the Claimant and his diabetes. He was diagnosed quite recently, but when he was extremely overweight. He has now lost many kilos, indeed many stones in weight, and is not overweight at all. There is no contemporary evidence of the state of his diabetes. Professor Almond, the physician expert for the Claimant, says he would be surprised if he was frankly diabetic at all today, although he concedes there must be a reduction in life expectancy in respect of diabetes. The authors of Leal 2009 themselves write that "the risk of many types of [adverse] events also increases with the duration of diagnosed diabetes". The Leal paper assumes five years from diagnosis, which would fit reasonably well with the timescale in the Claimant's case, but may well not fit with an individual who has lost such a dramatic amount of weight over the relevant time.

117. Mr Jamil's approach to the risk of diabetes and smoking is agreed as to the mathematical methodology. As to the values, Mr Jamil suggests 11% additional reduction taking 22% as the outcome of his calculations in respect of the diabetes viewed on its own. There is no real breakdown of how he reaches those figures. However, they are supported by Professor Almond.

118. Dr Waller, in discussion with Professor Almond on 4 February, modified his position somewhat. Conscious of the risk of double counting, he reduced his estimate of these risks, taken together, to 30%.

119. Doing the best I can, I consider that the combined risks for diabetes and smoking should be factored in at 25%.

120. Following the agreed mathematical approach, the risks of SCI, diabetes and smoking, taken together, can be represented as:

$$0.20 + 0.25\ (1.0 - 0.20 = 0.8) = 0.40$$

121. Finally, it is necessary to factor in the risk to life arising from the probable resumption of serious drug abuse. This aspect was discussed between Professor Almond and Dr Waller on 4 February. Professor Almond advanced the position that the reduction should be a further 22%, which was "half the risk associated with uncontrolled drug use (which includes daily intravenous drug use)." Dr Waller appeared to agree, applying "22% for substance abuse disorder."

122. In their closing submissions of 11 February, the Defendants attacked this apparent concession, and there may be force in their concern. Dr Waller's principal position of the effect of drug abuse, in his report of 23 June 2015 was that if the Claimant continued intravenous drug use, then his life expectancy would be "reduced by an amount closer to the estimates in the cohort studies, i.e. 16 years (43.2%). Dr Waller had already observed that this was based on an overall reduction of 13.6 years in life expectancy, in a UK study, a 15.6 years reduction across a Swedish study of men with substance abuse disorder, and on a longer term study of US males with an 18.84 years reduction. These average reductions make no allowance for the age of the individual, how long they had already survived etc. The figures are crude, and there is really no evidence as to the conditions under which these cohorts survived and died. Since all were studies of dates of death, all were historic.

123. It seems to me right that the Claimant, even if he returns to intravenous drug abuse, is likely to do so in more controlled conditions than the general population of intravenous drug abusers. In such circumstances, it is agreed he will lack capacity, and others will be in a position to take considerable control of the conditions of his life. He is unlikely to find himself in the chaotic conditions confronted by those who saw him in Exeter. I therefore conclude that the reduction in life expectancy is likely to be somewhat less than these studies imply. Doing the best I can, I find there will be a 30% reduction in life expectancy from this cause, viewed on its own.

124. The outcome of that finding is the following calculation:

$$0.40 + 0.30\ (1 - 0.40) = 0.58$$

Producing a 58% reduction in the Claimant's uninjured projected life expectancy. This means that the Claimant has a future life expectancy of 15.12 years, to age 65. I round that down to 15 years.

Lifetime Multiplier

125. In their final amended Schedule of Loss, the Claimant's counsel advance a life expectancy to age 66, therefore a further 16 years of life. They submit this should lead to a multiplier of 12.54, based on Table 28 of the Ogden Tables. This seems to me an error. Table 28 suggests a multiplier of 12.54 for 15 years term certain at 2.5%. Therefore (fortuitously for the Claimant) that is the appropriate lifetime multiplier given my finding as to the Claimant's life expectancy.

General Damages for Pain, Suffering and Loss of Amenity, Provisional Damages, Interest

126. The appropriate figure under this head is £192,500. This reflects the extent of the Claimant's disability, the limitations on his independence, the extensive impact on his psychological state, his age and his life expectancy, as I have found it to be. I have borne in mind that his pre-existing shoulder disability has meant he suffers considerable pain in the shoulder as a secondary consequence of his spinal injury and he is likely to undergo further surgery to the shoulder which he would otherwise have avoided. I also bear in mind the severe spasms, which are fairly relentless and cannot be relieved by intravenous Baclofen. I note that the Claimant falls within Section 44(6) of the Legal Aid Sentencing and Punishment of Offenders Act 2012, and thus is

ineligible for the 10% uplift in general damages provided for in *Simmons v Castle* [2013] 1 WLR 1239.

127. I consider that damages in this case must be provisional, to allow for the risk that the Claimant develops syringomyelia. I am satisfied that Section 32A of the Senior Courts Act 1981 applies. Hence I have reduced this aspect of the award from £195,000.

128. Interest on that sum is to be awarded in the sum of £11,550.

Past Gratuitous Care

129. I approach this head on the following basis. I prefer the evidence of Ms Sargent as to the aggregate rates of pay as the basis for this award: the help was given at various times, and travel was involved in some instances, particularly Mr Pearson. Clearly gratuitous care by CD and her partner can only arise from August 2014. I discount a proportion of this, since it would have arisen anyway, and thus I reduce by one third the amount estimated by Ms Sargent. However, there have been two weekend stays, which should be recompensed, and I have allowed an additional £200 in that regard. Gratuitous care must be carried forward to 1 February 2016 at those rates. I regard a 25% discount to be appropriate. I have found the mathematics of the Defendant's submissions problematic. I ask the parties to agree the correct figure on those bases.

Past Case Management

130. The Claimant's case would have been difficult and complex even if he had not been abusing hard drugs in the relevant period. However, some of these costs were clearly derived from the drug abuse and would not have arisen otherwise. It is not possible to analyse this closely with any accuracy. Doing the best I can, I allow 80% of the claimed cost, therefore an award of (£34,769 x 80% = £27,815).

Past Paid Care

131. I allow Schedule items (i), (ii), (iii) and the first item numbered (iv). The second item number (iv) is no longer claimed. I allow items (v), (vi) and (vii) as claimed. I allow £300 for item (viii). I then allow item (ix). This gives a later award of £10,260 plus item (iii) and the final sum up to trial under item (v). Hence I cannot provide the final total. The parties are asked to finalise here.

Past Aids and Equipment

132. The figures awarded are as set out in the Scott Schedule. The last items are incomplete and the parties are asked to finalise.

Past Medical and Therapy Expenses

133. The Defendants are correct to say that the costs associated with the Claimant's drug abuse are not recoverable. Thus the costs of Broadway Lodge and the Gladstone Clinic cannot be recovered. The care in the Royal Buckinghamshire Hospital was necessitated because of the combination of pressure sores and the drug problem. They cannot be recovered in full. However, it seems to me reasonable that some recovery should be made, since the Claimant did need attention to pressure sores

which were significant and a potentially serious complication. Doing the best I can, I award £10,000 for care and £1,500 for consultation fees at the Royal Buckinghamshire Hospital.

Past Accommodation Costs

134. I reject the cost of the fridge freezer as a duplication of a claim under aids and equipment. Council tax would have arisen anyway and is rejected. I allow the cost of the Claimant's move to Cornwall to rented accommodation in Illogan, when he might very likely not have done so if mobile. There would in any event have been much less expense, if the Claimant moved when uninjured. I therefore allow the house clearance and removal costs. I reject the water and sewage bill as unattributable to the injury, as was the repair to the Exeter flat. The extra furniture for the house in Cornwall is attributable. The costs incurred whilst looking for accommodation are attributable, but unspecified, large, and evidently estimated. I allow £4,000: see Annex I.

135. I accept that the search for suitable property in Cornwall was attributable to the injury, and was problematic. I accept it was reasonable to instruct a property consultant. Mr Chevalier gave evidence that the search was difficult. There is no evidence that the Claimant was deliberately difficult in communication, but it seems probable that his drug problems and the chaotic progress in late 2015 may have added to the cost. The cost is also high. Doing the best I can I award £15,000.

136. The rental deposit is returnable. I allow the rent at £1,100.

137. As a result of the above, the past holiday costs cease to be claimed.

Past Deputyship and Trust Costs

138. As I have made clear above, in my judgment the Claimant did lack capacity in the past, but that was attributable to his abuse of hard drugs and is not recoverable. I do not repeat my findings on this issue.

Loss of Future Earnings

139. The Claimant had a very patchy work record. Given my findings about his involvement with drugs, and as to his other problems, I conclude that only a very modest award for loss of future earnings is appropriate pursuant to *Blamire v South Cumbria Health Authority* [1993] PIQR 01. I award £5,000.

Future Care and Case Management

140. As I have already found, the Claimant will be under a disability for a year following the award, as the major and complex decisions are taken as to the setting up of his permanent arrangements. This will be so whether or not he reverts to misuse of hard drugs. However, it is also important to consider the nature and extent of such a disability. It means the Claimant needs intensive advice and support during that period to assist with his financial and other affairs. However, such a disability will not add to his day-to-day care needs, or costs.

141. I have found it probable that the Claimant will revert to abuse of hard drugs, although it is not possible to say when, or to specify the extent of such relapse. However, if and to the extent such relapse has an impact on his care needs and costs, it will not be recoverable, for the reasons I have given. It follows that his future care claim must be determined on what the experts have referred to as "Scenario A".

142. In her addendum report of February 2016, Ms Sargent for the Claimant advanced slightly lower figures for care and case management through to age 55. Her annual figure is £79,420. I accept this figure, subject to one adjustment. For the first year of this period, the Claimant will be under a disability and I find there should be an allowance for an additional 60 hours case management at £98 per hour plus travel expenses.

143. The care and case management award for this period therefore becomes:

[A] £79,420 x 4.66		£370,097
[B] Additional case management For year 1		6,300
	Total	£376,397

144. For the ensuing period to age 60 and beyond, each side has refined their position. The Defendant's figures contain very minor variations over those years, so minor as to be essentially immaterial. The significant difference between Ms Sargent and Ms Rodd is whether the model should move from one to two live-in carers, to deal with pressure and skin problems and the worsening problems of transfers in particular. It seems to me likely that the Claimant will need to be turned at night. I found unconvincing Ms Rodd's evidence to the effect that a single live-in carer could be expected to turn the Claimant two or three times in the night, provided each episode lasts 30 minutes or less. That does not seem to me a viable pattern of work long-term. I accept that travel expenses will arise, given the Claimant's living in Cornwall.

145. I therefore find in favour of the Claimant's multiplicand, as set out in Ms Sargent's addendum report of February 2016, in the annual sum of £150,140.00. Given a multiplier to age 65 of 8.56, if this head were expressed as a capital award it would be £1,285,198.

146. There is a chance that, at the end of his life, the Claimant will need care at a rather more intensive level. I would therefore allow a contingency of £30,000 to allow for the extra cost, reduced to reflect early receipt. This contingency was acknowledged by both experts in the course of their pre-trial discussions. The appropriate discount (Ogden Table 27) is 0.7077, meaning an award of £21,231.

Future Aids and Equipment

147. My findings on these disparate items are set down in the annexed Scott Schedule. In the great majority of cases, it will be clear which evidence I accept, and I will not write a discursive judgment dealing with each such item.

148. A significant item of difference between the two sides is the ceiling hoist. The Defendant's report appears to allow both the Arjo Maxi and the X-Y hoists. (Cosmos pp 1507 and 1509). I found this difficult to unravel.

149. I have allowed for an Aquanova Bath. Given the Claimant's painful spasms, his shoulder difficulties and skin problems, I consider such an item fully reasonable. He may well use a shower as well, but in my view both are reasonable. If provided, the bath must be maintained.

150. I allow for the specialist reclining armchair, but allowance must be made for the cost of a chair in any event.

151. After careful consideration, I allow the all-terrain chair. If uninjured, with family in Cornwall, the Claimant would have been very likely to access beaches and rough ground. He should have the opportunity to do so as much as possible now. However, as he becomes older, it is likely he will do so less. I therefore would allow one replacement only, at five years.

152. I ask the parties to agree the mathematical outcome of these findings.

Physiotherapy Equipment

153. I have allowed the butterfly board. Although the Claimant has used the ordinary sliding board to date, he will be strongly advised to use the equipment which will spare his shoulder. As the joint deteriorates, he will respond to the advice.

154. I have allowed the corset but with a reduced replacement cycle. This is properly allowable but the Claimant is likely not to use it all the time.

155. I have allowed the FES cycle. It seems to me unlikely the Claimant will use the stimulation shorts.

156. I ask the parties to agree the mathematical outcome of these findings.

Assistive Technology

157. The experts in assistive technology are Joe Greenwell for the Claimant and Donna Cowan for the Defendant. This is a rather detailed aspect of the claim. They have helpfully reached agreement over a large range of the claims.

158. For convenience I record my findings following the pattern of Bundle A, pages 94 and 95. The experts are agreed that there should be an allowance of £1500 for initial consultancy and £250 for future consultancy. They are agreed on the figure of £32,107.50 for environmental control systems, on £2,800 for maintenance of the systems and £1,945 for master transmitters and mounts. The multipliers as set out on page 94 are also agreed. In relation to an annual subscription to media service, I do find that an incremental annual cost is attributable. Whilst AB might, uninjured, have purchased some package, perhaps only for some of the time, I am satisfied that there is a need for a more varied and substantive package of service, not only because he will be static in his house much more often and for longer periods, but also because there will be care staff both on duty and off. I therefore award £250 per annum under this head.

159. I reject the claim for purchase and set up of a media server, media storage and a streaming system to two televisions. Provided there is wifi throughout the premises I do not see that it is justified to have a dedicated server. I accept that it is reasonable to have a TV mount which is adjustable for the bedroom, with a replacement on a ten-yearly basis. However, there must be a contra credit against this claim for the need to have a bedroom table in any event. I therefore award £150. I reject the claim for an annual subscription to an audio book service.

160. As to the provision of computers, it appears to me reasonable that the Claimant should have a desktop computer, connected to a printer which is capable of scanning. It is also appropriate that there should be a tablet device in addition with a rugged case, a screen protector and a stand. The assumption should be that he would have had some sort of computer anyway. There must therefore be a contra credit against the claim for the principal computer. Doing the best I can I award a net claim for the main computer of £400. In addition I award the tablet device with add-ons at £450 with a replacement on a three-yearly basis.

161. I reject the claim for specialist software and USB headset for voice recognition. It seems to me the Defendant is correct in saying the use of the primitive voice recognition on the phone does not provide the basis for voice recognition more generally. I accept the claim agreed at £700 for a height-adjustable table with a ten year replacement. I see no need for a set-piece computer training session for AB or (obviously) any training on voice recognition. However, it seems to me that care staff will need to be given some handover training on the use of the assistive technology. This is best achieved by a contingency award of £250 per annum.

162. I ask the parties to agree the mathematical outcome of these findings.

Future Aids and Equipment

163. The final contested item under this heading is the powered wheelchair. I am not convinced that the Claimant reasonably needs a standing wheelchair. There are concerns about his risk of pressure sores with such a device. However, as I have indicated, I do consider it reasonable that he should be able to go on beaches and other rough ground. His move to Cornwall was reasonable, and in part by his wish and need to be near family. But for his medical injury, he would be free to move on country such as this and would no doubt do so whilst living in Cornwall.

164. The powered chair claimed is very expensive because it is a standing chair. I note that Ms Cook's earlier recommendation was a Mobility DL All-Terrain chair at £9,750. I propose therefore to award £10,000 for an all-terrain chair, with a five year replacement cycle.

165. I agree with the Claimant's evidence on air mattresses. I reject the claim for an additional sports wheelchair, as being unreasonable and indeed risky. I have allowed for a good quality powered chair, but at a lower cost than claimed.

Future Household Expenditure

166. I have considered the evidence for both sides and the written submissions. The figures I have reached are set out in the Scott Schedule. The important points are as

follows. Although the Claimant has been mobile and out and about a good deal, age, better living conditions at home and deterioration in his shoulder are likely to diminish his movements, as the care evidence shows. However, it must be borne in mind he will now have much more extensive living accommodation than he would have had uninjured. His lifestyle uninjured would probably have meant very low domestic expenditure.

167. Applying the lifetime multiplier, the full award here would be £27,865.

Future Medical and Therapy Costs

168. The claim for annual cystoscopy is justified for 11 years post ileocystoplasty as agreed. I assume that means twelve years from now. With a lifetime multiplier of 12.54 and a discount for early receipt for 12 years at 10.39, the correct multiplier is 2.15.

169. The cost of annual spinal review should be recoverable. I also agree a contingency should be allowed for other future medical costs. Setting aside Section 2(4) of the Law Reform (Personal Injuries) Act, the future provision of such cost under the NHS may be limited, rationed or only available at particular times. However, this is a contingency and I reduce the amount claimed. I follow a similar course with pain management consultation. Viagra prescriptions are widely available on the NHS and very likely to remain so.

170. I do not find it likely that the Claimant will in fact seek to father another child.

171. There was a good deal of competing evidence concerning physiotherapy. I do not intend to rehearse the contrasting positions at length. The Defendant's contention is that once routines are established, carers will be perfectly competent to assist and oversee the Claimant's exercise regime. On the other hand the Claimant's proposition is for a fairly regular and intensive input from physiotherapists.

172. Perhaps unsurprisingly, I find that an award between the two positions is appropriate. As is already clear, the Claimant faces multiple problems: a relatively high paraplegia, a pre-existing troublesome shoulder, consequential stress on transfer and an established susceptibility to pressure sores. I am persuaded that a reasonably high degree of physiotherapy input is justified. I also consider that the predicted pattern of care in (relatively remote) Cornwall, might well mean a somewhat higher than normal staff turnover, adding to the need for physiotherapy input.

173. The figures awarded are set out in Annex 1.

174. After considerable thought I do not award a home hydrotherapy pool. It seems to me that it is not in the end reasonable to engage such a large capital expenditure, when there is a risk it might not be used in the long term. However, I do therefore award a considerable annual sum to support the maximum use of hydrotherapy facilities away from the home. There is a considerable range of facilities within a variable distance from the Claimant's current home, but of course he is likely not to remain there indefinitely. It may well be he will pay privately at a considerable rate for hydrotherapy facilities. He should be able to do so frequently, given the spasms from

which he suffers. I have therefore allowed a reasonably generous annual contingency for this head.

175. For occupational therapy I have allowed for £1,260 for the first year, plus £420 per annum thereafter. This may well be spent in a varied way over the Claimant's lifetime. The calculation is therefore:

Year 1		£1,260
Year 2 on	£420 x 11.54 =	£4,849
	Total	**£6,109**

176. I have allowed for half the claimed cost of CBT. In my view any such therapy will only partly be referable to the medical inquiry, and part to the Claimant's problems with drugs.

177. I have considered the claim for dental implants. In my view it is not realistic to think work to this level will be carried out. I do accept that, but for problems derived from the injury, the Claimant would not have had his teeth removed. He is entitled to some private dental work as a consequence. I have awarded a much reduced sum.

178. I am unconvinced that the Claimant will use a robotic walking system, particularly in the light of his pressure sore risks, but also derived from his personality and outlook.

Future Accommodation Costs

179. In my view the Claimant is entitled to claim the additional rent attributable to his larger premises in Cornwall, and the removal costs. I do not accept it is reasonable to spend £25,000 on adaptation of premises which will only be occupied for one year. I have allowed a smaller sum, anticipating that the Claimant may have some adaptation costs and some making good expense at the end of his tenancy.

180. I have already indicated my decision in relation to the home hydrotherapy pool. There is no question but that hydrotherapy costs are recoverable, as a means of addressing the Claimant's spasms. However, as indicated above, I am not satisfied it is reasonable for the Claimant to make such a large capital spend for the incremental gain of his own pool, as opposed to the frequent use of private facilities for which I have provided fairly generously above.

181. I find it is reasonable for the Claimant to purchase and adapt a four bed property, given his needs, the likely staff changeovers, and his family connections. He is likely to want family to stay reasonably frequently, given his disability and such is a reasonable head of claim.

182. I have set the lifetime multiplier above. It is a reasonable assumption that he will live in Illogan for one year, and the recurring costs can reflect that. The parties are asked to finalise the figures on this head of claim.

Future Transport Costs

183. I find that the claim for the VW Caravelle is not reasonable, given the cost. I accept from Ms Rodd's letter of 16 February that the Citroen Duo with the bench seat is a reasonable alternative. That gives a vehicle cost of £31,245.

184. It does not seem to me an extended warranty is necessary on such a new vehicle.

185. I do not consider the Claimant is likely to drive.

186. I do find there will be extra running costs. The Claimant would have been unlikely to run a car at all, and if he did, the cost would have been very low.

187. I reject the claim for purchase of a motor home. I do award extra costs for holidays, which could cover the hire of a motor home for holidays.

Future Deputyship/Trust Costs

188. The Claimant argues that he will need help in making his financial dispositions, and that Trust arrangements and the appointment of a Deputy should be recoverable. Part of this argument turns on his supposed incapacity, and on the causes of incapacity. I have addressed those above. I have concluded that there will be a lack of capacity, not derived from unlawful activity, for the period (I estimate to be one year) when the Claimant will face major choices about very large sums of money. This goes far beyond mere investment advice, and in my view is not caught by the principle stated in *Page v Plymouth Hospitals NHS Trust* [2004] 3 All ER 367 and in *Eagle v Chambers (No 2)(CA)* [2004] 1 WLR 3081. In the latter case the essential reasoning of the Court of Appeal is set out in the judgment of Waller LJ in paragraphs 88 to 98. We are here concerned not with maximising the returns on investment but with major purchases, disposals of money, and difficult choices covering the range of needs and services derived from the Claimant's injury. I therefore do award the Claimant one year's purchase of the Deputyship claim, which is agreed (subject to principle) in the sum of £39,023. I make no awards for costs claimed by reference to years 2 and following.

189. I also award the cost agreed, subject to principle, of drafting a statutory will. It would be entirely unreasonable to leave the Claimant without a will during this period. Again, I make no award beyond the first year. This head is in the sum of £9,060.

190. For the reasons expressed by Silber J in *Owen v Brown* [2002] All ER (D) 534, I make no award in respect of the costs of a trust for the Claimant's benefit. As Silber J pointed out (in paragraphs 160-163), such a trust could be broken by the Claimant essentially at will, once he has capacity.

191. For those reasons, the award under this section of the claim totals £48,083.

Conclusions

192. I am grateful for the help of all counsel in this unusual case. Given the facts, including the several relatively minor lacunae still to be completed in the figures, I am unable to express my decision now in a global award. I look forward to doing so in due course with the assistance of the parties.

Claim No: HQ12X02351

IN THE HIGH COURT OF JUSTICE
QUEEN'S BENCH DIVISION
Before Irwin J
AB (by his Litigation Friend CD) v Royal Devon & Exeter NHS Foundation Trust

SCOTT SCHEDULE
ANNEX 1 TO JUDGMENT

Notes:

1. The Court will find the following contained in this document:
    a. Summary table - into which figures in respect of some to the more straightforward items, e.g. general damages, can be entered directly
    b. Breakdown tables for the following heads of loss:
        i. Past Care
        ii. Past Aids & Equipment
        iii. Past Accommodation
        iv. Past Holidays
        v. Past Deputyship/Trust Costs
        vi. Future Care & Case Management (to be dealt with by PPO)
        vii. Future Aids & Equipment
        viii. Future Household Expenditure
        ix. Future Medical & Therapy Costs
        x. Future Transport Costs
        xi. Future Accommodation Costs
        xii. Future Holiday costs
        xiii. Future Deputyship/Trust Costs
2. Where a box is shaded grey, this indicates an outstanding area of dispute between the parties, requiring judicial determination. The Court will also need to determine life expectancy/life multiplier [M], and the likely future scenario for the Claimant - whether Scenario A, Scenario B or otherwise.
3. Figures in green indicate compromise between the parties during the trial.
4. Figures in red indicate departure (upwards) from the Schedule signed on 28/1/2016 served by C. D adopts a pragmatic stance and takes issue only with the altered figure for Past Deputyship costs (£54,672) which represents an increase of £10,719 from the latest pleaded figure. C's revised schedule which takes account of the evidence given at trial is served with this Scott Schedule.
5. The parties are agreed that Future Care and Case Management costs should be dealt with by way of PPO. These costs have therefore not been capitalised in the tables below. The Future Care and Case Management costs to 15/12/2016 (the anticipated date of the first periodical payment) will require to be pro-rated and added to the lump sum.
6. Future Aids & Equipment, and other future costs (which involve numerous repeat cost multipliers) will be calculated by the parties once the Court's determination in relation to life expectancy is known. However, the Court will be required to determine capital/initial costs and replacement periods in respect of a large number of items (as set out in the tables below). To identify the areas in dispute, the parties' summary comments in relation to various items are included below.

Summary

Item	Claimant closing submissions	Defendant closing submissions	Award
General damages for PSLA	£200,000	£168,000	£192,500
Interest on General Damages [the rate of 6% is agreed]	£12,000	£10,046	£11,550
Past Losses			
Loss of Earnings	£0	£0	£0
Care and Case Management	£65,551	£39,777	£52,376
Aids & Equipment	£20,674	£13,323	£20,363
Household Expenditure	£4,000	£4,000	£4,000
Medical & Therapy Costs	£65,506	£3,456	£14,956
Accommodation Costs	£41,201	£7,440	£27,694
Transport Costs	£8,000	£8,000	£8,000
Holiday Costs	£4,150	£0	£0
Deputyship	£54,672	£0	£0
Subtotal Past Losses	£263,755	£75,996	£127,389
Interest on Past Losses	£4,366	£1,026	£2,115
Future Losses			
Loss of Earnings	£50,000	£0	£5,000
Care and Case Management: A	PPO – see table below	PPO – see table below	£27,531 plus PPO – see table below
Aids & Equipment: A	£373,716	£119,793	£292,091
Household Expenditure	£33,447	£12,786	£27,805
Medical & Therapy Costs	£430,351	£56,407	£157,302

Accommodation Costs	£758,495	£335,019	£494,841
Transport Costs: A	£342,255	£6,406	£131,693
Holiday Costs	£38,638	£118	£18,978
Deputyship/Trust	£266,082	£0	£48,083
GRAND TOTAL (+PPO): A	**£2,773,105**	**£785,597**	£1,536,878

Past Care			
Item	**Claimant**	**Defendant**	**Award**
Gratuitous Care	£16,039	£4,468.99	£11,067
Paid Care	£13,001	£9,722.98	£13,494
Case Management	£34,769	£25,585.00	£27,815
Subtotal	**£63,809**	**£39,776.97**	£52,376

Past Aids & Equipment			
Item	**Claimant**	**Defendant**	**Award**
Clothing & footwear for wheelchair use (est @ £500 P/A)	£3,310	£1,655	£1,655
Electric Wheelchair	£80	£80	£80
E-Motion wheels	£3,995	£0	£3,995
Manual Wheelchair	£100	£100	£100
Wheelchair maintenance	£500	£500	£500
Wheelchair gloves (12 pairs at £15 per pair)	£180	£180	£180
Grab stick (£20), wheelchair bag (£20) and other misc items	£100	£40	£40
Wheelchair expenses incurred by Dave Pearson	£325	£325	£325
Exeter Disability Centre Ltd Invacare Pronto Repairs (labour) (11/02/11)	£75	£75	£75

Exeter Disability Centre Ltd Pronto Castor Wheel (09/03/11)	£11	£11	£11
Enhancements on wheelchair from Exeter Mobility Centre (05/04/13)	£200	£200	£200
Accessible Kitchen Table	£700	£700	£700
Easy reclining chair	£600	£600	£600
Laptops x 4	TBC	£0	£1,114
Mobile Phones (Averaged at £300 each)	TBC	£0	£0
Additional TV's	TBC	£0	£750
Free weights	£200	£70	£70
Blow up mattress purchased by Kymm Dear	£30	£30	£30
Mattress Protector purchased by Kymm Dear	£15	£15	£15
Replacement mattress, bedding etc purchased by Kymm Dear	£220	£220	£220
Incontinence materials purchased by Kymm Dear (estimated to Trial)	£171	£171	£171
Home Entertainment system (14/9/15)	£300	£0	£300
Scanner (16/9/15)	£100	£0	£100
Wheelchair and accessories (16/6/15)	£7,851	£7,851	£7,851
Wheelchair repairs (13/7/15)	£500	£500	£500
Cost of transporting equipment to Gladstones Clinic	£228	£0	£0
Cost of transporting equipment to Broadway Lodge	£190	£0	£0
Mobile Phone from Argos and other expenses	£694	£0	£0
Increased phone bills	TBC	£0	£781
Additional equipment purchased since 15 January 2016	TBC	£0	£0
Costs for aids and equipment up to 1 February 2016 (as estimated by Zoe Cocksedge)	TBC	£0	£0
Subtotal	**£20,675**	**£13,323**	**£20,363**

Past Medical and Therapy Expenses			
Item	**Claimant**	**Defendant**	**Award**
Podiatry	£75	£75	£75
Gym	£926	£926	£926
Physiotherapy	£1,955	£1,955	£1955
Viagra	£500	£500	£500
Rehabilitation assessment at Broadway Lodge	£6,000	£0	£0
Rehabilitation Programme at Gladstone Clinic	£9,800	£0	£0
Care for pressure sores at Royal Buckinghamshire Hospital	£39,500	£0	£10,000
Consultation fees at Royal Buckinghamshire Hospital	£6,750	£0	£1,500
Subtotal	**£65,506**	**£3,456**	£14,956

Past Accommodation Costs			
Item	**Claimant**	**Defendant**	**Award**
Flooring in Housing Association (Exeter) flat	£500	£500	£500
Flooring purchased by Dave Pearson	£90	£90	£90
Furnishing for Housing Association flat	£1,500	£1,500	£1,500
Furnishing provided by Dave Pearson	£250	£250	£250
Purchase of fridge freezer	£900	£0	£0
Decorating materials	£100	£100	£100
Estimated property finder fee	See PLG below	See PLG below	£0
Council tax 28/2/10	£725	£0	£0
Council tax 15/3/13	£173	£0	£0
Council tax 20/8/15	£194	£0	£0
House clearance	£86	£0	£86
Removal costs	£400	£0	£400
Water & sewage bill (11/9/14)	£851	£0	£0
Works by Glen Holland to Exeter flat	£100	£0	£0
Furniture for new property purchased (rental property rented unfurnished)	£950	£0	£950
Estimated costs of move to Cornwall	£1,718	£0	£1,718
Estimated further costs of furniture for rental property	£2,000	£0	£2,000
Costs incurred whilst looking for accommodation and/or visiting daughter (minimal but for sci)	£6,684	£2,000	£4,000
Property consultant's fees (PLG)			
PLG Invoice 100703 (31/03/2015)	£1,583	£0	See below
PLG Invoice 100739 (30/04/2015)	£2,465	£0	"
PLG Invoice 100778 (31/05/2015)	£1,665	£0	"

PLG Invoice 100815 (30/06/2015)	£2,272	£0	‘‘
PLG Invoice 100854 (31/07/2015)	£1,301	£0	‘‘
PLG Invoice 100896 (31/08/2015)	£923	£0	‘‘
PLG Invoice 100974 (30/09/2015)	£279	£0	‘‘
PLG Invoice 101008 (31/10/2015)	£3,036	£0	‘‘
PLG Invoice 101045 (30/11/2015)	£2,669	£0	‘‘
PLG Invoice 101082 (15/12/2015)	£105	£0	‘‘
PLG Invoice 101071 (31/12/2015)	£3,533	£0	‘‘
Estimated future invoice (PLG)	£500	£0	‘‘
Subtotal PLG	£20,330	£2,000	£15,000
Tidmans – rental deposit (Illogan)	£2,550	£0	£0
Rent – 15/1/16 to 1/2/16	£1,100	£1,000	£1,100
Subtotal	**£41,201**	**£7,440**	£27,694

Past Holiday Costs			
Item	**Claimant**	**Defendant**	**Award**
Trips to Cornwall *[Note : not pursued if allowed in Past Accommodation section]*	£3,150	£0	£0
Hotels in Cornwall *[Note : not pursued if allowed in Past Accommodation section]*	£1,000	£0	£0
Subtotal	**£4,150**	**£0**	£0

Past Deputyship & Trust Costs			
Item	**Claimant**	**Defendant**	**Award**
Trust Costs (Wrigley's invoices)	£29,298	£0	£0
Deputyship costs to date	£25,374	£0	£0
Subtotal	**£54,672**	**£0**	£0

Future Aids & Equipment

Item (Scenario A or B)	Capital Cost			Initial Cost			Repl'mnt Interval			Replacement Cost	
	C	D	J	C	D	J	C	D	J		
Aids & Equipment											
Ti-Lite Manual Wheelchair	£2,440	£2,295	£0 £2,440	£2,440	£0	£0	5	5	5	£5,758	
Annual service/parts for above	£150	£65	£125	£0	£0	£0	1	1	1	£1,442	
E-motion wheels	£4,380	£3,995	£0 £3,995	£4,380	£0	£0	5	5	5	£9,428	
Service/parts for above	£280	£0	£200	£0	£0	£0	1	0	1	£2,308	
Insurance for E-motion	£79	£54	£79	£79	£54	£79	1	1	1	£912	
Wheelchair gloves	£18	£0	£18	£18	£0	£18	1	0	1	£208	
Spare Wheelchair gloves	£18	£0	£18	£18	£0	£18	2	0	2	£104	
Wheelchair bag	£22	£0	£22	£22	£0	£22	5	0	5	£52	
Portable ramp	£250	£250	£250	£250	£250	£250	15	15	15	£0	
Roho Quadrato cushion	£480	£425	£450	£478	£425	£450	5	0	5	£1,062	
Spare cushion cover	£78	£65	£70	£78	£65	£70	2	2	2	£404	
Spare Roho cushion	£480	£425	£450	£478	£0	£450	7	0	7	£698	
Cushion clean and repair	£220	£0	£220	£220	£0	£220	5	0	5	£579	

Jay 3 backrest +supports	£757	£471	£600	£757	£471	£600	5	5	5	£1,416	
Ceiling hoist*	£9,863	£2,449	£9,863	£0	£0	£0	10	10	10	£7,672	
Slings for ceiling hoist	£744	£300	£744	£744	£300	£744	3	5	5	£1,756	
Warranty and servicing of hoist	£305	£100	£305	£0	£100		£305	1	1	£3,520	
Portable hoist	£1,900	£965	£965	£1,900	£965	£965	10	10	10	£753	
Slings for portable hoist	£200	£0	£0	£200	£0	£0	4	0	0	£0	
Travel case for portable hoist	£399	£0	£0	£399	£0	£0	5	0	0	£0	
Service and battery replacement	£277	£165	£200	£0	£0	£0	1	1	1	£2,308	
Garage door system maintenance	£79	£0	£79	£0	£0	£0	1	0		£0	
Profiling bed	£2,452	£549	£2,452	£0	£0	£0	0	0	0	£0	
Fleece heel protectors	£40	£40	£40	£40	£40	£40	0	0	0	£0	
Bed/chair table	£300	£0	£300	£300	£0	£300	10	0	0	£0	
Shower chair	£760	£500	£760	£760	£500	£760	5	10	10	£593	
Aquanova bath*	£10,839	£0	£10,839	£0	£0	£10,839	10	0	10	£8,454	
Bath servicing/parts	£594	£0	£594	£0	£0	£594	1	0	1	£6,855	
ClosomatWC*	£4,972	£0	£4,972	£0	£0	£0	15	0	0	£0	
WC servicing	£204		£204	£0	£0	£0	1	0	1	£2,354	

Reclining armchair	£1,240	£239	£940	£1,240	£239	£940	10	10	10	£733	
Reaching aid	£5	£14	£5	£5	£14	£5	2	5	2	£29	
Spare reacher	£11	£0	£11	£11	£0	£11	4	0	4	£27	
Lap tray	£45	£0	£45	£45	£0	£45	5	0	7	£70	
All terrain vehicle	£9,750	£1,295	£9,750	£9,750	£1,295	£9,750	5	5	5 Once only	£8,580 (mult 0.88)	
Servicing/parts for above	£415	£100	£200	£0	£0	£0	1	1	1	£2,308	
Insurance for all terrain vehicle	£107	£54	£75	£107	£54	£75	1	1	1	£866	

** initial cost provided for in accommodation adaptations claim*

Physiotherapy Equipment

Standing frame	£1,100	£1,100	£1,100	£1,100	£1,100	£1,100	15	15	15	£0	
Maintenance for above	£50	£50	£50	£0	£0	£0	1	1	1	£577	
Adjustable height plinth	£1,080	£945	£1,000	£1,080	£945	£1,000	0	0	0	£0	
Butterfly board	£350	£42	£350	£350	£42	£350	5	0	5	£826	
Bespoke corset	£550	£0	£550	£550	£0	£550	2	0	5	£1,298	
Floats for swimming	£31	£31	£31	£31	£31	£31	2	2	2	£179	
FES Cycle	£12,000	£9,100	£11,000	£12,000	£9,100	£11,000	10	10	10	£8,580	
FES support	£3,200	£0	£3,200	£3,200	£0	£3,200	0	0	0	£0	
FES Maintenance	£200	£200	£200	£0	£0	£0	1	1	1	£2,308	
FES stimulation shorts	£1,200	£0	£0	£1,200	£0	£0	5	0	0	£0	

Assistive Technology

Initial consultancy & advice	£1,500	£1,500	£1,500	£1,500	£1,500	£1,500	0	0	0	£0	
Future consultancy & advice	£250	£250	£250	£0	£0	£0	1	1	1	£2,885	
On-line shopping costs	£120	£0	£100	£120	£0	£100	1	0	1	£1,154	
Environmental control	£32,108	£32,108	£32,108	£32,108	£32,108	£32,108	10	10	10	£25,044	
Maintenance/repair	£2,800	£2,800	£2,800	£0	£0	£0	1	1	1	£32,212	
Master transmitters & mount	£1,945	£1,945	£1,945	£1,945	£1,945	£1,945	5	5	5	£4,590	
Film subscription	£420	£0	£250	£420	£0	£250	1	0	1	£2,885	
Media server, storage etc	£550	£0	£0	£650	£0	£0	5	0	0	£0	
TV mount for bedroom	£250	£0	£150	£250	£0	£150	10	0	10	£117	
Tablet device and warranty	£450	£0	£450	£450	£0	£450	2	0	3	£1,814	
Audio book service	£96	£0	£0	£96	£0	£0	1	0	0	£0	
Computer and warranty	£700	£650	£400	£700	£650	£400	3	3	3	£1,612	
Voice recognition software	£130	£0	£0	£130	£0	£0	3	0	0	£0	
Scanner	£60	£0	£60	£60	£0	£60	3	0	3	£242	
Broadband service	£200	£0	£0	£200	£0	£0	1	0	0	£0	
Adjustable computer table	£700	£700	£700	£700	£700	£700	10	10	10	£546	
Training	£500	£0	£0	£500	£0	£0	0	0	0	£0	
Voice recognition training	£750	£0	£0	£750	£0	£0	0	0	0	£0	

Top-up training	£250	£250	£250	£0	£250	£250	1	0	1	£2,885	

FUTURE AIDS AND EQUIPMENT

Item (Scenario A only)	**Capital Cost**			**Initial Cost**			**Repl'mnt Interval**				
	C	**D**	**J**	**C**	**D**	**J**	**C**	**D**	**J**		
Powered wheelchair	£20,980	£1,295	£10,000	£20,980	£1,295	£10,000	5	7	5	£23,600	
Servicing/batteries	£350	£100	£250	£0	£0	£0	1	1	1	£2,885	
Insurance for powered chair	£220	£54	£150	£220	£54	£150	1	1	1	£1,731	
Air mattress	£2,271	£1,785	£2,271	£2,271	£1,785	£2,271	6	0	6	£3,653	
Servicing - mattress	£100	£0	£100	£0	£0	£0	1	0	1	£1,154	
Softfoam mattress until 65	£900	£777	£900	£900	£777	£900	5	0	5	£2,214	
Sports wheelchair	£5,000	£0	£0	£5,000	£0	£0	0	0	0	£0	
Dycem roll	£12	£12	£12	£12	£12	£12	5	5	5	£28	
Lap tray	£45	£0	£45	£45	£0	£45	5	0	5	£106	
				Totals		**£95,767**				**£196,324**	

Future Household Expenditure

Item	Multiplicand			Multiplier			Sum			C comment	D comment
	C	D	J	C	D	J	C	D	J		
Gardening and household maintenance	£730	£730	£730	13.22	8.80	12.54	£9,651	£6,424	£9,154		Agreed, save for M
Window cleaning	£190	£190	£190	13.22	8.80	12.54	£2,512	£1,672	£2,385		Agreed, save for M
Heating/Electricity costs	£691	£0	£500	13.22	8.80	12.54	£9,135	£0	£6,270	C will be at home and vulnerable to the cold more than if he were uninjured. Also costs for carers	C reports that he is out as much as possible.
Clothing	£200	£100	£200	13.22	8.80	12.54	£2,644	£880	£2,508	Extra wear and tear from wheelchair use and soiling.	Claim excessive. D allows £100 p.a.
Latex disposable gloves	£75	£53	£75	13.22	8.80	12.54	£992	£466	£941	£75 pa is £1.40 pw which is entirely reasonable	Can be obtained at lower cost
Incontinency materials	£500	£250	£390	13.22	8.80	12.54	£6,610	£2,200	£4,891	Claim is modest in any event for wipes, pads and cleaning materials	Need accepted. Costed lower.
Laundry	£144	£130	£137	13.22	8.80	12.54	£1,904	£1,144	£1,718	Reasonable as claimed	Need accepted. Costed slightly

											lower.
Total							**£33,447**	**£12,786**	**£27,805**		

Future Medical & Therapy Costs

Item	Multiplicand			Multiplier			Sum			C comment	D comment
	C	D	J	C	D	J	C	D	J		
Urodynamics etc	£470+ one-off £875	See notes	£875 + £470	13.22	See notes	12.54	£9,191	£5,011	£6,769	C accepts the correct costing is one-off urodynamic study at £875 plus annual costs of £470 (£195 consultation and £275 u/s)	Mr Shah's report suggests one-off urodynamic studies (£875) followed up with annual consultation (£195) and ultrasound (£275).
Botox	£3,000	£3,000	£3,000	2	2	2	£6,000	£6,000	£6,000		Agreed
Augmentation ileocystoplasty	£17,500	£17,500	£17,500	1	1	1	£17,500	£17,500	£17,500		Agreed
Annual cystoscopy	£2,000	£0	£2000	3.59	0	2.15	£7,180	£0	£4,300	The cost is incurred annually starting 11 years after ileocystoplasty, so dependent on Life Ex	Not required owing to C's shortened l.e.

Spinal review	£750	£0	£750	13.22	0	12.54		£0	£9,405	This is for annual review with a spinal consultant – something not provided in NHS for C. C is entitled to elect private treatment in any event (see s.2(4) Law Reform (Personal Injuries) Act 1948). Will address potential complications timeously – see Mr Jamil's report at [D/43/636] for support	Not reasonably required. Given lack of private provision for acute services, C is likely to receive any such care (including hospital admission where necessary) through the NHS. This has the further advantage of maintaining continuity of care in the management of a complex, long-term problem.
Contingency for private care in specialist SCI centre & comprehensive review	£4,000	£0	£2,000	13.22	0	12.54	£52,880	£0	£25,080	This allows an average of 5 days admission pa for complications – see MrJamil's report [D/43/636]. In fact this may be a significant underestimate.	See above.
MRI	£1,400	£0	£1,400	6.45	0	6	£9,030	£0	£8,400	See above. MRI not provided routinely on NHS	See above.

X-rays	£100	£0	£100	13.22	0	12.54	£1,322	£0	£1,254	As above	See above.
Shoulder decompression	£7,000	£0	£7,000	0.8839	0	0.8839	£6,187	£0	£6,187	Mr Constant (for D) agreed C will come to surgery within 10 years – Day 2 p.26	Not required owing to C's shortened l.e.
Shoulder arthroplasty	£10,000	£0	£10,000	0.3	0	0	£3,000	£0	0	Unlikely before 20 years, so dependent upon Life Ex	Not required owing to C's shortened l.e.
Pain management consultations	£900	£0	£200	13.22	0	12.54	£11,898	£0	£2,508	C is entitled to elect private treatment in any event (see s.2(4) Law Reform (Personal Injuries) Act 1948). And see Munglani [D/45/688]	Not reasonably required. Any necessary follow-up will be available to C on the NHS free of charge.
Viagra	£468	£0	£0	13.22	0	0	£6,187	£0	£0	Entitled to private provision. Long term NHS supply questionable in any event. £9 per pill	Available free of charge as NHS prescription.
IVF (contingency)	£3,500	£0	£0	1	0	0	£3,500	£0	£0	The £3,500 is based on a 20% chance of C having one further child	Not reasonably required.
Surgery for pressure sores (contingency)	£20,000	£0	£5,000	1	0	1	£20,000	£0	£5,000	C is entitled to elect private treatment in any event (see s.2(4) Law Reform (Personal Injuries) Act 1948). In 2015 his pressure sore	Any such surgery is likely to be performed within the NHS as part of the continuity of care for C's spinal condition.

										treatment had to be private.	
Initial physiotherapy	£4,832	£3,296	£3,500	1	1	1	£4,832	£3,296	£3,500	Costs as per Ms Constantine	D allows 26 sessions in first year. Cost as per Ms Wilkinson.
Maintenance physiotherapy until trained carers in place	£1,510	£0	£1,000	1	0	1	£1,510	£0	£1,000	Reasonable need and bearing in mind carer turnover	Included in first year's costs. Simple exercises can be performed by C.
Trial of water-based exercise	£640	£640	£640	1	1	1	£640	£640	£640		Agreed.
Ongoing maintenance physiotherapy	£1,656	£1,380	£1,500	12.22	7.8	11	£20,236	£10,764	£16,500	Important for C to have input from professional	Physio JS recommends 8-10 sessions. D allows 10 at £138 per session.
Management of musculo-skeletal complications	£300	£300	£300	12.22	8.8	11.54	£3,666	£2,640	£3,462		6 sessions per year at £50 per session agreed. M to be determined.
Personal training	£280	£0	0	12.22	0	0	£3,422	£0	0	No longer pursued in light of Ms Constantine's concession	Not reasonably required. Appears conceded by C's expert in physio joint statement

											para 5.05
Hydrotherapy (if home pool not allowed)	£8,640	£5,000	£2,000	13.22	1	12.54	£114,221	£5,000	£25,080	In the event C is not awarded a home facility, this alternative claim is reasonable allowing flexibility and also for carer costs. D's contingency sum is wholly inadequate.	D does not accept that C is likely to visit a private hydro pool 3 times a week, 48 weeks a year. If he chooses to perform water-based exercise, this will mainly be in public pools, accompanied by his live-in carer. Nonetheless, D would allow a contingency of £5,000 against future costs associated with water-based exercise / hydrotherapy.
OT (annual)	£1,260	See notes		13.22	See notes		£16,657	£3,796	£6,109	Ms Cook's provision is reasonable and necessary. C will benefit from regular professional input.	In line with SR's recommendations in the OT JS, D allows an initial 7 sessions in the first year, followed by 1 session per year thereafter, with a further 4 sessions around the age of 55.

OT (wheelchair seating assessment)	£600	£0	£600	1	0	1	£600	£0	£600	One-off cost claimed – particularly important to avoid sores.	Included in item above.
Podiatry	£210	£200	£200	13.22	8.8	12.54	£2,776	£1,760	£2,508		Need agreed, cost slightly lower.
CBT	£3,000	£0		1	0		£3,000	£0	£1,500	CBT advised in Dr Munglani's report [D/45/689] and is supported by D's own Neuropsychologist – Dr Welch : "*I suspect that there are also psychological issues associated with his paralysis which need further exploration and therapy input*" [F/60/1238]	Need not agreed. C has not adduced any psychiatric evidence in support of this.

Dental Treatment	£15,000	£0	£4,000	1	0	1	£15,000	£0	£4,000	Teeth all removed when C had difficulty accessing dentist for treatment because of paraplegia. Entitled to election. Cost based on a quote received by C, but possibly less work required.	It is not agreed that C requires any additional dental treatment as a result of his spinal injury. In addition, any dental treatment he receives is likely to be provided free of charge on the NHS. The Claimant's suitability for dental implants is not admitted. The estimate is expressly based on implants whereas C's evidence was that only a few implants to anchor dentures was recommended. Nil allowed.

Further Drugs Rehabilitation Programme	£30,000	£0	0	1	0	0	£30,000	£0	0	In principle management of polysubstance abuse disorder necessary to enable care for SCI – see Spinal JS [A/A/57]. However, the psychiatrists now support community based treatment with a CPN and attendance at NA, so no further inpatient treatment indicated.	Any need for this arises from C's illegal and unreasonable behaviour in consuming illicit drugs. In any event, cost not agreed.
Orthotic walking equipment	£50,000	£0	0	1			£50,000	£0	0	The Rex system does not require use of the upper limbs. C accepts there is concern about suitability in the light of his vulnerable skin. A contingency sum for trials and/or rental would be reasonable.	Robotic walking systems will not be appropriate for C in view of need for upper limb support, pressure sores and/or C's increased tone. Ev of C's own experts was that the currently-available systems would not be suitable and would not be of therapeutic benefit.

Total							**£430,351**	**£56,407**	**£157,302**		

Future Accommodation Costs

Item	Claimant	Defendant	Award
Rental for 12 months in Cornwall	£13,200	£0	£11,000
Removal expenses and legal fees (estimate)	£2,000	£0	£2,000
Adaptation of rental property (estimate)	£25,000	£0	£10,000
Purchase price if space for hydro-pool	£454,500	£454,500	-
Purchase price if no-hydro-pool 4-bed	£411,200	£411,200	£411,200
Purchase price if no hydro-pool 3-bed	£357,500	£357,500	-
Credit for rent in an event	£2,200 pa	£2,200 pa	£2,200 pa
Suitability survey	£2,925	£2,925	£2,925
Solicitor's fee	£1,138	£1,138	£1,138
Stamp duty (subject to purchase price)			
Surveyor's report	£950	£950	£950
Moving costs	£660	£660	£660
Additional furnishings	£3,495	£3,495	£3,495
Adaptations after betterment	£232,500	£232,500	£232,500
Annual running costs			
Heating	£1,771 pa	£1,771 pa	£1,771 pa
Electricity	£1,100 pa	£1,100 pa	£1,100 pa
Water	£600 pa	£600 pa	£600 pa
Maintenance	£2,750 pa	£2,750 pa	£2,750 pa
Window cleaning	£190 pa	£190 pa	£190 pa
Gardening	£730 pa	£730 pa	£730 pa
Insurance	£217 pa	£217 pa	£217 pa
Council tax	£1,700 pa	£1,700 pa	£1,700 pa

Future Transport Costs

Note : D's primary case is that C should only recover additional taxi Costs of £14 per week and any vehicle purchase would be betterment. The figures below, which set out D's secondary case, are themselves subject to argument as to what costs C would have incurred in any event (see D closing submissions para 98(a))

Item	**Claimant**	**Defendant**	**Award**
Scenario A			
Vehicle	VW Caravelle	Berlingo Blaze[1]	Citroen Duo
Vehicle cost	£52,950	£9,998	£31,245
Replacement interval	5 yearly	5 yearly	5 yearly
Extended warranty	£600	£0	£0
Adaptations for hand controls	£1,725	£0	£0
Additional insurance costs	£1,000	£500	£750 pa
Running costs	£1,872 pa	£250 pa	£1,200 pa
Driving lessons (inc hand controls)	£2,135	£0	£0
Car valet	£180 pa	£0	£180 pa
Adapted motor home (less camping equip)	£65,800	£0	-
Replacement interval	6 years	£0	-
Warranty for motor home	£300 pa	£0	-
Servicing and MOT of motor home	£530 pa	£0	-
Scenario B			
Vehicle	Fiat Doblo	Berlingo Blaze	-
Vehicle cost	£22,995	£9,998	-
Replacement interval	5 yearly	5 yearly	-
Extended warranty	£600	£0	-
Additional insurance costs	£1,000	£500	-
Running costs	£1,144 pa	£1,144	-
Car valet	£180 pa	£0	-

[1] The Berlingo Blaze represents D's secondary case. In the event that the Court considers it reasonable for the costs of a vehicle in which C can travel as a front seat passenger, D advances a tertiary case that C's needs would be met by a Berlingo Duo at an initial cost of £29,995 with a replacement period of 5 years; a bench seat for 2 carers would be an additional £1,250. Following the invitation by the Court, these costs are set out in the letter of Ms Suzi Rodd dated 16/2/2016 provided with this Scott Schedule.

Future Holiday Costs

Item	Claimant	Defendant	Award
Fishing training for carer			
Initial cost	£50	£0	£50
New carer training every 5 years	£118	£118	£118
Adapted motor home (in Transport section)			
Holiday costs alternative to motor home	£2,910 pa	£0	£1,500

Future Deputyship/Trust Costs

Note : Costs subject to arguments of principle

Item	**Claimant**	**Defendant**	**Award**
Deputyship costs			
Application to appoint Deputy [in past cost]			
Year 1 Deputyship	£39,023	£39,023	£39,023
Year 2 Deputyship	£19,977	£19,977	£0
Year 3 and on-going	£12,138 pa	£12,138 pa	£0
Application to replace the Deputy	£3,748	£1,874[2]	£0
Application to discharge the Deputy	£3,861	£0	£0
Statutory will application	£9,060	£9,060	£9,060
Review of statutory will	£357	£0	£0
Winding up costs	£3,706	£0	£0
Contingency fund	£25,000	£25,000	£0
Trust Costs			
Executing Trust Deed	£900	£900	£0
Year 1 Trustee costs	£40,935	£12,000	£0
Year 2 Trustee costs	£22,459	£8,400	£0
Year 3 and on-going	£11,955 pa	£4,800	£0
Discharge of Deputy	£3,891	£0	£0
Preparation of Will	£900	£900	£0
Revision of Will	£600	£600	£0
Replacement Trustee	£900	£900	£0
Contingency	£34,500	£6,000	£48,083

[2] In the event that such costs are judged to be recoverable at all, D invites the Court to discount this figure by 50% to reflect (a) the contingency that it will not be incurred (b) early receipt.