

THE HIGH COURT

[2009 No. 10043 P.]

BETWEEN

AMY VANCE (A MINOR)

SUING BY HER MOTHER AND NEXT FRIEND,

REBECCA MIDLETON

PLAINTIFF

AND

HEALTH SERVICE EXECUTIVE (WEST)

AND

CHRIS KING

DEFENDANTS

JUDGMENT of Mr. Justice Cross delivered on the 16th day of February, 2017

1. The plaintiff was born on 13th January, 1998. At birth she suffered a very severe hypoxic ischaemic insult as a result of which she developed severe cerebral palsy in the form of spastic quadriplegia.
2. Amy and her mother reside near Lifford, Co. Donegal with two younger half siblings of Amy. The plaintiff's next friend is not working and has not worked since Amy was born. Prior to that she worked in a factory job nearby. Amy's father is not living with Ms. Midleton.
3. By a settlement entered into between the parties dated 1st December 2011 the proceedings against the second named defendant were struck out and the second named defendant entered into a settlement providing for the payment of a total of €1,165,677, for the plaintiff's general damages loss of earnings travel expense to date retrospective care costs of external works and an extension to a bungalow and the future aids of appliances future GP visits and costs of further surgery if any. In addition a sum of €70,000 was provided for the cost of care for the plaintiff for two years from 1st December 2011. The defendants admitted liability.
4. On 16th April 2012 the plaintiff made a Ward of Court.
5. Notwithstanding that the costs of future care had only been provided for two years, the matter appeared in the List again, on 9th July, 2015, and an interim settlement was initially provided for up to 1st December, 2016.
6. The matter then came for hearing before me on 24th January, 2017, and by agreement between the parties and pursuant to the terms of the original settlement the matter to be determined was to the cost of the future care of the plaintiff for the remainder of her life.
7. There were two issues in the case before me (a) was the nature and extent and costs of the care required on an annual basis for the plaintiff; and (b) was the life expectancy of the plaintiff.

The Extent of the Plaintiff's Care

8. Up to date the substantial nature of the plaintiff's care has been provided by the plaintiff's mother and next friend. It is accepted by both sides that all the future care needs of the plaintiff must be professionally funded and that it is not appropriate for the plaintiff's mother and next friend to be required to provide any of the special care that Amy needs into the future.
9. The plaintiff has a history of severe quadriplegic cerebral palsy with spasticity dislocated left hip and evolving neurogenic kyphoscoliosis. She has a profound mental handicap impaired hearing blindness inability to communicate meaningfully at all save rudimentary recognition it seems of her mother. She can also show when she is in distress. She has a history of epilepsy which is now controlled by medication. Her swallowing is significantly impaired. Her drooling is constant and has worsened. She coughs while she is being fed. She has gastro-oesophageal reflux. She has fecal urinary incontinence and a genitourinary reflux for which she requires ongoing anti-biotic treatment to prevent urinary tract infections. The plaintiff has sleep apnoea and requires an oxygen mask at night. The plaintiff cannot move herself at all and her condition has worsened recently. She is fully dependent for all personal activities of daily living and requires 24 hours care. The plaintiff is fed orally by her carers. It is possible that a peg feed may be inserted in future, if this can be done by a local anaesthetic.
10. The plaintiff is transferred by means of an electric hoist to and from her bed and to and from her wheelchair. The defendants agree that the plaintiff requires two carers for any transfers, as she is incontinent she requires to have nappies changed and two persons are required for this and for all hoisting. The defendants contend that the appropriate level of care could be accommodated by one carer full time and an extra carer for four hours a day on those days when Amy attends a day centre (which she does from Monday to Thursday) and six hours a day on the days i.e. Friday, Saturday and Sunday when she does not. The plaintiff, however, contends through her expert witnesses that she requires two carers all the times she is not at the day centre. The times when the plaintiff requires two persons to lift and manoeuvre are not predictable and there maybe times when she will need the two carers at irregular times when it is necessary to have a transfer or do things such as changing a nappy or the like and accordingly it is contended that it is necessary for two carers to be present at all times in order to fulfil the agreed requirements that the plaintiff's mother should not be required to provide any of this case.
11. At night time the plaintiff contends for one waking carer and one carer who will be asleep. The defendants state that there need only be one carer at night and they have provided in their costings for some extra hours throughout the year to cater for any emergencies when a second carer could be called.
12. There are also some other differences between the parties in relation to the need for a Case Manager and other attendees which I shall discuss in greater detail hereafter.

13. Suffice it to say it is accepted by both plaintiff and defendants that the plaintiff's mother should not be required to provide the care for Amy that she has been doing up to now. It is accepted that at all times any care for Amy ought to be provided by the defendant and what is in issue is the detailed costings of the care and also the level required. Though the difference between the parties is in theory quite limited, the practical consequences in terms of the award are significant.

14. Though the original settlement in 2011 provided for money for accommodation improvements for the plaintiff was only provided quite recently due to difficulties in planning and builders. The accommodation improvements were relatively modest being rooms off the plaintiff's bedroom providing for sleeping accommodation etc. for carers. After the completion of the accommodation, a system of carers has been put in place by the Irish Wheelchair Association (IWA) in consultation with the plaintiff. The plaintiff attends day care on Mondays to Thursdays and this is likely to continue for the rest of her life. At present, two carers are provided by the IWA on Friday morning at 9am and two carers remain in place until 9:30 on Sunday night.

15. During the weekdays, when Amy is at the day centre, two carers come in at 9am until 11am and the plaintiff's mother looks after Amy in the weekdays when she returns from the day centre.

16. I had the benefit of hearing the evidence from the plaintiff's next friend and mother and seen a short video of Amy being transferred by two assistant as well as hearing from the experts on both sides.

17. I have previously set out in *Gill Russell v. HSE* (18th December, 2014), the basis of assessment of costs of future treatment or care. I approved the statements of Gillen J. in *K.D. (A Minor) v. Belfast Social Health and Care Trust* [2013] NIQB 78:-

"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."

Indeed in this case, counsel on both sides indicated agreement that the principle that the court must be concerned with is not whether any other identified treatment or care plan is reasonable but whether that plan as chosen by the plaintiff is reasonable, recognising that a plaintiff or those looking after him are entitled to make a choice. This is an aspect of the basic principle that a defendant is obliged to put a plaintiff back insofar as money can into the position he would have been but for their negligence.

18. To adopt an approach which, in effect, looks at proposals from the plaintiff and proposals from the defendant and in some way "takes an average" is fundamentally incorrect. It has been described as paternalism by Pill L.J. in *Sowden v. Lodge* [2005] 1 WLR 2129 at 2144 (38):-

"paternalism does not replace the right of a claimant, or those with responsibility for the claimant, making a reasonable choice..."

19. Accordingly, the approach is as outlined by Irvine J. in *Lennon v. HSE* [2014] IEHC 336, when she stated:-

"...the plaintiff ought to have access to sufficient funds to enable her purchase the care required to live as normal a life as is reasonably possible... to maximise her capabilities...that award must be one which is fair to the defendant in the specific circumstances of this case."

20. It is with those principles in mind that I come to assess the reasonableness of the care proposals from the plaintiff and also the arguments of the defendants to the contrary.

Determination of the Extent to the Plaintiff's Care

21. I start from the point that the plaintiff's care needs have been assessed, in consultation with the plaintiff's mother by the IWA and insofar as there is, at present, provision for care, that provision stipulates two carers at all times. In essence, this is the same level of cover as is urged upon the court for the plaintiff's care needs by her experts into the future.

22. It was suggested by the defendant's expert that the provision of two carers at night in particular was excessive and that it was stated in evidence that the plaintiff's mother said that at present both of the carers provided by the IWA were sleeping for long periods throughout the night. This proposition was not put either to the witness from the IWA or to the plaintiff's mother and I therefore cannot accept that proposition as evidence.

23. Accepting as both sides do, that it is wrong for the plaintiff's mother to be obliged to provide any of the ongoing care for the plaintiff and that she should be free to act as a mother with an adult child who is not totally dependent, I first assess the plaintiff's care plan as recommended by Ms. Noreen Roche and indeed which builds upon the present care plan in place. I accept as reasonable that the plaintiff will require two carers during the day for those hours Amy is not at the day care centre. I have carefully listened to both the plaintiff's expert and the plaintiff's mother. I have seen the video of the plaintiff and I have heard the evidence by Christine Kydd and of Patricia Kinsella, Nursing Consultants on behalf of the defendant, and I note that especially in the report of Ms. Kinsella, it is conceded that in addition to their basic contention of one carer full time with two carers being provided at limited times for hoisting and manoeuvring that a contingency figures should be allowed of 42 hours (late changed in evidence to 52 hours) per annum during the day and also an additional carer at night for 28 nights. Ms. Kinsella suggests that these additional hours should provide sufficient hours to provide for all of the plaintiff's needs allowing for various emergency calls throughout the year.

24. The provision of additional hours for carers who could be on call is to my mind entirely unsatisfactory. I accept the evidence of the plaintiff's experts, in particular Ms. Noreen Roche and also Dr. Christina Williams that the plaintiff's need for two carers at the time of hoisting and manoeuvring is entirely unpredictable. Ms. Kydd pointed out, as I accept, that the plaintiff's mother could physically help, in any unforeseen contingencies. But this, of course, runs counter to the agreement that it was inappropriate for the plaintiff's mother to be required to provide any further care for the particular needs of the plaintiff's disability. Second of all, Ms. Kydd stated that in reality, any manoeuvre by a hoist could be done perfectly safely by one person. This statement ran counter to the allowance for two carers at times of changing the plaintiff which Ms. Kydd in her report provided for and which is also, of course, provided for by the second carer expert, Ms. Kinsella, (on behalf of the defendant). Whereas one person might with safety utilise the electronic hoist, this might be suitable for a family member but it is entirely wrong to expect a single paid employee whose employer has a duty of care in respect of them to be required to hoist at any stage. The IWA provides for two carers, full time, to be available for this hoisting and other manoeuvres and the defendant's experts too have conceded the need for two carers at the time of hoisting and manoeuvring.

25. Accordingly, to expect as the defendants do, that at times outside those provided for by their estimates that the plaintiff's next friend or the existing carer should ring up some hypothetical person who may or may not be available in the locality to come into the

plaintiff's house and provide assistance in hoisting is entirely unrealistic, unreasonable and unfair. This solution would leave the plaintiff possibly distressed or uncomfortable needing to be manoeuvred or hoisted and left with potentially a faeces soiled nappy for a extensive period of time until the existing carer could find someone who was on call and available. Even if the number of additional hours for "floating" carers as provided by Ms. Kinsella was not exceeded in a given year, the fact that the plaintiff may be left with her needs untended for considerable periods of time is not acceptable.

26. I believe that such an approach is to adopt the "paternalistic" approach that has been rejected time and again in legal proceedings in this jurisdiction and in the United Kingdom.

27. In relation to the plaintiff's night time care, it follows from the above analysis that the plaintiff does require two carers, one of whom can be a sleeping carer. It may well be the case that on many occasions, the extra carer will have little practical work to do and indeed that is hoped to be the case but to provide only one carer at night in circumstances in which the plaintiff may wake or require to be manoeuvred as was done by Ms. McCafferty of IWA when she acted as a night carer and to expect such manoeuvring to be done by the one carer calling on a hypothetical person somewhere in the vicinity to come in and effect the manoeuvre or the change that is required is again entirely unreasonable.

28. I do not accept that because the plaintiff's mother agreed that Amy generally slept well that this, in any way, obviates the necessity for two carers at night. It is clear that from the expert evidence of Ms. Roche and Dr. Williams, as well as the practical evidence of Ms. McCafferty that two carers are required at night, one of whom to be sleeping. Having heard the evidence of Ms. McCafferty, and of the plaintiff's experts, I find that the sleeping carer is likely to be called on frequently and at irregular intervals. It is not acceptable that both of the night time carers be "sleeping carers".

29. Accordingly, I accept the hours for the two carers during the day when Amy is not in the day centre and at night, also, two carers one of them being a sleeping carer as claimed by the plaintiff.

30. In addition, to the full time carers as discussed above, the plaintiff seeks claims of clinical support of a nurse or equivalent for one hour per week. This is not unreasonable and was not seriously contested by the defendants. The services of a Case Manager were also claimed on behalf of the plaintiff. It is accepted by the defendants that a Case Manager is required. The only difference between the parties is that Ms. Kinsella on behalf of the defendant contends that less hours will be required and in this regard, while accepting the need for a Case Manager, I accept the workload and the hours as suggested by Ms. Kinsella who has calculated the cost of a Case Manager at 5% of the care total for each year.

31. Further, the plaintiff claims the need for a "Lead Personal Assistant" who would be someone to perform various managerial functions and this lead PA would not be one of the two carers rostered. The lead PA apparently provides administrative assistance in other cases and has been provided by the IWA in their plan which is in place at the moment. However, in the circumstances of Amy's care, I believe that the administrative work which is claimed for at 15 hours per week can be carried on by one of the day carers or the night carer who is awake. There will be adequate time when the plaintiff does not require caring as when she is asleep during the day or at night time for the administrative work to be carried out by one of the resident carers. In the circumstances, I do not believe it to be reasonable to allow the claim for a lead PA at 15 hours per week or at all.

32. I have accepted the plaintiff's claim for the number of carers as being reasonable. I have preferred the defendants' evidence in relation to the hours of the Case Manager and for the lack of requirements of a lead PA. I do not believe that the plaintiff's proposal is reasonable in this regard. I believe the issue of the hours of the Case Manager and the need or otherwise for a lead PA can be distinguished from the essence of the care regime for the plaintiff. The requirements of the hours for the Case Manager and the need for a PA to do administrative duties concern not so much the care of the plaintiff but the technical facilities that will be needed to back up or support the care and in this regard, I do not see the contentions on behalf of the plaintiff in this regard as being entirely reasonable.

33. I have been furnished with an agreed actuary's report which has given the different costs per annum and per week as provided from the reports of Ms. Noreen Roche on behalf of the plaintiff and Ms. Kinsella on behalf of the defendant. The cost per week for 2017 for Ms. Roche's full plan is €7,452 for 2017 and €7,375 per week from this year for the rest of the plaintiff's life. The difference between the two is that Ms. Roche provides for additional case management costs in the first year over and above the remainder of the plaintiff's life.

34. Taking Ms. Roche's figures, one must remove €390 per week which is the cost of the lead PA which I have not allowed and also removed the costs of the Case Manager as provided by Ms. Roche and substituted that as suggested by Ms. Kinsella. I therefore must first of all reduce Ms. Roche's costs by €17,000 per annum for the first year (€326.92 per week) and €13,000 per annum thereafter, (i.e. €250 per week). I must now add back the figures for the case manager on the basis of Ms. Kinsella's calculations.

35. Having deducted Ms. Roche's lead PA and case management hours, I will take Ms. Kinsella's figure which is €10,309.38 per annum but this is calculated on the basis of 5% of the remainder of the total. Accepting the 5% basis of the calculation, this is, of course, now 5% of Ms. Roche's net figures which are of course somewhat higher than Ms. Kinsella's figures. The net figures for the first year is €6,735.08 and 5% of that is €336.75 and accordingly, the total costing for the first year is €7,071.83. The net figures after the deductions for all subsequent years is also €6,735.08 and 5% of this figure is also naturally €336.75, and accordingly, the weekly figure for one year's time for the rest of the plaintiff's life is also €7,071.83.

Life Expectancy

36. The second matter I decide is as to how many more years the plaintiff will live. This is of course a very difficult problem and as a matter of virtual certainty any figure that I arrive at will be wrong. Should the plaintiff not survive for as long as I calculate then of course there will be a problem of over compensation "for the benefit of Amy's family". Should Amy survive longer then of course there will be under compensation and the money provided for Amy's future care will run out. The fact that the latter outcome is of course far more detrimental to the party in respect of which I have miscalculated, is no reason for me to depart from my obligation to decide the matter of Amy's future in accordance with the evidence.

37. I had the benefit of hearing the evidence and reading the reports of two excellent witnesses who are expert in the field, Professor Nicola H. Ryall, associate professor and consultant in rehabilitation medicine, on behalf of the defendant and Dr. Christina J. S. Williams, who is a consultant in rehabilitative medicine in respect of children and adults who are profoundly compromised.

38. Whereas both of the experts adopted a different methodology and arrived at a different conclusion both experts acknowledged the expertise of the other and both agreed that while the statistics were important as a guide the most important factor was clinical judgment. Each witness also acknowledged the clinical expertise of the other.

39. Irish life expectancy tables are historic, British life expectancy tables look forward into the future. There are, from my point of view difficulties in both approaches. As Professor Ryall stated "mean average" life expectancy of a cohort is most accurate in that it requires everyone in the cohort to have died and then to indicate what the life expectancy has been. (Subject to a discussion as to whether or not the figure should be adjusted looking forward or be entirely retrospective). Median life expectancy are most commonly used in cerebral palsy literature as these represent estimates of additional years before 50% of the surviving children in a cohort die. This is the age to which on the balance of probability a person will have lived. Median life expectancy does not of course measure the individual's actual survival time which may be much shorter or longer than the median life expectancy. Whereas all of the averages point to a considerably shortened life expectancy for persons in the plaintiff's condition. The average figures, of course, include persons who had died in their infancy or in the case of fifteen year olds, persons who died within a year or so and Dr. Williams indicated that at least one of her patients was in his 90s.

40. The largest cohort in which studies have been done was from California and evidence was given by both of the experts that recent studies have contra to what might be expected indicated that cerebral palsy sufferers have not had an expanding life expectancy in line with the rest of the population. It also seems, however, that the statistics in California in this regard, refer to persons with standard care rather than what might be described as excellent care.

41. The general life expectancy in California in 2010 (when the study was undertaken) was higher than in Ireland in 2010 but the general life expectancy in Ireland in 2017 has increased and I take it from the evidence of Professor Ryall that there is little practical difference between the general life expectancy of the population in Ireland today and that in California in 2010.

42. The study in California takes sufferers from cerebral palsy and grades them in accordance with the level of their disability whether they cannot lift their head, as in Amy's case, and how they are fed whether tube fed or fed orally and the life expectancy of members of the cohort are then compared to the life expectancy of the general population.

43. From those figures a fifteen year old in 2010 in California, a person like Amy who was unable to lift her head and be fed by others at the age of fifteen would have had an additional life expectancy of eighteen years. These figures were of course retrospective and it means that 50% of the cohort who were fifteen years old eighteen years prior to 2010 i.e. 1992 would have died by 2010. These individuals would of course have been born in 1977.

44. Even accepting that the future life expectancy of persons with cerebral palsy is not expanding in line with the general population or at all, to compare as a matter of probability what the plaintiff's future will be based upon studies of persons who were born in 1977, is of doubtful value.

45. I will refer to Professor Ryall's report:

"4.8..2.3 If one applies the second series of data published for those aged fifteen years and older, then Amy being unable to lift her head and being fed by others at age fifteen would have had an average life expectancy of eighteen additional years or 27% of that expected compared with the general population...using this data for a female aged nineteen years old at next birthday and assuming a linear relationship, Amy would be expected to live an average 29.6% of that of the normal population. Using Irish CSO 2010-2012 life tables – the most recent – the average life expectancy of a nineteen year old female is 64.19 years. Applying a 29.6% life expectancy implies a further nineteen year life expectancy approximately being, bringing her to the age of 38 years old, a significantly different figure from that in (para.)4.5.2.4, highlighting the difficulty in trying to predict life expectancy at all, especially in some with such significant co morbidity. It should be noted that the figures quoted in this study do not include the independent risk factors of epilepsy or obstructive sleep apnoea. Unfortunately there are no clear figures one can use to know by how much life expectancy should be reduced to consider these additional risk factors although some reduction should be allowed for.

4.8.24 I previously estimated that she would survive to about age 27 years old, a figure between these figures I quoted above...In reality it is very difficult to know how long Amy might survive as she has significant risk factors for acute and serious deterioration. On the positive side she appears to have survived reasonably well in terms of not having frequent recurrent chest infections(subject to information on her respiratory status in January 2016), although this is probably in part because she is on antibiotics for her urinary tract and is on lifetime oxygen, and appears to have reasonably well controlled epilepsy. On the negative side, she is not anaesthetically fit for procedures that would require sedation which, while not specifying her respiratory impairments, as a statement indicates the precariousness of her respiratory function, although I believe this is an overwhelming negative factor to be very poor prognostically and not consistent with a further nineteen years survival. I am still of the opinion therefore that I expect Amy will on average survive to her mid-late twenties but it is improbable that she will survive to thirty years of age."

46. Amy was born in 1998 over twenty years after the cohort who would have made the sample in California and accordingly it is not the advances or otherwise in life expectancy in the future that is relevant but any advances between 1977 and 1998. There was no evidence of what those advances might have been. Amy has survived those initial years of life which pose most danger for cerebral palsy sufferers and early mortality would go into create the "average" figures. Accordingly, I am not satisfied that approaching the problem on the basis of past averages is necessarily useful.

47. However the prospective approach adopted by Dr. Williams is also not really satisfactory. We cannot tell what the future will bring and utilising the California figures for the cohort which is closest to Amy's situation and then utilising these figures as a percentage of the normal life expectancy in California and transferring this percentage figure as a percentage of the prospective British life expectancy figures to obtain a baseline figure for the plaintiff's cohort is, I believe, far too problematic also. Dr. Williams utilised the Californian figures and determined that the added life for someone in the plaintiff's condition (a person who cannot lift her head and is fed by others) would be an additional eighteen to nineteen years. Dr. Williams also referred to the possibility that the plaintiff will be tube fed which has certain advantages but might reduce her life expectancy.

48. From the foregoing it will be seen that utilising her figures Prof. Ryall puts the baseline of additional years Amy as being nineteen. This is a very similar figure to that arrived at by Dr. Williams, though by a different route.

49. Dr. Williams' opinion is that because of the adverse consequences of the plaintiff's particular condition, the plaintiff's future life expectancy is between twelve and fourteen years. Professor Ryall ultimately concluded is that it is unlikely that the plaintiff would survive for a further ten years and most likely that her average life expectancy will be a further six to eight years.

50. Both Professor Ryall and Dr. Williams then agree that the plaintiff's life expectancy is lower than the average of persons in her cohort. Also, as stated both experts agree that the life expectancy figures, however, obtained should be used as a guide. I agree

with both experts that ultimately that the conclusion as to the plaintiff's expected extra years will be one based on clinical judgment rather than statistics.

51. Accordingly, the difference between the experts which in theory centres around whether the figures should be historic or prospective, in fact, centres on what reductions from the "averages" in the cohort should be made to take account of Amy's particular difficulties. Both experts come to a similar baseline in respect of the cohort closest to Amy's situation of approximately eighteen years. From a practical point of view it is the clinical opinion of each expert that is different.

52. Both experts agree that the plaintiff's life expectancy is likely to be lower than the average in her cohort as a result of her marked scoliosis. Dr. Williams referring to the clinical situation puts a figure of twelve to fourteen years extra life carrying the plaintiff to her early 30s. Prof. Ryall reduces the plaintiff's likely further life between a further six to eight years.

53. Given the plaintiff's survival to date and accepting that, as a matter of probability, she is not going to survive as long as others in her cohort I do not see the logic of how Professor Ryall can reduce the nineteen year life expectancy of her cohort to a just six to eight years. In other words, Prof. Ryall concludes that Amy's expectancy is less than 40% of the cohort to which she most resembles. It is undoubtedly the case that the evidence from both experts is that her life expectancy would be lower than the eighteen to nineteen years however in addition to the factors tending to reduce her life expectancy she will be for the rest of her life under excellent and not standard care. The possibility of a choking incident however she is fed must be reduced as the likelihood is that carers will be on hand to deal with emergencies that would otherwise be more significant. Furthermore the figures from California relate to the persons with necessary or average care rather than extra care and there are no figures as far as I understand dealing with persons with excellent care.

54. I therefore, while I have reservations about any of the methods of calculation suggested, prefer the clinical view of Dr. Williams and will find the plaintiff will as a matter of probability have an additional twelve to fourteen years of life and I will take the average of those figures of thirteen as being the likely additional years for Amy's life.

Conclusions

55. Taking the actuaries figures and there is no reason for any deductions other than the ones I have made, the capital value of Amy's care for 2017 is €360,663.33 (i.e. €7,071.83, the weekly figure multiplied by 51) and the capital value for the rest of Amy's life as I have allowed is €3,981,440.29 (i.e. €7071.83, the weekly figure multiplied by 563), the total of these figures is €4,342,073.62.

56. The figures are calculated upon the actuarial multiplier allowed by the Court of Appeal in the Gill Russell case.

57. The sum of €4,342,073.62 is fair and reasonable to both sides and the plaintiff is entitled to judgment in that sum.