Neutral Citation No. [2013] NIQB 78

Ref: **GIL8862**

Judgment: approved by the Court for handing down
*(subject to editorial corrections)**

Delivered: **05/07/2013**

IN THE HIGH COURT OF JUSTICE IN NORTHERN IRELAND

QUEEN'S BENCH DIVISION

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BETWEEN:

KD (A MINOR) BY DK, HIS MOTHER AND NEXT FRIEND

Plaintiff;

and

BELFAST SOCIAL HEALTH AND CARE TRUST

Defendant.

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GILLEN J

Background

[1] In this case the minor plaintiff has suffered a tragic catastrophic injury and is a severely disabled child with:-

- spastic quadriplegic cerebral palsy;
- epilepsy;
- learning difficulties;
- developmental delay with his right side being more severely affected than the left;
- inability to verbally communicate. He is dependent on others for everyday functional needs,

as a result of sustaining two episodes of coliform meningitis in the early neo natal period.

[2a] As is now commonplace in cases of this nature a joint meeting of the parties' advisers was held in order to explore the prospects of settlement and the type of structure most suited to this case. Liability was eventually admitted and counsel (Ms Higgins QC with Mr Dornan on behalf of the plaintiff and Mr Elliott QC with Mr McAlinden QC on behalf of the defendant) have agreed substantial areas of the quantum subject to my approval.

[2b] Certain aspects of the case were not agreed and as a result I presided over a trial that lasted 24 sitting days or thereabouts spread over several months due to the unavoidable indisposition of counsel midway through the trial and latterly due to the desire on the part of the plaintiff's advisers to revisit the epilepsy aspect of the case. The court inevitably relies on experienced counsel, familiar not only with the calculation of damages in such catastrophic injury cases but also with the financial structures that can be put in place to ensure the needs of the injured person are met whilst at the same time providing a measure of assurance for insurers that uncovenanted windfalls do not result should the estimates at trial have proved to be over optimistic from the plaintiff's perspective (see Follett v Wallace [2013] EWCACiv 146). Virtually all catastrophic cases where the issue is confined to quantum settle subject to the approval of the court. Blinkered certainty and lambent precision are rarely productive of a satisfactory outcome in these catastrophe cases. The good sense of such experienced counsel almost invariably ensures a recognition that experts may often genuinely and with good reason differ and a degree of creative compromise across the board by both parties – generosity in one area being marked by a degree of austerity in another – is usually in the best interests of the plaintiff in order to avoid the uncertainty of litigation given that he/she has the assurance that judicial approval is required at the end of the process. I could not fail to observe the strain that the unfamiliar adversarial nature of this prolonged trial had upon the plaintiff's mother as she watched the cut and thrust of the court process. The stoicism and courage with which she has met the plight of her son would have been better served if she could have been spared this added stress both within the witness box and without. It was unfortunate therefore that the legal advisers on both sides were unable to resolve their differences in the instant case and I trust that similar future cases will find it possible to fashion a return to the conventional approach.

[2c] Certain discrete areas of quantum accordingly fell for determination by me on a broad principles basis with the parties thereafter translating these findings into a periodical payments order (PPO) for my approval. Thus I shall not be dealing with any arithmetical calculations in this judgment but merely setting out guidance for the completion of the PPO by the parties for my approval. I draw the attention of the parties to RH v University Hospitals Bristol NHS Foundation Trust [2013] P.I.Q.R p12 in this regard. To that end, I have indicated that this judgment will be subject to the parties returning to me to deal further with any matter which proves

intractable despite my findings and of course any other matter which the parties reasonably consider I have not dealt with or which in the course of further discussions requires my determination.

[3] The Damages Act 1996 as amended has brought in a new regime under which damages for future losses can be awarded by way of PPOs in personal injury actions. Section 2(1) of the Act gives the court the power to make a PPO and importantly imposes a duty on the court to consider whether to make such an order in every claim for damages for future pecuniary loss in respect of personal injury. It is common case that this is a case suitable for a PPO. A PPO involves meeting a future loss by a series of future payments, set to run for life for a determined period. It has the key advantage over lump sum payments of being a more accurate way in which to access future loss. Subject to the limited power to make variable PPO under the Damages (Variation of Periodical Payments) Order 2005, a PPO is set at trial in just the same way as is a lump sum for future losses. In other words, there is no opportunity for either party to revisit the terms of the PPO once the case has been tried or settled.

Care Needs

Legal Principles

[4] The principles governing this aspect of the case in terms of the compensation to be awarded are no different from the overall approach to the damages in this case. The governing principles are as follows:-

[5] First, the starting point is as ever the statement of Lord Blackburn in Livingstone v Rawyards Coal Co [1880] 5 App CAS 25, 39 that the measure of damages is:

> "that sum of money which will put the party who has been injured, or who has suffered, in the same position as he would have been in if he had not sustained the wrong for which he is now getting his compensation or reparation".

[6] What has to be first considered by the court is not whether other treatment is reasonable but whether, given the needs of the plaintiff, the treatment chosen and claimed for by the plaintiff is reasonable. (See Stephenson LJ in Rialas v Mitchell [1984] 128 SJ 704.)

[7] There is a difference between what a plaintiff can establish as reasonable in the circumstances and what a judge objectively concludes is in the best interests of the plaintiff. As Pill LJ said in Sowden v Lodge [2005] 1 WLR 2129 at 2144 (38):-

> "In this context paternalism does not replace the right of a claimant, or those with responsibility for the claimant, making a reasonable choice…… the objective approach was rejected in the Rialas case".

[8] Accordingly, the flow of the authorities is that the court is first concerned not with whether other identified treatment is reasonable but whether that chosen by the plaintiff is reasonable recognising that a plaintiff or those looking after him are entitled to make a choice. A lesser sum is payable only if the plaintiff's choice of care is unreasonable and another form of care was reasonable. Reasonableness must be seen from the plaintiff's point of view. He must not be dictated to by the court. The action of the innocent party is not to be weighed in nice scales by the wrongdoer. The means of a defendant are irrelevant to the question of what sum will in all the circumstances of the case afford the plaintiff fair compensation.

[9] I summarise my approach in the matter by adopting a three stage approach:

- What are the plaintiff's needs?
- Is the model of care chosen by the plaintiff reasonable?
- What are the reasonable costs of meeting the plaintiff's needs? In this context there is an objective test which may incorporate an element of proportionality – the costing and figures put forward by the defendant may well be relevant if the defendant can prove that it is possible to meet the plaintiff's requirements by paying carers less per hour or working fewer hours.

[10] Ms Higgins regularly punctuated her submissions, both written and oral, with references to the need for the court to comply with Articles 3, 6, 8 and 10 of the European Convention on Human Rights ("The Convention") and the Human Rights Act 1998. It was unusual to find counsel invoking these provisions in a quantum only case to the length developed by Ms Higgins. I can deal with this approach in short compass. The correct approach for the courts to the quantification of awards of damages under the Human Rights Act (HRA) is to use the application of domestic law as its starting point but subject to any true principle which:

- emerges from the jurisprudence and consistent practice of the ECtHR;

- may apply to the case in which a party is successfully able to argue it displaces the practice of the domestic courts.

[11] The principle of restitutio in integrum underlies the provision of just satisfaction set out in Article 6. There is thus no conflict between the principles of the Convention and the principles of our own courts leaving the courts free to apply the principle in the way that it is usually applied under our own system and in accordance with precedent.

[12] Article 8 in terms of the need to respect the private life, privacy and right to self-autonomy of the plaintiff and his right to freedom of expression under Article 10 must be afforded proper regard. In doing so in this case I record that once again their observance reflects the principles that have underlined countless precedents in our own domestic courts.

Witnesses on the care issue

[13] The plaintiff called and or relied on statements made by the following witnesses.

- Ms Anne Cossar a highly experienced care professional with significant clinical and managerial experience of providing services and care packages for those affected by catastrophic injury or profound and multiple conditions. Inter alia she had been Director of the British Association of Brain Injury Case Managers between 2008-2012 and had wide experience as an expert witness in complex cases relating to the needs of those affected by disability or injury including cerebral palsy. She had been an Occupational Therapist having qualified in the 1990s and had been involved with about 20 care packages for children for cerebral palsy.

- Ms Breda Jamison an occupational therapy consultant and part time lecturer who works as a consultant occupational therapist with the Northern Ireland Police Fund. She had wide experience working as a care manager specialising in assessing and commissioning care packages for heavily dependent people living in the community.

- Ms Angela Clarke a physiotherapist since 1990 with a speciality in manual handling. She was employed as a manual handling specialist and ergonomic adviser by the defendant. Her job was to provide manual handling advice and risk assessment to staff and solving problems for staff in manual handling areas.

- Ms Sweeney, the child's current teacher at Glenveagh School which is a special education school.

- Ms Fionnuala Leneghan, the Principal of Glenveagh School for the last 7 years.

- Ms Sharon Dunn the Nursing Manager at Balmoral Homecare and Healthcare where she had the professional lead for all care provision into homes. She was responsible for the home care for KD.

- DK who is the mother of KD.

- Mrs K and Mr K, the grandparents of KD.

The defendant's witnesses

[14] The defendant called and or relied on statements made by the following witnesses.

- Ms Stephanie Martin a Nursing Care Consultant involved in assessing care needs for personal injury claims and providing expert opinion on nursing issues. She is a Registered General Nurse and Nurse Lecturer/Practice Educator who has a Master of Science Degree in Advanced Nursing and is a Nursing Lecturer at the University of Ulster. In 2006 she joined the team at Carmoney Care Consultancy as a part-time Nursing Care Consultant to provide expert opinion on nursing issues and to take individual care assessments for personal injury claims. Her evidence was that she had cared over the years for many children like the plaintiff with severe brain injuries at home and at hospital on neurosurgical wards. She is a member of the Northern Ireland Back Care Society.

- Ms Barbara Lockhead who is qualified as an occupational therapist since 1998. She currently works with the Western Health and Social Services Trust as an occupational therapist and since January 2001 started her current post as senior occupational therapist in the community setting. She works with all client groups e.g. the young physically disabled carrying a large caseload of clients with complex needs. A large portion of her work revolves around assessment of risk and the provision of manual handling equipment and manual handling risk assessments to safeguard carers. She had been undertaking medico legal assessments since 2004.

- Ms Christine Kydd whose specialist field was in nursing care with extensive clinical experience in nursing adults and children. In 1994 she had been an

Inspector to the Western Health and Social Services Board, (NI) Registration and Inspection Unit responsible for ensuring compliance with legislative standards and adherence to good practice guidelines in residential, nursing and children's homes within the Board's catchment area. In February 2001 she formed the Carmoney Care Consultancy Ltd which provided case management services for individuals who needed to employ substantial care and/or related health professional services. She has case managed clients since about 2010. Her clients have included a number of those with cerebral palsy injuries.

[15] I do not intend to burden this judgment with a detailed recitation of the contents of the evidence of each of these witnesses given over the course of many days in this trial. Instead, in setting out the salient points of the respective parties' case on this matter I shall synthesise the cumulative thrust of their points and from time to time make reference to the evidence given by one or other of them. I have of course read all of their evidence again in my notes as well as their various reports which are before me.

In light of the plaintiff's needs is the requirement by the plaintiff that this child/man has available two carers during the entirety of the day a reasonable choice of care?

The plaintiff's case

[16] It is the plaintiff's case that the use in this case of a ceiling track hoist ("the hoist") alone would dictate the choice of two carers apart from a host of other manhandling tasks. The day is full of manhandling tasks of this child which include:

- Dressing and undressing.
- Repositioning him when he slips down the wheelchair.
- Assisting when he gets off and on a mat on the floor on which he is playing either at his own home or in his grandparents' home. He enjoys being out of his wheelchair to play on the mat and to take him up and down onto the mat for spontaneous play activity requires use of the hoist.
- Getting in and out of a car.
- Being taken to and from hospital.
- Having his nappy changed. When he reaches puberty in order to preserve his privacy and dignity it is inappropriate for his mother to be performing this task.
- Arranging for him to be fed.
- Toileting bearing in mind his double incontinence needs.

- Dealing with him when he becomes non-cooperative. He is given to involuntary movements and he thrashes about and flails. He also attempts to grab the carer/operator. The child has periodic spasms which make it difficult to hold him particularly when he arches his back.
- In the hoist he is liable to hit his head on the gantry.
- Showering needs.
- He is unable to assist in any way in getting in and out of the hoist or wheelchair.
- He is liable to epileptic fits generally and thus when being transferred into the hoist.
- Ms Cossar argued that two people are needed to use the hoist to change nappies.
- Ms Cossar made the point that he cannot cognitively follow instructions and cooperate or assist in transfer or to take weight even momentarily.
- Ms Cossar's evidence was that he needs two people to be present when he is feeding to deal with any choking episodes. His mother had given evidence of two choking episodes when he choked on a piece of bacon and on a piece of orange. In those cases he needs to get out of the chair and be positioned in order to relieve the choking. In addition he needs supervision when one carer is cooking, organising the assistive technology or arranging his medication.
- Ms Cossar felt that two carers were required to help KD use the assistive technology recommended by Ms Moore. There is a considerable amount of preparation involved in planning the sessions. One carer could be organising this and the other remain with KD. The second carer could also encourage him to participate. She also asserted that art and painting and most social/play activities require two carers. One would prepare and organise the activity and the other would engage with KD. It is right to say that Glenveagh School had indicated that he requires two people to supervise him when he is painting.
- Unplanned trips or visits to the garden/outside require use of the hoist.
- He will become more difficult to deal with in the hoist as he grows older and heavier.
- He is given to self-injurious behaviour. The evidence from the Glenveagh School was that he requires more supervision than others. He can be challenging and difficult to handle.
- Ms Clarke, a physiotherapist, asserted that it was good practice in the Belfast Health and Social Care Trust to use two people with a hoist. It was her view that the transfer of a patient in a care setting and at home is the same. She drew attention to similar recommendations in the Guide to Handling of People 6th Edition National Exchange (Trading Manual).
- Ms Leneghan, the Glenveagh Principal indicated that they have two people working both the ceiling and mobile hoists in the school.

- The evidence of the plaintiff's grandmother and grandfather was that on the occasions when they took the child to outpatient's appointments at the hospital, they were informed by the hospital authorities that two nurses were required to operate a hoist. They underlined the enjoyment he gets from playing on the mat.
- Aches and pains in his hip joints make for added difficulties in moving him.
- Helena Palmer, the plaintiff's Physiotherapist (see section below on aquatic services) also indicated that two people were required to work the hoist.
- Ms Cossar had indicated that in her view (and in good practice guides in the defendant Trust) he should not be left with a carer of the opposite gender on his own to avoid abuse. Two females were required to minimise the risk of abuse in his case.
- It was her view that the dangers to normal family life of two carers being constantly there can be met by sensitive carers who are trained to recognise the problem. With the benefit of a room allotted to them family life can continue without undue intrusion.
- Only one carer would leave the carers themselves at risk of injury.

[17] In her evidence Ms Cossar indicated that she felt there would be difficulty obtaining a care package where only one person would be operating the hoist. Absent a second professional carer throughout the day, she considered that it would be necessary to rely on the mother to act as a second carer leading to tension in the family with the carers.

[18] The defendant had produced a DVD in which Ms Lockhead demonstrated working the ceiling hoist with one person. Ms Cossar criticised this and the demonstration therein on the basis that it was made with DK who was a fully cooperative adult able to understand instructions and take appropriate care for herself.

[19] Other witnesses on behalf of the plaintiff who stressed the need for two carers included:

- Ms Dunn from Balmoral Care (who were providing the care package at the time of this trial) indicated that KD's care is intense, demanding and he requires lots of stimulation. It was her evidence that the current package could not be carried out if his mother was not involved. A variety of factors contributed to this (see paragraph 16 above) but a not insignificant factor was his profound learning difficulties. She denied that a second carer would be "twiddling her thumbs" most of the time because the various activities in which he engaged required two helpers. Because of this child's challenging behaviour they had lost 11 staff from May to October involved in his care.

- At school Ms Sweeney gave evidence that he gets 1/1 support and he needs more assistance than most children.

[20] In addition, counsel drew my attention to a number of documents which were in evidence before me which allegedly supported the proposition that two carers were needed to perform the various tasks involved with the plaintiff. Illustrations included:

- There was an entry in the Glenveagh daily notes of 3 November 2011 indicating a difficulty in hoisting the child single-handedly. Reference was made to his inclination to thrust and reach for the straps. The Glenveagh history sheets refer to repositioning him as a task requiring two carers. In this context Ms Cossar had given evidence that cerebral palsy patients had difficulty sitting symmetrically due to muscle spasm hip dislocation and required to be repositioned often during the day.

- The Belfast HSC Trust care/support plan of 11 February 2010 refers to the requirement for two people to transfer him with the use of a hoist.

- The Belfast BSC Trust care pathway for the moving and handling of patients dated 7 August 2012 also referred to two people being required to hoist him from chair to bed, from wheelchair to shower and from floor to wheelchair.

- The Forest Lodge risk assessment also referred to the need for two care assistants.

[21] I have also viewed on two occasions the DVD "A Day in the Life" and have observed the challenging circumstances of the child's day to day life.

[22] This child's epilepsy was also a factor to be considered in the context of whether or not two carers constituted a reasonable requirement by the plaintiff. One of the reasons why this case was adjourned for a lengthy period was to update the position about the plaintiff's epilepsy. I had before me a report of January 2013 from Dr Mairead McGinn, consultant paediatrician with the Belfast Health and Social Care Trust who, inter alia, supervises the medical needs of children attending Glenveagh Special School. She had extensive experience in paediatric epilepsy. She recorded that the child had an underlying brain abnormality with seizures likely symptomatic of this and as such was likely to require lifelong antiepileptic medication. She recorded however that "it is reassuring that [the child] continues on his first anticonvulsant and has not required rescue medication for his seizures which are brief and self-limiting". She went on to record:

> "[the child] has had previous increases in his anticonvulsant sodium valproate in keeping with similar seizure presentations. These dose adjustments in line with his weight gain have to date resulted in good seizure control. Any opinion in relation to long term prognosis may be more appropriately addressed to an expert in paediatric neurology and epilepsy."

[23] The plaintiff was also examined by Dr Gupta, a consultant paediatric neurologist, who in his report of 6 January 2012 had recorded "he does suffer from epilepsy but this is currently well controlled on medication".

[24] In a report of 18 April 2013 Dr Gupta recorded:

> "When [KD] was reviewed by Dr McGinn on 14 January 2013 it was reported that he had had a brief seizure lasting less than two minutes one week previously. Prior to this he had been seizure free for a six months period …. However, according to the school seizure record, he had two episodes at school – one on 6 February 2013 and another on 20 February 2013. During these episodes he appeared to freeze briefly for a few seconds. His class teacher, Ms Sweeney, reported that he had a number of other similar episodes during the school year … Dr McGinn felt that some of these episodes may represent a startle response to external stimuli rather than seizure activity."

[25] Dr Gupta indicated that:

> "It is generally felt that factors such as hormonal changes during puberty, inter-current illness, underlying stress or anxiety and excitation can be triggers for seizures in people who had epilepsy. In addition, if an individual who is on antiepileptic medication gains weight … this may in turn also result in an increase in the frequency of seizures."

[26] Dr Gupta concluded in his report:

> "In my experience changes in pattern/frequency of seizures in individuals who have epilepsy are

> common and do not usually have any implications for the future pattern of seizures and their control. On the balance of probabilities I am of the opinion that this also is the case for [the child]. It is reassuring that his seizure control has remained relatively good on the first antiepileptic drug that he was commenced on. Similarly it is reassuring that when he does have seizures that these come under control again with an increase in dose. … I am therefore of the opinion that his future outlook in terms of seizure control remains good."

[27] Finally, it was the plaintiff's case that the plaintiff's mother has been under physical and psychological stress over the years. Counsel drew detailed attention to her medical notes and records and for example the care plan meeting minutes of 12 March 2012 which noted that she often reports feeling stressed and tired due to her caring responsibilities for this child alongside caring for two younger children. It noted that she was experiencing some difficulty lifting KD to change his nappy or shower him due to his physical size and strength. She has had back problems for 5 years and is currently taking anti-depressants. She wished to resume her role as a mother to all three of her children rather than as a carer.

The defendant's case

[28] It was the defendant's case through the evidence largely of Ms Martin, Ms Kydd and Ms Lockhead (who produced a DVD of a ceiling hoist being operated by one person) that it is perfectly reasonable for one person to operate a ceiling hoist. There is no danger strapping in the patient. The strapping precludes movement with a harness over the shoulder and clips around the waist. There are limited movements available and a well-trained carer can easily strap the patient in. Jerking/thrusting movements are thus well controlled. Carers are well trained to look out for problems e.g. choking and can minimise any risk. Provision will be made for KD in the new bungalow which will include a bedroom suite, sitting room, sensory room, bathroom, a smart chair and a ceiling hoist throughout all the rooms. The operator will use a remote control device which is of great assistance in getting the person into the sling and hoisting it.

[29] It was the defendant's case that everything depends upon individual assessment of patients. Ms Lockhead gave evidence that she frequently assesses the risk in the community and makes decisions as to whether it is legitimate to have one person using such equipment. To do this she looks at the equipment, the area in which it is being used and the precise use that is being made of it etc. Ms Cossar conceded in evidence that not every circumstance will require two people to use the

hoist. The three defendant witnesses were adamant that provided two carers attended for busy periods such as early morning dressing, feeding and toileting and in the evening for similar bedtime duties together with the availability of drop in service for emergencies one carer was adequate for most daily hours.

[30] There is no blanket policy, legislation or regulation therefore that requires two people to use every ceiling hoist.

[31] The repositioning and slipping down can be met by the use of a moulded inset. The spasms are dealt with in the chair with the use of slings.

[32] Diarrhoea in this patient only occurred about twice per year and his constipation problems seemed to have been resolved. In any event there is a specialist incontinence nurse who would advise on methods of dealing with this and can structure in solutions. In school he is toileted at 9.30 and again at 1.30 and that system seems to work. Similarly his toileting could be structured at home. There is no evidence of skin problems.

[33] Ms Martin in particular was adamant that a nappy can be easily changed by one person. One simply rolls the patient to one side with the sheet using the "Wendylette" system (hereinafter called "the Wendy system"). It is already done by the plaintiff's mother on her own and this was amply demonstrated by the mother to Ms Kydd and Ms Lockhead. A trained carer would have no difficulty changing a nappy on her own.

[34] There is no need for a carer to accompany him to school or to the adult education centre. (It is common case that there is no need for a carer to accompany him to school.) So far as the Adult Education/Day Care Centre Service is concerned the case was made that these are trained operators who regularly transport people such as the plaintiff and are well versed in dealing with any problems. There has been no evidence of him evincing any distress on the school bus and there is no reason to think that it would be any different in the future years when being transported to Adult Educational Courses. Day centres are staffed by professional people who would assess his needs and the caring skills to be provided. Ms Cossar admitted that his health and safety was not at risk at such adult centres but she was concerned about the level of participation without a carer being there.

[35] All the defendant witnesses emphasised that carers around the clock have the potential to create a negative effect on the enjoyment of family life and bears comparison with an institutionalised lifestyle. It presents too great an intrusion on family life and involves the loss of parental input. Any mother wishes to be at the centre of the life of her family. This is well evidenced by the fact that in her current

home the plaintiff's mother had emphasised to Ms Martin that she did not want a stranger in the house at least at night time.

Conclusion

[36] I have come to the conclusion that subject to the riders that I will add below, the requirement by the plaintiff that this child has available two carers during the day is a reasonable choice of care. I make no distinction in this need whether he is a child or an adult. He will require this level of care for the rest of his life.

[37] I commence my reasoning by making it clear that I do not consider there is any need for any carers during the child's school hours i.e. there is no need for a carer on the bus or in the school itself.

[38] I am also of the opinion that the overwhelming likelihood is that after he leaves school KD will regularly attend day care centres. I found unconvincing the suggestion by Ms Cossar that there is a trend away from such day care centres and the documentation relied on by Ms Higgins fell far short of establishing this proposition. On the contrary I accept the evidence of the defendants that these are regularly used and are staffed by caring professional and highly skilled people providing precisely the kind of care and stimulation that the plaintiff will require in his adult years. I see no basis for arguing that he will require any assistance or other stimulation at these days care centres other than that provided by the highly skilled operators there in attendance. Hence the necessity for two carers during the day will not be necessary during the periods when he will be attending the day care centres during his adult life.

[39] I understand it is agreed that there will be respite care one weekend per month which will be a total of 24 days. (I note that there was some suggestion at one stage by the defendants that this had been agreed at 30 days. Accordingly, if I am incorrect in my assessment of 24 days it should be drawn to my attention.)

[40] I also understand that there will be 14 weeks school holiday periods and only 6 weeks holiday period for the day care centres. Again if I am incorrect in my understanding of the agreement of the parties on this basis the matter should be brought back to me.

[41] In short, day care will amount to 14 hours (less the periods at school/day care/respite etc) and night care for 10 hours.

[42] I commence my reasoning for the need for two day time carers by declaring that I have no doubt that this child (and when he becomes an adult) could from time to time be dealt with in a ceiling hoist by one carer. I found the evidence of

Ms Lockhead (especially her DVD evidence), Ms Martin and Ms Kydd on this topic to be very compelling. I therefore make it clear that I have been convinced in this case that a ceiling hoist with a remote control can be safely and properly operated by one person with this plaintiff. I fully understand that institutions may take a different approach from a domiciliary setting for reasons of consistency of approach, and regulatory, legislative and employment circumstances but in domiciliary setting different options may obtain. Slipping down in his chair can be minimised by moulded insets. This in any event had not surfaced as a problem in any of the reports before me. On the nappy changing issue, I was also satisfied that it had been demonstrated to me that it is eminently possible for one person to roll the plaintiff over on his side, using a slip sheet and the "Wendy" system to change his nappy whether as a young man or as an adult without invoking the use of a hoist. I accept the evidence of Ms Martin that steps can be taken to establish a bowel pattern so that the child would rarely fail to follow the pattern. Care providers are well versed in arranging meal break cover etc especially on a package the size of this one. The risk of abuse by a carer exists even if there were two carers and in any event the unpredictable presence of the mother should arrest concerns.

[43] However, it is necessary to look at each individual case on its own facts. I believe that the particularly challenging nature of this child/young man coupled with the sheer number of manhandling tasks which the daily life of this child will bring (see paragraph [16] above) dictate that for most of the time two carers will be required for this child during the course of the day both now and in adulthood. If these tasks were not so numerous and diverse and behaviour not so challenging, then I could have been persuaded that two carers were to be confined to the limited hours suggested by the defendants. Thus I have no difficulty understanding that Ms Kydd, Mrs Martin and Mrs Lockhead all could genuinely state that they were aware of individual cases where operation of a hoist is safely carried out by a single carer.

[44] The fact of the matter is that this is a child who has significant spasticity and has developed secondary orthopaedic complications in his lower limbs resulting in him suffering from aches and pains in his muscles and joints. Great care has to be taken moving him. He has severe learning and communication difficulties with limited understanding and no speech. His behavioural problems and daily tantrums make for difficulties dealing with his flailing arms and his attempts to interfere with carers. The large number of daily tasks set out in paragraph [16] makes for a cumulative risk to both carers and the child if he does have maximum help. I have no doubt that each individual task could be performed by one carer on one or more occasions but it is the sheer weight of numbers that convinces me that two carers are required for most of his day care needs.

[45] On the other hand I am completely convinced by the argument that the approach to his care must be married wherever possible with the need to provide some basis for intimate and close family life both now and in his adulthood. He should not become institutionalised. Notwithstanding the benefits conveyed by the presence of two carers, they must by their very nature intrude enormously on normal family life and, as Ms Kydd opined, can make a mother feel excluded. Home must be distinguished from life in an institution. I do not believe that it is a reasonable choice of care which would result in him being deprived of periods when he can enjoy normal family life without the attendance of his two carers. There have to be periods both as boy and man when the house echoes solely to the sound of family exchange and not the perfectly understandable institutional sounds of carers performing their duties. Even in the new home to be arranged for him, I do not accept the evidence of the plaintiff's witnesses that it is possible for trained carers to obviate this problem. I believe there have to be periods during each day when no more than one carer should be in the house on a standby basis making herself as invisible as possible in some area removed from family life. Whilst I am conscious of the need for the court to avoid a paternalistic approach, nonetheless this is a balancing exercise that has to be carried out by a judge. Risks have to be balanced. It should be simple through experience to select periods when such a choice can be made i.e. when two carers are usually not busy and one carer who remains can make himself/herself as invisible as possible but is close at hand if needed. I tentatively suggest for example periods in the mid-morning, mid-afternoon, or in the aftermath of family meal times when he should be surrounded only by his family as far as possible both as a child and as an adult. These periods must be sufficiently lengthy to make it clear to him that they are family periods without the invasive intrusion of 2 carers.

[46] I conclude therefore that during school/day centre days there should be two carers for all daytime care outside school/day centre hours save for a period of 1½ hours when there should only be one carer. On non-school/day centre days, there should be two carers for all daytime care with the exception of a period of 3 hours when there should only be one carer. The one carer who is available during this time should make herself scarce, perhaps even to the extent of leaving the house for a short walk around the garden etc so long as she is immediately available if required in the case of an emergency. If a problem arises on rare occasions during these hours, particularly if the times are carefully chosen by experience, I am satisfied the one carer can deal with the one-off emergencies. I am equally certain that on those occasions when his mother is there she will not challenge the need to give any gratuitous extra assistance required if an emergency arises.

[47] I assume that daytime care will embrace appropriate carers should the plaintiff attend for pool attendance up to three hours per week. I was informed by counsel that provision for training of carers can also be agreed.

In light of the plaintiff's needs is the requirement by the plaintiff that this child/man has available two carers at sleeping rate during the entirety of the night a reasonable choice of care?

The Plaintiff's Case

[48] It is the plaintiff's case that two sleeping carers are required every night for the following reasons:

- The plaintiff needs to be regularly checked at night especially since he may climb over the rails of his cot and fall out or become caught up in the cot causing serious injury.

- He may be ill at night with diarrhoea or vomiting e.g. during an epileptic fit with the need for the bedding to be changed and the need to clean and shower him when this happens.

- He does have disturbed sleep. Forest Lodge notes record on 21 August 2012 him going to bed at 20:45, up at 00:02 and then 05:45 am. Reports from Care Pathway record that his sleep is disturbed several hours during the night. Sleeping care rates turn into waking care rates if there is more than 3 wakeups in a night. The mother claimed that his sleep is disturbed two to three times per night.

- He requires repositioning during the night which involves rolling him and therefore requires two carers although he has a night sleeping system (blocks of foam to help maintain his posture).

- Change of nappy at times requires two carers as it involves a rolling exercise to get the clothes off him. Two people are required to change the pad.

- He requires two carers to deal with his seizure disorder. When he has a seizure he can hurt himself against the hard surface.

- Risk of choking during night.

- It is not fair or appropriate to rely on the mother being available.

- The risk of fire, bomb alerts and need for evacuation during the night could require two people in such an emergency.

- In Forest Lodge, when he was there, he was checked on an hourly basis with two carers available.

- The only reason he has his mother as a current night carer is because there is no suitable space for two carers in their home.

- Ms Cossar had challenged the defendant's evidence of a "drop in service" on the basis that it was very difficult to organise such a drop in service and have someone available who would do this. In her view it was unrealistic as it would require paying carers to remain on standby in case they were needed. Whilst a care provider could provide assistance on a one-off situation, it could not provide a consistent care service on a regular basis. Ms Cossar emphasised the difficulties with this child relying also on the evidence of Sharon Dunn of Balmoral Care, who had indicated that they had lost 11 staff between May and October involved in KD's care.

<u>The Defendant's Case</u>

[49] It is the defendant's case that the requirement by the plaintiff for two carers at night is an unreasonable choice of care for the following reasons:

- One sleepover carer is adequate.

- The wide variety of reports to date on this child makes no positive mention of diarrhoea problems during the night or of constipation. He is doubly incontinent but an incontinence nurse is available to address this matter with strong advice on controlling fluid intake to reduce problems overnight. Moreover, alongside proper bowel and fluid intake advice, the incontinence nurse can give proper and appropriate advice on the type and size of appropriate absorbent nappy to deal with any problem of incontinence occurring during the night. I formed a clear impression from the witnesses that there was a reasonable expectation of significant improvement on this problem once the assistance of the incontinence nurse had been invoked.

- Unlike the daytime, night time is not full of manual handling tasks. The constipation problem seems solved and diarrhoea has been recorded as only happening twice per year. A raised cot should meet the rare problem of the child trying to climb out.

- According to Ms Martin, the mother informed her that she did not want outside carers in the house overnight until 14 November 2016 because she did not want anyone outside the family in the house at night. In any event "when he falls asleep that is usually him until the morning". According to

Ms Martin the mother also told her that the management of nappies was not a problem at night or at all for her. Ms Lockhead and Ms Kydd saw her changing a nappy on her own without difficulty. With appropriate medication constipation was not a problem either. No mention was made to Ms Martin of any problem with diarrhoea. Ms Martin gave evidence that she had experience of incontinence problems being well controlled with properly sized incontinence pads. Ms Cossar indicated that she hoped that the stage could be reached that the child would be sleeping through the night with nappies that were appropriate size and absorption.

- As mentioned above, if sleep was disturbed, one person can easily reassure him or, as indicated above, refresh the bed or change a nappy by the appropriate method. Similarly, if he was to choke, there is no reason why one person cannot deal with this. The records of epileptic fits do not appear to have created problems at night and the reports of Dr Gupta and Dr McGinn are optimistic about control.

- Abuse is unlikely given the presence of the other family members there in the house.

[50] In the event of extra help being needed, the defendant has proposed a drop in carer service to support the primary carer. Ms Martin indicated that ½ hourly services are routine in Agencies in most organisations and indicated that an assigned team of carers would probably be employed to look after KD, fully trained and with a detailed knowledge of KD's complex needs. Whilst Ms Martin and Ms Kydd had no experience of working with an unscheduled drop in service in Northern Ireland, Ms Kydd said that there were a number of agencies who provided such service e.g. in Whiteabbey who could provide this, namely North West Care.

Conclusions

[51] I am satisfied that there is no need for two carers throughout the night for this child now or in the future. The requirement by the plaintiff that this child has available two carers during the night is not a reasonable choice of care. I am satisfied that a reasonable choice of care for his needs would be one carer during the night with sleeping rates. I am of this view for the following reasons.

[52] First, this night care is in an entirely different category from day care. The manual handling tasks are reduced to a minimum compared to day care. If for example a ceiling hoist was required it would only likely be required on one or two occasions in very rare instances. I see no reason why the appropriate carer would not have been trained in the method outlined to me by Ms Lockhead in using that ceiling hoist for one person. With an appropriate assessment having been made, a

domiciliary package could employ carers who could use a ceiling hoist with one person as indicated above.

[53] I am also satisfied that the incontinence position could be addressed with the advice of an incontinence nurse. If a nappy did need to be changed, then, as indicated above, it should only be on rare occasions at night and once again I am satisfied as indicated by the defendant witnesses that a fully trained carer should be able to do this on her own using for example the Wendy method without the benefit of two carers. Other problems during the night of requiring to re-assure KD, prevent him choking (which seems to have happened only twice in recent years) changing the bed or dealing with a brief seizure all seem to happen so rarely that it can all be accommodated by one carer. Similarly, I have no doubt that on the very rare occasion over the years when a night time emergency might arise e.g. the need to vacate the house, on a one off basis again the carer could do this on her own with the appropriate ceiling hoist. As I have indicated earlier, I have no doubt that these ceiling hoists can be operated by one carer properly trained. I believed Ms Martin's account of what the mother had told her about her experience of night care and I considered that this was more likely to be accurate than the mother's account to me in the witness box when she was seeing matters through the prism of the current litigation. I cannot ignore the fact that the mother has been caring on her own at night for this child to date without mishap and for whatever reason has eschewed the need for any night time assistance. It illustrates how rarely, if at all, complications arise and consequently I consider it to be an unreasonable choice of care to change the system whereby two carers would be necessary every night.

[54] I am also persuaded by the evidence of Mrs Martin and Ms Kydd, that drop in services would be available. This is an extremely costly package service for this child and I would be surprised if a domiciliary service, anxious to obtain this contract, did not make such provision for this contract.

[55] Out of an abundance of caution I have decided that additional provision should be made each year for a three week period when two carers at sleeping rate will be required. This would cover periods when KD was very ill or particularly disturbed etc and would cover any extra costs of a drop in service. Finally, I do not accept the defendant's assertion that in reality there should be no commercial care at night until the plaintiff is aged 18. Whilst I accept fully that the plaintiff's mother told that to Ms Martin, notwithstanding her denial to me, I still consider that she is entitled to change her mind as I believe she may well have done and for that reason I consider that the assistance of one carer at night provided it is vouched for, should be included in the PPO from the date of this judgment onwards.

Aquatic Exercise Needs

[56] The issue now before me is to determine whether the award should include hydrotherapy/aquatic exercise needs. Given the needs of the plaintiff is the requirement by the plaintiff that this child has available aquatic care a reasonable choice of care?

The experts

[57] It is the plaintiff's case that a reasonable requirement of choice of care for this child is hydrotherapy/aquatic exercise. The primary source of this contention was found in the evidence of Ms H Palmer MCSP. This witness was a highly qualified person whose professional qualifications included MSc Paediatric Neuro Physiotherapy and a first class Honours in BSc (Hons) Physiotherapy. Her work experience included her being a Paediatric Physiotherapy Team Leader with Cambridgeshire Community Services from 2007 to 2011. She led a Paediatric Physiotherapy Team in Huntington in providing a physiotherapy service for children in both the acute and community sectors. She had 12 years' experience with children with neurological deficits.

[58] It is the defendant's case that this choice of care is unreasonable and the plaintiff has no reasonable requirement for hydrotherapy. The primary source of this contention was found in the evidence of Ms Elizabeth McKay MCSP. She was also a well-qualified expert being the lead clinical specialist in special schools between December 2002 and May 2009 with the Belfast Health and Social Care Trust and as Superintendent Physiotherapist at Mitchell House School 1992-2002. She had attended a course on Aquatic Therapy and Catastrophic Injury Litigation in 2011. Ms McKay had a speciality in neuro developmental work but she also had been managing physiotherapy in special schools including provision of aquatic therapy.

[59] I therefore regarded both these witnesses as well-qualified to comment on this matter.

[60] Both experts reported and in addition attended in May 2012 at a hydrotherapy pool. I saw a DVD of the events of that day. Ms Palmer was actually in the pool with the child and Ms McKay observed the exercise.

The plaintiff's case

[61] Ms Palmer made the following points in favour of hydrotherapy:-

- It provides a good means of pain relief.

- The warmth and movement within the water encourages relaxation, freedom of movement, alternative sensory information, the potential to exercise, increased cardiovascular fitness, head control and encourages vocalisation through enjoyment.

- The resistance in the water serves to strengthen muscles.

- Due to the severe nature of his disability KD is completely dependent on various items of equipment to maintain his postural management. The only medium in which he could be free from all these constraints is in the water. He can be mobilised in water in a way that is not possible on dry land.

- It is much easier working with KD in the water with the effects of buoyancy.

- He needs to be treated in 34 degrees thermo neutral temperatures. He is unable to move actively in order to get his body heat raised. A normal pool is about 30 degrees.

- He needs to be in a pool where there are facilities with suitable changing equipment including access to ceiling hoists and sufficient space for showering.

[62] Relying on her experience with KD in the pool (which was the subject of the DVD), she made the following points:-

- He was enjoying himself in the pool and was squealing with delight. He was distressed when he came out of the pool.

- In the pool he was able to stretch his contractures. She was able to get him to straighten out on the pool.

- She noticed a degree of further movement to his left hip after the exercise.

- His legs were able to be wrapped around her body which was impossible on land. She made the point that it is for example easier to change his nappy if his legs can be further apart with a better range of hip movement.

- Increase in range of movement is important because he cannot use a standing frame because of the level of pain in his hips and the deformity that is present.

- Assistance in head control is important because it impacts on feeding and communication.

- A spa bath would not be adequate because it does not give enough room to propel him up and down and is not deep enough to stand in.

[63] It was Ms Palmer's calculation that he should have weekly attendance at a hydrotherapy pool for leisure activity, enjoyment and mobilisation with a physiotherapist present to assist him. A carer could be taught to do part of this but the propulsion and standing work requires a trained physiotherapist. Up to the age of 19 she recommended 40 sessions per year with a physiotherapist at a cost of £4,760 per annum. After the age of 19 she recommended weekly hydrotherapy but only 6 with a physiotherapist as by that stage he would have stopped growing and did not require a programme with standing and the earlier range of movement.

[64] Ms Palmer concluded that this was the one leisure facility open to him where he is not constrained. He has complete freedom in this instance.

[65] In cross-examination the following points emerged:-

- Ms Palmer had elicited 5 degrees of movement of the plaintiff's hip after the exercise in the pool in May 2012. A report from Mr Cosgrove FRCS of 16 November 2011 recorded that the left hip could be "brought away from the midline to just about 10 degrees before the pelvis started to move". It would appear therefore that either there had been deterioration between November 2011 and May 2012 or else it was difficult to see how the hydrotherapy had brought about any improvement.

- It was unclear whether the stress the child manifested shortly after being taken out of the pool was through pain or because he was unhappy about leaving the pool. Ms Palmer's view was that it was not uncommon after one hydrotherapy treatment for some discomfort in joints which had not been taken through this range of movement for some time.

- She resisted the suggestion that a spa could perform the same functions because it was not large enough, had no drag effect of the water and there was insufficient room for the child to be moved up and down the pool.

- In response to the suggestion that the Glenveagh School had found no improvement when applying the child's nappy the next day she asserted that she would not expect improvement after one session.

- The witness felt that this exercise could improve his spine and might help long-term. It might avoid surgery if there was enough work in the pool.

The defendant's case

[66] On behalf of the defendant Ms McKay made the following points:

- The child had been in the water in May 2012 for about 20 minutes. Once out of the water he became quite distressed. Ms McKay said that they attempted to distract him and whilst he was lying on his back she moved his leg movement slightly and this caused him in her view to cry right away. She had done this to ascertain if there was pain from the hip and she concluded that the movement did cause pain. This was in contrast to the hope that the relaxation in the pool would have brought a reduction in pain. She felt that the exercise had resulted in increased pain with muscle tone increase.

- She did not feel there was any clinical improvement as a result of the hydrotherapy despite the fact that the child could enjoy being in the pool and obtained recreational benefit.

- Upon his return to Glenveagh School the next day she contacted the relevant physiotherapist who in turn spoke to the classroom assistant. The information received was that the muscles were not relaxed and there was no change at all in the range of hip movement. Whilst he did enjoy being in the pool there was no greater degree of flexibility after the return to land.

- Ms McKay asserted that there was no evidence to support that 6 sessions would have any further benefit. It was her experience that hydrotherapy benefit was often lost once you were out of the pool. Minimal gains in the pool were lost once the child was back in his chair. The child would benefit from a home spa bath with a jacuzzi which would provide sensory impact, pain relief, and reduction in muscle spasm which could be done daily at home. Thermo neutral temperature control 34 degrees – 36 degrees could be obtained as the optimum for relaxation and reduction in spasm. He could also obtain the same benefit by attending a swimming pool at Muckamore Abbey which is a purpose built facility with disabled facilities and a hoist. Muckamore Abbey would also accommodate group sessions with four people which would enable him to enjoy the benefit of company. The cost was £30 per hour and if in a group this would be less.

- Both witnesses had agreed that 6 sessions were required to train the physiotherapist to help the boy in the pool i.e. a total of £480. Mrs Palmer felt there should be 40 hours in the hydrotherapy pool at £80 per hour i.e. £3200pa. In contrast Mrs McKay felt 6 sessions in 3 blocks i.e. 18 sessions at £30 per week in the swimming pool at Muckamore Abbey would be equally beneficial.

- The witness challenged Ms Palmer's assessment that there would be an increase in the lordosis and his back could be flattened out. Ms McKay asserted that there was no evidence to show there would be any impact on his scoliosis. It was Ms McKay's evidence that with fixed contractures no amount of relaxation would affect this.

- His pain was due to subluxation of the hip. Whilst it may relax the abductors in the pool no medium or long-term benefit was obtained. With fixed contractures no amount of relaxation will affect this.

- The benefits of aquatic therapy will include cardiovascular strength, increased muscle strength and improved balance. However, none of these recognised goals of aquatic therapy will avail this patient.

- With fixed contractures in the hip, it could relax the spine but once he is back in the wheelchair the lordosis will recur.

Conclusion

[67] I prefer the evidence of Ms McKay on this matter and the plaintiff has not satisfied me that in the circumstances of his needs aquatic therapy was a reasonable choice of care. I have come to this view for the following reasons:-

(i) There was no objective evidence before me that any benefit was obtained as a result of aquatic therapy. The informed observations of Ms McKay after the child came out of the pool, the independent indications from the school the following day and the evidence of Mr Cosgrove all added weight to Ms McKay's propositions. I found Ms McKay's view reassuringly direct on this issue based as it was on empirical evidence.

(ii) Secondly, in the overarching narrative of this aspect of the case there was no firm medical evidence before me that any other material benefit would be obtained by hydrotherapy treatment which could not be obtained by use of a spa treatment advocated by Ms McKay.

(iii) Thirdly, I do not believe that the enjoyment which the child obtained from the pool could not be obtained at least to some degree in the spa context. Overall therefore I found a lack of objective evidence in the account given by Ms Palmer.